A feminist investigation into the reasons for attrition of women doctors from the South African medical profession and practice: exploring the case of UCT medical school between 1996 and 2005

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Dissertation presented for the degree of Doctor of Philosophy in the Department of Political Science at Stellenbosch University

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March 2011

DECLARATION

By submitting this dissertation, I declare that the entirety of the work contained therein is my own, original work, that I am the owner of the copyright thereof (unless to the extent explicitly otherwise stated) and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

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SUMMARY

This dissertation aims to establish the reasons underlying possible gendered attrition trends in the South African medical profession between 1996 and 2005. Noting the international trend of the increasing feminisation of medical education and the profession, the dissertation illustrates that this is also a reality in our national context, and frames this phenomenon as being plagued by difficulties very similar to those encountered in other traditionally male-dominated fields. The particular relevance for further research and debate is illustrated through the noticed discrepancy between women's representation in enrolment and graduation at medical schools in South Africa, and their representation in the profession itself. The decision to approach this investigation from a feminist-organisational perspective was based on the fact that this would not only be a novel, but indeed also an appropriate, research approach to the study of gendered trends in medical education and the profession within the South African context.

The research project thus sets out three main objectives relevant to this investigation. Objective 1 aims to establish the sex composition of the cohort of medical graduates that have not entered, or decided to exit, the medical profession. In terms of this objective, findings show an increasing rate of progression of men into the profession, accompanied by a decreasing rate of progression of women into the profession.

Objective 2 attempts to establish the reasons behind sex trends in South African medical schools and in the profession. Thus, in an effort to comprehensively investigate the issues underlying attrition, I employ a mixed-methods approach to the primary data collection and analysis. Firstly, the findings show, through a quantitative analysis of the interview data, that this sample of women felt that both institutional and societal factors influenced a women doctor's propensity to remain in the profession. Secondly, it is established that whether these respondents felt that they had appropriate role models in the profession was the most important factor in terms of their identification with, and propensity to stay in, the profession. Thirdly, it was also found that the respondents felt strongly that the culture of the medical profession impacts negatively on a woman doctor's propensity to stay in

the profession, but similar to the findings of other studies, this does not bring us closer to an understanding of what that culture constitutes. Thus, lastly, through a qualitative analysis of the interview data I find that the respondents clearly recognise the presence of a gendered substructure in medicine in the South African context, and identify some elements of this structure as most commonly linked to attrition.

Objective 3, based on the outcomes of the previous objectives, aims to provide recommendations for the retention of medical doctors in general, and women doctors specifically, in the South African context. It concludes that flexibility[1] in the medical profession is paramount to the retention of doctors, and women doctors specifically. This is a difficult challenge to overcome, as central values such as the importance of continuity of care in the medical profession would suggest that providing increased flexibility to medical doctors would impact negatively on patient care. However, it appears that there is increasing recognition amongst scholars, policy makers and medical practitioners themselves of the importance of acknowledging alternative work patterns.

On the basis of the outcomes of my research, it is clear that the national gender attrition trends are a cause for concern in terms of resourcing the National Health System against the backdrop of a widely acknowledged shortage of doctors in South Africa and elsewhere. If women doctors do not progress effectively into the system, but form the majority of graduates, this is a tragic loss, as well as a waste of resources during training. This aspect also has policy implications, because it appears that the government, in trying to retain doctors, has increasingly turned to measures that are restrictive (compulsory community service, restrictions on foreign doctors), rather than focusing on ways in which to make doctors want to stay. The dissertation thus closes by suggesting two main areas within which these findings and recommendations would be employed most usefully: 1) medical schools/ training/education, and 2) the medical profession/culture.

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[1] In terms of, for example, providing greater access to part-time posts, part-time specialisation, flexi-time working arrangements, etc.

OPSOMMING

Hierdie proefskrif het ten doel om die redes onderliggende aan geslagsverskille in die verlies van vroue uit die Suid-Afrikaanse mediese beroep tussen 1996 en 2005 vas te stel. Die internasionale tendens van die toenemende vervrouliking van mediese opleiding en die mediese beroep wys dat dit ook 'n realiteit in die Suid-Afrikaanse nasionale konteks is. Hierdie verskynsel word veroorsaak deur probleme soortgelyk aan dié wat in ander, tradisioneel manlik gedomineerde beroepe ondervind word. Die spesifieke relevansie vir verdere navorsing en debat word geïllustreer deur die aangetoonde proporsionele verskil tussen vroue se inskrywing en graduering in mediese skole in Suid-Afrika, en hul verteenwoordiging in die beroep self.

Die besluit om hierdie ondersoek uit 'n feministies-organisatoriese perspektief te benader, is nie net omdat dit 'n oorspronklike benadering sou wees nie, maar ook gepas vir 'n studie van geslagstendense in die mediese onderwys en professie binne die Suid-Afrikaans konteks.

Die navorsingsprojek bevestig dus drie hoofdoelstellings wat relevant tot hierdie ondersoek is. Doelstelling een probeer om die geslagsamestelling van die kohort van mediese gegradueerdes wat nie tot die beroep toegetree het nie, of dié wat besluit het om die beroep te verlaat, te bepaal. Daar is bevind dat daar 'n verhoogde koers van vordering van mans tot die beroep is, gepaardgaande met 'n verlaagde koers van vordering van vroue tot die beroep.

Doelstelling twee probeer om die redes onderliggende aan die geslagstendense in die mediese skool en die beroep vas te stel. Dus, om 'n omvattende ondersoek te doen om uit te vind wat onderliggend aan die verlies is, het ek van 'n gemengde metode benadering tot data insameling en analise gebruik gemaak. Die resultate van die onderhoud data wys dat hierdie vroue voel dat beide institusionele en sosiale faktore 'n vroulike dokter se besluit om in die beroep te bly, beïnvloed. Tweedens is daar vasgestel dat geskikte rolmodelle in die beroep die belangrikste faktor is in vroue se identifikasie met die beroep, en hulle besluit om in die beroep te bly. Derdens is gevind dat die respondente baie sterk voel dat

die kultuur van die mediese beroep 'n negatiewe impak het op 'n vroulike dokter se besluit om in die beroep te bly, maar soos ook in ander studies bevind is, bring dit ons nie nader aan 'n begrip van die aard van die kultuur nie. Ten slotte is daar dus met die onderhoud data gevind dat die respondente duidelik bewus is van die teenwoordigheid van 'n geslagsubstruktuur in die mediese beroep in Suid-Afrika. Ek identifiseer ook sekere elemente van hierdie struktuur wat bydra tot die verlies van vroulike dokters uit die mediese beroep.

Doelstelling drie, gebaseer op die uitkomste van die vorige doelstellings, probeer om aanbevelings te maak vir die behoud van mediese dokters in die algemeen, en vroulike dokters spesifiek. Die gevolgtrekking is dat buigsaamheid in die werkskultuur van die mediese beroep van kardinale belang is vir die behoud van dokters in die algemeen, en vroulike dokters meer spesifiek. Dit is 'n moeilike uitdaging om te oorkom omdat sentrale waardes, soos die belang van kontinuïteit van versorging in die beroep, persepsies laat ontstaan dat meer buigsaamheid in werksomstandighede 'n negatiewe impak op die versorging van pasiënte sou hê. Dit blyk egter ook dat daar 'n toenemende erkenning is deur akademici, beleidsontwerpers en mediese praktisyns self van die belang van alternatiewe werkspatrone.

Gebaseer op die resultate van die ondersoek is dit duidelik dat die nasionale geslagsverliestendense 'n rede tot kommer vir die verskaffing van menslike hulpbronne vir die nasionale gesondheidstelsel is, veral teen die agtergrond van 'n algemeen erkende tekort aan dokters in Suid-Afrika. As vroulike dokters nie effektief in die stelsel opgeneem word nie, hoewel hulle die meerderheid van gegradueerdes is, is dit 'n tragiese verlies en vermorsing van hulpbronne wat vir opleiding gebruik is. Dit het ook implikasies vir beleid omdat dit blyk dat die Suid-Afrikaanse regering, in sy pogings om dokters te behou, meermale maatreëls gebruik wat perke stel (verpligte gemeenskapsdiens, beperkings vir buitelandse dokters, ens.), waar hulle eerder behoort te fokus op maniere om dokters in Suid-Afrika te hou. Ten slotte stel die proefskrif twee hoofareas voor waarin hierdie bevindings en aanbevelings aangewend kan word: 1) mediese skole/opleiding/onderwys, en 2) die mediese beroep/kultuur.

ACKNOWLEDGEMENTS

Although difficult to single out a few, because so many have contributed to the completion of this dissertation to varying degrees, and mostly unknowingly, some deserve a more public acknowledgement. I would like to express my most sincere gratitude to and acknowledge my promoter, Professor Amanda Gouws, for her steadfast guidance throughout this process. I was not always confident, but your calm confidence and insightful remarks inspired me to have belief in myself. I would also like to thank my co-promoter, Professor Marietjie de Villiers, for her support, especially at the start of this process, as well as for her helpful comments and insights on earlier drafts. It is also necessary to thank the three external reviewers for very comprehensive and helpful feedback on the previous draft of this dissertation.

It would be inappropriate not to acknowledge the contributions made by the interviewees. Thank you all for being so generous with your very limited time, as well as being so open and candid about the difficulties you have all experienced in trying to navigate and juggle the responsibilities of combining a very demanding career with some sort of quality of personal life.

I also have to give thanks to and acknowledge my immediate family. Mom, Dad, Earl and Cailean: through your love and unending support I have been given the very best foundations upon which to build my dreams. I love you all dearly. Then to the people that have to endure me for the most part of every day(and do so mostly with love): Clayton, Nicholas, Matthew and Aunty Marie. I am not me without any of you, and undoubtedly I would not have been able to achieve any of this without knowing that I have you to come home to.

Lord God, how do I put into words the gratitude I have for being able to get up every morning, have the energy and strength to make it through the day, and have countless blessings throughout this journey to show me that indeed You are here with me every step of the way? All glory and praise must go to You.

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AAMC	Association of American Medical Colleges
AIDS	Acquired immunodeficiency syndrome
ANC	African National Congress
BMA	British Medical Association
CEJA	Council on Ethical and Judicial Affairs
CIDA	Canadian International Development Agency
DENOSA	Democratic Nursing Organisation of South Africa
DoE	Department of Education
DoH	Department of Health
DoL	Department of Labour
FHS	Faculty of Health Sciences
GDP	Gross domestic product
GP	General practitioner
HEMIS	Higher Education Management Information System
HIV	Human immunodeficiency virus
HPCSA	Health Professions Council of South Africa
HSRC	Human Sciences Research Council
HST	Health Systems Trust
HWI	Historically white institution
ICMP	Impact of the culture of the medical profession
LFS	Labour Force Survey
MBChB	Bachelor of Medicine and Bachelor of Surgery
MEDUNSA	Medical University of South Africa
NHIS	National Health Insurance Scheme
PHC	Public health care
SA	South Africa
SANC	South African Nursing Council
SAPPF	South African Private Practitioners Forum
SASMW	South African Society of Medical Women

SPSS	Statistical Package for Social Sciences
STDs	Sexually transmitted diseases
TB	Tuberculosis
TRC	Truth and Reconciliation Commission
UCT	University of Cape Town
UNITRA	University of Transkei

CHAPTER 1

INTRODUCTION: WHY CONSIDER WOMEN IN THE MEDICAL PROFESSION IN SOUTH AFRICA?

1.1   BACKGROUND AND MOTIVATION FOR STUDY

Women are still the minority compared to men in the South African medical profession, despite equality in terms of access to educational opportunities, training and advancement in the profession, and the drastic increases in female medical student enrolment and graduation during the last decade. In 2006 it was reported that, in South Africa, "men still dominate the profession forming nearly three quarters of the number of registered practitioners" (Breier & Wildschut, 2006: 47). As recently as 2008, the figure changed marginally to men constituting 69% of the medical profession in South Africa (Health Professions Council of South Africa [HPCSA] register, 2008).

Women's increased entry into the public sphere has been a reality for quite a period of time. Their entry into the medical profession, however, has been plagued by difficulties, which is quite characteristic of any traditionally male-dominated field increasingly being feminised (Reskin & Roos, 1990; Young, Leese & Sibbald, 2001; Adams, 2005). The fact that social institutions "continue to produce gendered outcomes which can be constraining or disadvantageous for women means that we must investigate these institutions and organizations from a feminist perspective" (Goetz, 1997: 1). Thus, a study investigating women's experiences in becoming doctors and entering the profession, from a feminist-organisational approach, is important for establishing the reasons behind emerging gendered trends observed in South African medical school and professional data (Wildschut, 2008). Based on the schools of thought and ideologies central to feminist research, a feminist-organisational approach essentially searches for causes and/or consequences of taken-for-granted practices, beliefs and attitudes that create and perpetuate systems of relative advantage and disadvantage within organisations (Code, 2003).

Widely acknowledged as it is, the feminisation of the medical profession has not been theorised very extensively in South Africa. Due to the country's specific racial legacy it is understandable that many studies concentrated rather on the transformation debates brought about by the changing racial profile of students during the last decade, but also the curriculum/teaching shift to problem-based learning and primary health care (Zwi, Zwarenstein, Tollman & Sanders, 1994; De Villiers & De Villiers, 1999; Sanders, Chopra, Lehmann & Heywood, 2001; Kent & Gibbs, 2004; Karim, 2004; Mclean, 2004; Iputo & Kwizera, 2005; Breier, 2006).

Studies that have considered the feminisation of the profession in SA have been focused largely on establishing the quantitative and historical profile of women's entry into the profession (Barlow, 1983; Walker, 1997a, 1997b; Brink, Bradshaw, Benade & Heath, 1991; Hay & Jama, 2004). There are some studies that have moved beyond just a quantitative analysis, considering important issues such as discrimination against women doctors (Unterhalter, 1985), and the drop out of women doctors (Saxe & Van Niekerk, 1979). There are more recent studies that extensively consider the debates surrounding the impact of gender (Wynchank, nd; Walker, 2003, 2005) and race (Walker, 2005; London et al, 2008) on the profession. I would situate my analysis in this study as beyond just the quantitative profiling of the profession; rather, it is an in-depth investigation into the societal and institutional factors underlying gendered outcomes and trends in medical education and the profession in SA. Although the study will focus on the gender-related factors influencing the documented trends, the analysis will consider the changing socio-cultural, political and professional context (Breier & Wildschut, 2006).

1.2   THE SOUTH AFRICAN MEDICAL CONTEXT

It is important here to present a brief description of the history of the medical profession in South Africa in order to contextualise the relevance of this study to the broader profession. The relevance of a consideration of gender in the South African medical profession is underscored by the nature of medical professionalisation in South Africa, which is deeply gendered and racialised. This will be elaborated upon further in an

overview of women's entrance into the medical profession, to follow later. However, what is important to note here is that the gender inequality in the medical profession is reflective of the much wider-spread institutional inequality that underlies the South African health system in general.

As recognised in Breier and Wildschut (2006: 9),

> "the major consideration in any overview of the medical profession in South Africa at the start of the 21st century must surely be the skewed distribution of health resources in the country. This defining feature of the professional milieu is reflected in the professional labour market where there are gross imbalances….".

Thus, the history of the medical profession in South Africa is one of great inequality, not only in the provision of health care for its citizens, but reflected in the skewed distribution (public/private, rural/urban, etc.) of healthcare providers, especially doctors.

The history of the medical profession, and consequently the nature of the profession in South Africa today, is very particularly shaped by the impact of the apartheid system, as well as by the overwhelming "patriarchal structures of a largely colonial society" (Walker, 1997a: 1509). In reviewing this history, it is very difficult to ignore that the systems of medical professionalisation, colonialism, patriarchy and politics were intertwined, and thus "there is little doubt that medical politics were deeply linked to and shaped by more general colonial politics in South Africa and the rapidly changing social and economic relations in the first two decades of this century" (Walker, 1997a: 1509). It is not surprising that the issues in these systems are intertwined. Not only was the country undergoing political changes, but these happened at the same that that the medical profession was attempting to define itself organisationally, legally and politically (Walker, 1997a).

1.2.1 Circumstances during apartheid

To put South Africa's current situation into context, the University of Cape Town's (UCT) Faculty of Health Sciences (FHS) truth and reconciliation (TRC) report (FHS, 2002: 1) notes that

> "post-apartheid South Africa is emerging from decades of systemic discrimination that severely affected every aspect of civil society, including the health sector. Testimonies to the Truth and Reconciliation Commission (TRC) special hearings on the health sector in June 1997 highlighted the widespread and systematic allegiance of health professionals to apartheid ideology".

It is thus not surprising that our government is struggling to eliminate inequality in our national healthcare system that has, over many years, been supported and reinforced by other systems within the social and political realm. As noted in the introduction to the African National Congress's (ANC) 1994 *National Health Plan* (ANC, 1994):

> "the South African government, through its apartheid policies, developed a health care system which was sustained through the years by the promulgation of racist legislation and the creation of institutions such as political and statutory bodies for the control of the health care professions and facilities. These institutions and facilities were built and managed with the specific aim of sustaining racial segregation and discrimination in health care".

Essentially, the apartheid government established a

> "homeland system in which each of the four black so-called 'independent' states and six self-governing states had autonomous health departments. Health services were further fragmented by the introduction of three racially based Houses of Parliament in 1983, which resulted in 14 health ministers in the country, each administering an independent health service" (Hunt 1991, cited in Hall & Erasmus, 2003: 524).

So, although quite a large percentage of GDP (8.5%) was being spent on health care before 1994, the distribution of this money was highly fragmented across the 14 health

ministries (Breier & Wildschut, 2006). Furthermore, the focus of healthcare provision was on urban, high-technology hospital treatment, which was not based on health need in specific areas.

Thus, in 1994, the recently established democratic government inherited a health system in which the majority of the South African population had inadequate access to basic health services, clean water and sanitation, and where 53% lived in poverty-stricken rural areas (of which women and children were amongst the most vulnerable groups). Furthermore, "the infant, under-five and maternal mortality rates were all much higher than could be expected of a country with South Africa's level of income" (Breier & Wildschut, 2006: 9). This situation was further exacerbated, firstly, by the impact of the HIV/AIDS pandemic, and later by the growing prevalence of other diseases, such as TB, STDs (such as syphilis and gonorrhoea) and other poverty-related illnesses (such as malaria).

Although race and gender have both had a profound impact on medical professionalisation in South Africa, these will be elaborated on later, in the review of the relevant literature on women's entrance into the medical profession in South Africa in Chapter 2.

1.2.2   Circumstances after the advent of democracy

Since 1994, the government of the country has been focusing on creating a less fragmented health system with simpler regulatory systems. The first major policy imperatives for change were contained in the 1994 *National Health Plan* (ANC, 1994), but considerably strengthened in the *White Paper for the Transformation of the Health System in South Africa,* published in 1997 (DoH, 1997). This document is the main driver for rectifying the racial, gender and regional disparities in the South African health system. As the preface of this policy document summarises:

"we intend to decentralise management of health services, with emphasis on the district health system - increase access to services by making primary health care available to all our citizens; ensure the availability of safe, good quality essential drugs in health facilities; and rationalise health financing through budget reprioritisation. Furthermore, the development of a National Health Information System will facilitate health planning and management, and strengthen disease prevention and health promotion in areas such as HIV/AIDS, STDs and maternal, child and women's health".

However, a glaring gap in this introduction is the silence on the necessary health human resources and facilities infrastructure that would need to underpin these changes. Although mentioned in later sections of the policy, one would need to consider whether this omission signals a lack of prioritisation of these very important factors.

Hall and Erasmus (2003) summarise the most important interventions put in motion by the Department of Health since the advent of democracy:

- *Streamlining of regulatory systems:* For example, the nursing profession is now regulated by only two bodies, the Democratic Nursing Organisation of South Africa (DENOSA) and the South African Nursing Council (SANC), whereas previously it was characterised by fragmentation and racial separation.
- *Addressing of regional imbalances*: The elimination of separate health departments aimed to decrease wasted limited financial resources, improve poor infrastructure, and attend to the lack of facilities and address instances of poor equipment and a shortage of personnel in the former homelands.
- *Promotion of equality in terms of race and access to training:* Various measures have been put in place to upgrade and enhance growth in the output of black candidates.
- *Shifting of focus to primary community-based health care* as well as the tenets of *holistic care*, with *emphasis on certain diseases such as TB and HIV/AIDS*.

The government has made progress towards developing a more equitable national health system and addressing the aforementioned objectives, but most problems are difficult to eradicate. Kautzky & Tollman (2008: 17) have noted that

"despite over a decade of structural reform and genuine commitment to achieving 'Health for All', a series of obstacles continues to limit the full implementation of Primary Health Care today. These include: the HIV and AIDS pandemic; health worker shortages and inequities in resource distribution; shortcomings of political, public sector and medical / health leadership; and a complex and protracted health transition."

Thus, amidst the achievement of considerable transformation in both medical education and the profession, as well as policy improvements, the challenges plaguing the profession at present are those associated with: the struggling public health system, the HIV/AIDS and TB pandemics, the shortage of medical practitioners, exacerbated by the medical brain drain, and the continuing public/private and urban/rural divides.

1.2.2.1 The struggling public health system

Arguably, the entire public health system is struggling. Some people assert that it is on the verge of collapse, due to a myriad of problems. It is observed that the biggest problem is its failure "to meet the health care needs of citizens and its failure to use scarce public funding efficiently and appropriately to improve accessibility, quality of care and health outcomes" (Bateman, 2009: 563). Although Kautzky and Tollman (2008: 26) attribute the problems in the public sector mainly to a protracted and complex health transition, occurrences such as the recent (June 2009) doctors' strike indicates a sector in crisis. Highlighting the extent of the crisis is the estimation that roughly 41% of medical practitioners are in the public sector, serving roughly 85% of the population (Breier, 2009).

1.2.2.2 The HIV/AIDS and TB pandemics

Two major HSRC studies on the prevalence of HIV/AIDS estimated prevalence at 11.4% in 2002 (Shisana & Simbayi, 2002) and 10.8% in 2005 (Shisana et al, 2005). Other estimates are considerably higher. For instance, in a South African Regional Poverty Network (SARPN[2]) ranking of the top 20 sub-Saharan countries by HIV/AIDS

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[2] The Southern African Regional Poverty Network (SARPN) is a non-profit organisation that promotes debate and knowledge sharing on poverty reduction processes and experiences in Southern Africa. SARPN was originally established as a project of the Human Sciences Research Council in 2001. In 2004 it became

prevalence rate (at the end of 2005), South Africa ranked 6th (18.8%), with Swaziland ranking 1st with a prevalence rate of 33%, and Angola the lowest with a rate of 3.7%. The ability to provide efficient health care to all South African citizens is severely impacted on by both HIV/AIDS and TB. As noted elsewhere, the

> "HIV and AIDS pandemic contribute a wildcard to the structural transformation of the health system and implementation of primary health care (PHC)…. [continuing to place] immense strain on all aspects of the national health system, the pandemic exploited many of the persisting deficiencies in the coalescing health services" (Kautzky & Tollman, 2008: 25).

Coovadia et al (2009) also note the stress exerted on the public health system by the AIDS epidemic and restricted spending in the sector. The extent and pervasiveness of the HIV/AIDS pandemic was exacerbated by President Mandela's lack of prioritisation, and by President Mbeki's outright denial, of the disease, which not only led to confusion, but also delays in delivery. Thus, it is not surprising that many (Coovadia et al, 2009; Breier & Wildschut, 2006) point to the negative impact of poor stewardship, leadership and management of the South African health system.

1.2.2.3 The shortage of medical practitioners exacerbated by the medical brain drain

Breier and Wildschut (2006: 18) note that the "emigration of health professionals is one of the greatest concerns of the health authorities in this country". Although the medical brain drain is highly publicised, it is very difficult to ascertain the extent of emigration by medical practitioners. Problems in terms of the quantification of medical practitioner emigration have been explored elsewhere (Breier, 2009). Nonetheless, according to available Statistics South Africa (StatsSA) figures, it seems that we experienced a gain in physicians between 1989 and 1994, but that, by 2002, South Africa had experienced a net loss (Breier, 2009). Coovadia et al (2009) note that "in 2001 43% of doctors in community service, expressed their intention to leave South Africa to work overseas". Other international sources of data suggest a far more serious migration problem, estimating our loss at "about one quarter of all South African born doctors… working in

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an independent regional entity, supported by a board of 20 regional policy makers, academics and civil society members.

seven other countries around the world" (Clemens & Petterson, 2008, as cited in Breier, 2009: 119).

1.2.2.4 The continuing public/private and urban/rural divides

The South African health system continues to be burdened by inequalities. According to Monitor Group[3], based on an "independent rating of health care system performance across 43 countries, South Africa's public sector ranked 36th, [while] the private sector ranked among the top 7…" (Bateman, 2009: 562). Although, as noted before, our health system has undergone significant reform, it is plagued by continuing inequality of health care provision. "Significant disparities in the content, quality and coverage, of health services remain, despite over 15 years of profound structural transformation and reform" (Kautzky & Tollman, 2008: 26). McIntyre and Van Den Heever (2007: 74) have also noted that the greatest challenge for the South African health service "is that of the distribution of financial and human resources between the public and private health sectors relative to the population served by each sector".

1.2.3   The way forward

Arguably, the most significant piece of legislation to affect the provision of health services over the next decade would be the proposed National Health Insurance Scheme (NHIS). This is a concept that has been in debate since the early 1990s, and the first time that this proposal was incorporated formally into a policy-related document was in the ANC's *National Health Plan 1994*.

Although well-intentioned, and considered by many as necessary and imminent, the readiness of the South African Health System, and the public health sector specifically, for the challenges of effecting such a plan will continue to be a moot point. On the other hand, the implications for the private sector might also be problematic, as noted by Chris Archer, CEO of the South African Private Practitioners Forum (SAPPF),

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[3] This is a global, high-level strategy and management consulting firm offering a wide range of services, for example advisory services, capability building services, capital services, and case studies.

"unless managed with great caution and circumspection, this could easily result in 'a catastrophic loss' of much-needed skills and resources, which would actually worsen delivery. The collapse of the private sector would lead to significant emigration of both principal members of medical schemes and specialists, and with them would go any hope of a viable system of universal access".

Although this issue might not be seen as directly related to the focus of this study, it is important to consider the context within which medical doctors in South Africa have to practise, and the future challenges that lie ahead. Furthermore, it is important to consider other possible contributory factors to the phenomenon of attrition from the medical profession.

It is impossible to ignore the impact of this proposed system on the future of South African health care, and on its attempt at providing equal and quality health care to all its citizens. This is underscored by Kirby (2009), who states that

"the debate about healthcare in South Africa is to be reframed around the principles of the NHIS… and the inevitability of this system as the system to govern the provision of healthcare to all South Africans and the access of the healthcare system by all South Africans… into the future".

Given the history of inequality in the South African healthcare system, it is encouraging that, ambitious as it may be, such a system of provision is a possibility in the future. Hoosen, Jewkes, Barron, Sanders and McIntyre (2009: 1) succinctly summarise that

"the roots of a dysfunctional health system and the collision of the epidemics of communicable and non-communicable diseases in South Africa can be found in the policies from periods of the country's history, from colonial subjugation, apartheid dispossession, to the post-apartheid period".

However, as is evident from the previous discussion, this would entail very clear and comprehensive considerations of the required health human resources (also referred to as human resources for health), the available infrastructure and the health profile of our

citizens across geographical, racial and class divides. Within this national health system context, it is also important to address gender inequality in the medical profession. In the next section I will focus on situating the motivation for my study.

1.3 HSRC STUDY ON PROFESSIONS AND PROFESSIONAL EDUCATION

My interest in the research topic arose from involvement in a Human Sciences Research Council (HSRC) study on the profession and education of medical practitioners. This motivated my interest in the extension of the analysis to include a focus on gender in the profession. The broader Professions Project investigates the state of certain "professions and occupations and their educational programmes in relation to post-1994 policy goals, labour market supply and demand issues and changing local and international discourses of professionalism and professional education" (Breier, 2005). The project achieved this through conducting case studies on relevant professions (social workers, engineers, nurses and doctors). The specific study on medical practitioners involved two case studies, one of the University of Cape Town (UCT) medical school and the other of the former University of Transkei (UNITRA) medical school.

I chose UCT as the most appropriate case for the further analysis of gendered trends in medical education and the profession for two reasons. Firstly, it contained the highest proportion of female medical student enrolments and graduations during the period of investigation (1996 – 2005). I thought it appropriate to consider a 10-year period of data, mainly because of two reasons: 1) having access to enrolment and graduation data during this time period (through HEMIS), as well as cohort data for the UCT case study for the same period, and 2) the length of training for this degree has changed considerably between 1998 and mid-2004, and thus I considered it appropriate to have a period from 1996 to 2005 to present a fuller picture, capturing those who might have been in transition during the 2004 period. Secondly, when the national medical student data was disaggregated by sex and race, very significant differences between male and female medical student enrolments, graduations and specialisation preferences were found across all universities, but most prominently at UCT.

Thus, using UCT as my case study I aim to illuminate gendered trends in medical schools and, in addition, by using semi-structured interviews of three samples of individuals (the selection of which will be explained later), I aim to provide the reasons behind the attrition we have deduced from the preliminary analysis of the data for the wider Professions Project. It is appropriate here to briefly consider the South African medical training and professional context, firstly to contextualise the prospective analysis of the UCT medical school trends, and secondly to illustrate the sex[4] trends evident in the profession.

1.4   SA MEDICAL TRAINING CONTEXT

Table 1.1 indicates that, as shown by the international literature, the feminisation of medical schools is also experienced in our country. We notice an increase in female medical students, from 4 540 in 1996 to 4 760 in 2005, together with a concomitant decrease in male students, from 5 937 in 1996 to 3 723 in 2005. Put differently, we notice a 37.3% decrease in male medical student enrolment, accompanied by a 4.9% increase in female medical student enrolment over the same period.

Table 1.1: MBChB enrolments at all medical schools by sex, 1996, 1999 - 2005

Year	Males	%	Females	%	Total
1996	5 937	56.7%	4 540	43.3%	10 477
1999	4 118	50.3%	4 062	49.7%	8 180
2000	3 991	48.8%	4 187	51.2%	8 178
2001	4 099	47.9%	4 459	52.1%	8 558
2002	3 938	46.5%	4 536	53.5%	8 474
2003	3 875	45.4%	4 661	54.6%	8 536
2004	3 777	44.4%	4 722	55.6%	8 499
2005	3 723	43.9%	4 760	56.1%	8 483
% change[5]	-37.3%		4.9%		-19.03%

Source: South African Department of Education (DoE) HEMIS (1996 – 2005).

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[4] Sex refers to biological differences between persons (male and female), whereas gender describes the characteristics that a society or culture delineates on the basis of a person's biological sex (masculine or feminine). Gender is socially constructed, and it thus is more appropriate to refer to sex in presenting the quantitative data (discussed further in Chapter 2).
[5] *Percentage change* describes the change in values as a percentage/fraction of the old/original value. In this case it calculates the percentage change in values from the 1996 value to the 2005 value. This is different to calculating a *percentage point change* (also referred to as percentage difference), which would simply subtract the new percentage value in 2005 from the old percentage value in 1996.

Examining the next table in terms of female medical student representation, UCT clearly ranks first, with 49% in 1996 and 63% in 2005 of their MBChB enrolments being women. This is even higher than the national proportion of 43% in 1996 and 56% in 2005. While all universities had a minority of women medical students in 1996, only Medunsa had a female minority (43%) in 2005.

Table 1.2: MBChB enrolments at medical schools by institution and sex, 1996 and 2005

Institution	Male (%)			Female (%)		
	1996	2005	% point change	1996	2005	% point change
KwaZulu-Natal (Natal)[6]	56%	41%	-15%	44%	59%	15%
Cape Town	51%	37%	-14%	49%	63%	14%
Pretoria	53%	40%	-13%	47%	60%	13%
Stellenbosch	54%	42%	-12%	46%	58%	12%
Free State	59%	47%	-12%	41%	53%	12%
Witwatersrand	53%	42%	-11%	47%	58%	11%
Limpopo (Medunsa)	67%	57%	-10%	33%	43%	10%
Walter Sisulu (Transkei)	55%	48%	-7%	45%	52%	7%
All medical schools	56%	44%	-12%	44%	56%	12%

Source: South African Department of Education HEMIS (1996 and 2005)

Evaluating the overall increase in women at medical schools in South Africa (from 44% in 1996 to 56% in 2005), it is clear that feminisation has taken place at SA medical schools, with the trend being more pronounced at some institutions[7]. As illustrated in a consideration of percentage point changes, KwaZulu-Natal had the highest change in male and female proportions, while Transkei experienced the smallest change. Not only does national and international research on this topic point to the increasing enrolment of

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[6] The issue of the merger of tertiary institutions in South Africa was dealt with by using the new name of the university, and adding the former relevant institutional name (in brackets) to avoid confusion. Thus, some information might refer to times when the institution was named differently (data for the new merged university before 2005 is thus a combination of all relevant institutions' medical student data). The only institutions affected by this are Medunsa, which is now part of the University of Limpopo, the University of Natal, which is now part of the University of KwaZulu-Natal, and the University of Transkei, which is now part of Walter Sisulu University for Technology and Science.
[7] I would like to indicate here that, although we are interested specifically in women's experiences in this investigation, it is not sufficient to examine trends by sex only, because this might disguise gains or losses for specifically African, Indian, White or Coloured men and women. Thus, Chapter 4 will also consider the impact of race, but for the purposes of introduction, the tables in this chapter concentrate on illustrating mainly the sex trends in the national data.

women in medical schools, there also is literature suggesting that female students are starting to outperform males in medical schools[8].

Table 1.3: MBChB graduates at all medical schools by sex, 1996, 1999 – 2005

Year	Male	%	Female	%	Total	%
1996	792	53.5%	688	46.5%	1480	100%
1999	699	53.4%	610	46.6%	1309	100%
2000	577	51.0%	554	49.0%	1131	100%
2001	608	49.5%	621	50.5%	1229	100%
2002	618	51.0%	594	49.0%	1212	100%
2003	639	49.3%	657	50.7%	1296	100%
2004	629	45.0%	770	55.0%	1399	100%
2005	663	43.9%	848	56.1%	1511	100%
% change	-16.3%		23.3%		2.1%	

Source: South African Department of Education (DoE) HEMIS (1996, 1999 – 2005)

Table 1.3 also supports these findings. We see that women medical students have increased their proportional share of graduations (from 46.5% to 56.1%), as well as very significantly their numbers (from 688 in 1996 to 848 in 2005). Men have experienced a drop in numbers over the period (from 792 in 1996 to 663 in 2005), as well as a percentage decrease of 16.3 %.

Table 1.4: MBChB graduations at medical schools by institution and sex, 1996 and 2005

Institution	Male (%)			Female (%)		
	1996	2005	% point change	1996	2005	% point change
Free State	59%	40%	-19%	41%	60%	19%
Cape Town	50%	32%	-18%	50%	68%	18%
Walter Sisulu (Transkei)	67%	51%	-16%	33%	49%	16%
Limpopo (Medunsa)	72%	59%	-13%	28%	41%	13%
Pretoria	52%	43%	-9%	48%	57%	9%
Stellenbosch	54%	45%	-9%	46%	55%	9%
Witwatersrand	46%	41%	-5%	54%	59%	5%
KwaZulu-Natal (Natal)	42%	37%	-5%	58%	63%	5%
All medical schools	54%	44%	-10%	46%	56%	10%

Source: South African Department of Education HEMIS (1996 and 2005).

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[8] See Breier, 2005; Levinson & Lurie, 2004; Brink et al, 1991; Unterhalter, 1985; Hay & Jama, 2004; Burton & Wong, 2004; British Medical Association (BMA), 2004; Association of American Medical Colleges (AAMC), 2003.

Furthermore, Table 1.4 indicates that, similar to the trends in enrolment, against the backdrop of women's overall increases in graduation this trend is more pronounced at certain institutions. The University of the Free State experienced the biggest percentage point changes for males and females, with the smallest changes notes at KwaZulu-Natal.

It thus is quite clear that women have increased their representation in enrolments as well as in graduation, but whether this has translated into a concomitant increase in women doctors in medical practice is not clear. We now briefly consider the sex trends in the South African medical profession in an attempt to formulate an answer to this question.

1.5   SA MEDICAL PROFESSIONAL CONTEXT

In an effort to describe the South African medical profession, I obtained figures from the Health Professions Council of South Africa (HPCSA), which indicate a clear majority of male medical practitioners (69.2% in 2007).

Table 1.5: Registered medical practitioners by sex, 2002 – 2007

Year	Male		Female		Total	
	No	%	No	%	No	%
2002	21 881	73%	8 022	27%	29 903	100%
2003	22 066	72%	8 512	28%	30 578	100%
2004	22 305	71.5%	8 909	28.5%	31 214	100%
2005	22 750	71%	9 447	29%	32 198*	100%
2006	23 250	70%	9 966	30%	33 220*	100%
2007	23 762	69.2%	10 561	30.8%	34 323	100%
% change	9%		32%		15%	

Source: Health Professions Council of South Africa (HPCSA) (2002 – 2007)
*One person did not disclose his/her sex

Although it is important to acknowledge gains made over the period (men experiencing a proportional decrease from 73% in 2002 to 69.2% in 2007, and women having a proportional increase from 27% in 2002 to 30.8% in 2007), we do have to question whether these gains are sufficiently in line with the considerable gains at the enrolment and graduation levels.

Table 1.6: Registered medical practitioners and specialists by sex, 2004

Types	Year	Male		Female		Total	
		No	**%**	**No**	**%**	**No**	**%**
General Practitioners	2004	13121	67.7	6249	32.3	19370	100
Medical Specialists	2004	6796	82.1	1481	17.9	8277	100

Source: Health Professions Council of South Africa (HPCSA) (2004)

Moreover, although we will not be able to focus on specialisation trends in this study, Table 1.6 indicates that, when we consider that approximately 80% of medical specialist in 2004 were men (and these figures are not likely to have changed very significantly), it becomes evident that the more we explore the trends within the profession, the less favourable women's representation seems to be, despite recent progress[9].

1.6 CONSIDERING THE IMPLICATIONS OF TRENDS

Returning to the issue of women's entry into the profession, when crudely comparing graduation rates of SA medical students with HPCSA data on the number of newly registered medical practitioners per year, questions arise concerning the attrition of medical graduates, and a possible sex difference in this regard[10]. An investigation of the reasons behind gender trends in the medical school and profession thus became a central interest for me.

Against this backdrop, this study sets out to meet three objectives, of which the first attempts to *establish the sex distribution of the cohort of MBChB graduates not entering the SA medical profession*, and the second attempts to *establish the reasons for attrition of women doctors from the South African medical practice*. Taking the aforementioned into consideration, the third objective aims to *provide recommendations on the retention*

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[9] The difficulties experienced by women in certain medical specialisms, in academic medicine and in specific work/practice types is widely acknowledged (Tesch, Wood, Helwig & Nattinger, 1995; Deech, 2009).

[10] Deech (2009), for instance, notes in her analysis of UK medical student data, an attrition rate of women medical doctors that is higher in comparison to men and that remains fairly constant between junior and consultant level.

of women doctors specifically, and doctors in general[11]. This information could help to inform medical training and public policy in order to retain and create a more enabling environment for all doctors, but for women doctors more specifically. Such information can "inform and improve policies and programs, and is essential in ensuring that the different needs of both women and men are met" (Canadian International Development Agency, 2006).

In this chapter we have considered the background to and motivation for the study, and looked at why the specific case of UCT is best for further investigation. Chapter 2 will consider the relevant literature with regard to the issue of attrition of women medical doctors, as well as my conceptualisation of the theory that is relevant to, and which will inform, my investigation and analysis. Chapter 3 will consider the research methodology that was employed. Chapter 4 is essentially concerned with meeting Objective 1 of my study, which aims to establish the difference between the graduation rate of men and women medical students compared to their entry rates into the South African medical practice, between 1996 and 2005. Chapters 5 and 6 attempt to meet Objective 2 of the study, which seeks to establish and explain the reasons underlying the attrition trends of women doctors in the SA medical profession between 1996 and 2005, the former through a quantitative, and the latter through a qualitative, analysis of the interview data. Chapter 7 will conclude by considering the main findings of the previous chapters, and interpret these findings in terms of what this supports, refutes and/or contributes to the field of study.

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[11] This should also create a better understanding of why women are not advancing and/or entering certain specialisations and specific practice types at the same rate as their male counterparts.

CHAPTER 2

LITERATURE REVIEW AND CONCEPTUALISATION:

THE GENDERING OF MEDICINE

"It would have been difficult in the nineteenth century, as it remains today, to ignore the ways in which discussions about the nature of science were intricately gendered"
(Tuchman, 1999: 135).

2.1 INTRODUCTION

The increasing entry of women into medical education and the profession reflects changes in society at large: "(i) the emergence of women's rights issues; (ii) greater representation of women in the workforce; (iii) heightened expectations as a result of better education; and (iv) diminishing discrimination against women" (Hudson, Kane-Berman & Hickman, 1997: 1512). In this quote, Hudson et al (1997) highlight the myriad of factors impacting on women's entry into the medical profession, and illustrates that a comprehensive approach will be necessary to the study of women in the profession. Thus, in order for us to accurately understand and be able to comprehensively reflect on the state of and trends relating to women in the South African medical profession, we need to evaluate the literature that considers a variety of interrelated concepts and theory.

2.2 CONCEPTS AND CONCEPTUALISATION

Before we consider the relevant theory, we need to delineate the main concepts to be used, as well as their associated meaning within the context of this study. These concepts are listed below, each with a brief description.

- **Gender** should be understood as a social construction indicating what it means to be female or male. Contemporary uses of this term often "highlight practices, conflict, identity, power, and change" (Martin, 2004: 1249). It is thus not surprising that the **analysis of gender/gender analysis** will focus on making

"gender's invisible dynamics and complex intersections with other institutions more apparent" (Martin, 2004: 1249). A definition of gender would also have to take into account the related aspect of gender identity, often expressed as masculine or feminine (the important influences of these concepts on creating and/or maintaining a gendered construction of a profession will be elaborated on later). This distinction is important for feminist theory, because on it is premised the argument that gender is not a biological trait, and that the oppression of women under patriarchy is a cultural phenomenon not necessarily following from biological differentiation. The distinction allows feminists to criticise gender inequality while acknowledging some form of biological sexual difference

- **Feminism** used to refer to a historically specific political movement in the United States (US) and Europe, but since the 1890s it is most commonly used as a term for the belief in and advocacy of equal rights for women based on the idea of the equality of sexes and the eradication of discrimination. Following from this, a **feminist investigation/feminist research** centres and makes problematic women's diverse situations, as well as the institutions that frame those situations (Denzin & Lincoln, 2003).

- A **feminist-organisational approach,** following from the above description, entails a feminist investigation of a phenomenon with a keen consideration of the organisational institutions that underpin this phenomenon.

- **Attrition** *within medical school*: should be understood as the dropout of MBChB students anytime between enrolment and graduation.

- **Attrition** *from the medical profession*: for the purposes of this study should be understood as the dropout of MBChB graduates between graduation and registration as a medical practitioner in the category independent practice (General Practitioner, GP). Although attrition can also take place after registration as a practitioner, this kind of attrition is more difficult to measure, as a medical practitioner may still be registered, but not practising.

- A **medical practitioner** should be understood as a person registered as a medical practitioner in the category independent practice (GP), after the successful completion of an MBChB degree, an internship and community service[12].

Before moving to a very specific discussion and consideration of the theoretical debates concerning the possible attrition of women from the medical profession in South Africa, it is necessary to insert this investigation into the broader realm of relevant literature.

This firstly requires an explanation of the route (feminist-organisational approach) I felt was most appropriate to investigate this phenomenon (attrition of women medical doctors) in the South African medical profession. An obvious starting point would be a review of all literature investigating women in the medical profession or the feminisation of the medical profession. However, through conducting the literature review and trying to apply the available concepts as an explanation for certain gendered outcomes evident in the South African medical education and professional landscape, this literature was found lacking (the reasons behind this assertion will be elaborated on in Section 2.5, which considers the relevant micro-level theories and literature). Thus I draw on wider bodies of knowledge in which one can find relevant and useful theoretical concepts that will contribute to theorising the phenomenon. Although this act necessarily simplifies wide and complex bodies of knowledge, this is how I would describe and insert my debate into the relevant literature.

The reader will note that my investigation is framed within macro-level theories, such as theories on feminism, power and gender. I will also make use of constructs found in the more meso-level theories on gender in the professions and organisations, as well as micro-level literature that focuses specifically on the phenomenon of feminisation in professions, but also in the medical profession specifically (see Figure 2.1 below for a

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[12] Traditionally, the MBChB was a six-year degree, followed by a one-year internship. Since mid-2004, the regulations changed, allowing for a five-year degree with a two-year internship. Six-year degrees were permitted to continue with a single year's internship until mid-2006, when the requirement was fully instituted that all internship training would be of two years' duration (HPCSA, 2004). Furthermore, since 1998, newly graduated medical practitioners, pharmacists and dentists were required to undergo one year of paid community service after completion of their internship.

diagrammatic representation). Most importantly, examining the literature on feminisation allows us to use this phenomenon as the lens through which to explore and uncover the **gendered organisation of medicine** as a possible driver of attrition.

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│      │   Macro-level theories (feminism, power, gender)│      │
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│                            ↓                                │
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│      │ Meso-level theories (gender in the profession   │      │
│      │ and organisations)                              │      │
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│      │ Micro-level theories and literature (feminisation│      │
│      │ of medical schools and profession)              │      │
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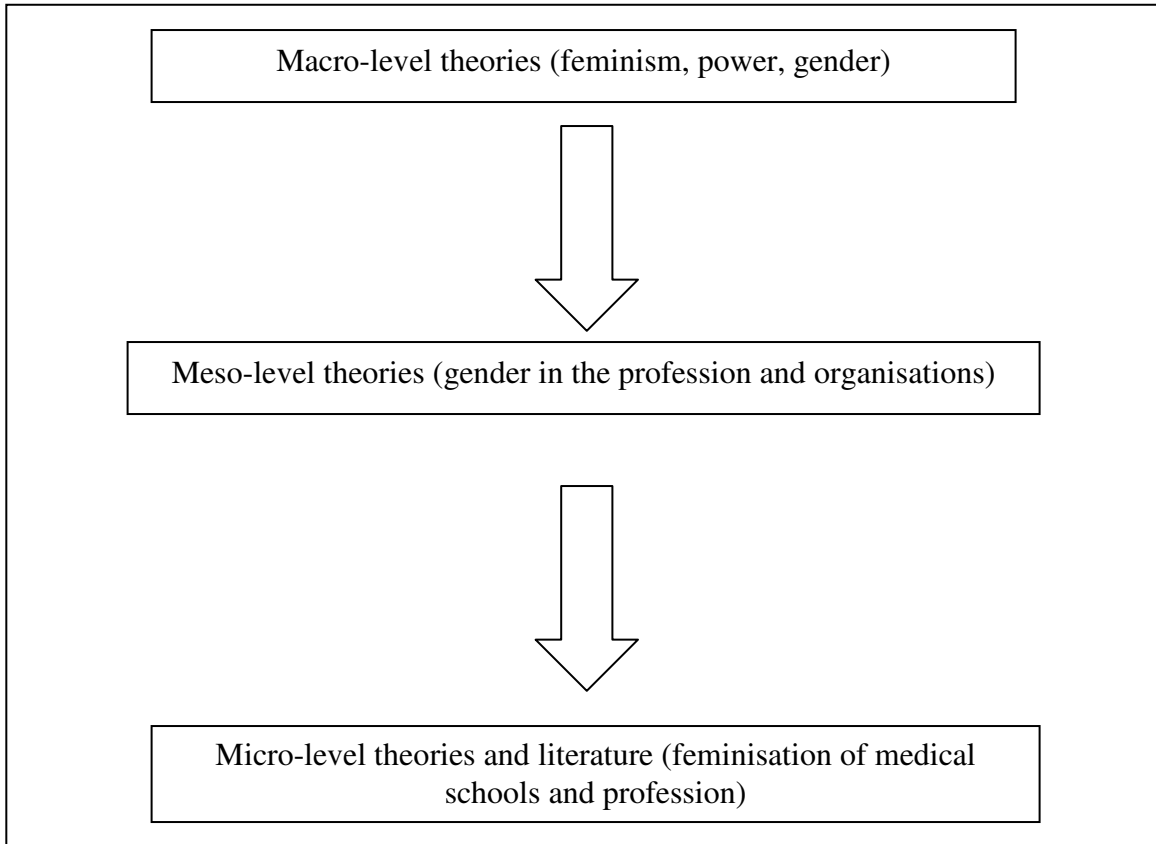
Figure 2.1: Diagrammatic representation of how the investigation for this study is framed

2.3 THE INFLUENCES OF MACRO-LEVEL THEORY

2.3.1 Feminism, gender and power

Relevant to a consideration of the gendering of professions (Messner, 1989; Mclean & Rozier, 2009; Frehill, 2004) and evident in phenomena such as closure (refer to discussion in Section 2.5.1), is the concepts of masculinity and femininity. Femininity and masculinity are conceptualised as gender identities, in which the former is characterised by traits such as caring and nurturing, whereas the latter would be characterised by traits such as athleticism and technical ability. Theorists in this area agree that these concepts are not static and are subject to historical context, changes in the global world, local and regional differences, race and class, etc. (Miller, Forest & Jurik, 2003; Connell & Messerschmidt, 2005; Mclean & Rozier, 2009[13]). What is important to recognize in any definition of gender, is that it will aim to prescribe an ideological perspective, but it is also fundamentally a set of practices.

The concept of masculinity has been theorised most extensively in the field of men's studies[14], although feminist accounts of patriarchy as well as sociological considerations of gender have undoubtedly contributed to this area. This research has contributed to a more comprehensive understanding of gender identity in various ways, but arguably, and most notably, in terms of a recognition of multiple femininities and masculinities, as well as the relational nature of these concepts. Relevant to our consideration of discrimination in the medical profession is the concept of hegemonic masculinity, which is "constructed in relation to women and to subordinated masculinities" (Connell, 1987, cited in Connell & Messerschmidt, 2005: 840). This concept illustrates the masculinist practices that maintain the privilege, power and status for elite men within differing contexts. What some authors (Connell & Messerschmidt, 2005; Simpson, 2004) also importantly identify in relation to the perpetuation of this concept are the aspects of complicit masculinity and

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[13] Others have applied this term to a consideration of its impact on international relations (Parpart & Zalewski, 2008; Hooper, 2001).
[14] The field of men's studies examined masculinity as a category both of privilege and oppression (Carver, 1996).

compliance among heterosexual women that maintain its hegemony. Femininity has an equal term that, although originally formulated as hegemonic femininity, was soon renamed as emphasised femininity to "acknowledge the asymmetrical position of masculinities and femininities in a patriarchal gender order" (Connell & Messerschmidt, 2005: 848).

However relevant these social constructions of gender might be, for a consideration of women in the medical profession one has to remain cognisant of the fact that this is a feminist investigation. In other words, although the concept of gender is essential to a description of feminism, the feminist project tries to capture and make explicit the different situations and interests of different women. Since this is a feminist investigation of the experiences of women, it is not entirely within the scope of the research paradigm, or possible with the kind of data that was gathered (only of women), to include a comprehensive consideration of masculinity and femininity. Moreover, for this investigation to be able to present a competent gender analysis, I would have to have included men in the sample. Masculinity and femininity can only be adequately explained in relation to each other, as "gender is always relational, and patterns of masculinity are socially defined in contradistinction from some model (whether real or imaginary) of femininity" (Connell & Messerschmidt, 2005: 848).

It thus is important for the reader to bear in mind that, when I do reflect on the influence of masculinities or femininities in the gendered construction of the medical profession in Chapter 6, this is presented from the perspectives and experiences of women only. However, in their accounts the respondents may reflect on experiences in relation to men. Thus, in support of a *limited* consideration of the impact of these concepts on gendering in the medical profession within the constraints of the context of my study, Connell and Messerschmidt (2005: 848) note that "research on hegemonic masculinity now needs to give much closer attention to the practices of women and to the historical interplay of femininities and masculinities".

Moving on to a related discussion of power and feminist research, the complementarity of feminist theory and power theory cannot be ignored. Feminist theory has been important in its consideration of gender, not only as a category or associated social hierarchy or role enactment, but it has always centrally considered the implication of power within gender relations.

Feminist approaches have been the main platform (for various individuals, such as political scientists and sociologists) providing ways in which to theorise gender relations and, through advocacy, to revolutionise societal thinking and practice regarding gender inequality in all its forms. In its most general sense, feminism is "an argument against political and social systems, ideological practices, and cultural discourses that subordinate women…" (Wiegman, 1999: 108) with the ultimate aim of creating gender equality.

Based on the historical development of this term, three 'waves' of feminism have been identified. First-wave feminism is associated primarily with the struggle to achieve basic political rights during the period from the mid-19th century, whereas second-wave feminism was feminism revived in the late 1960s, at which time feminists pushed beyond earlier quests for political rights to attempt to fight for greater equality in all spheres of society. Second-wave feminism was thus also concerned with the aspect of power, focusing on power relations between men and women and the discrimination that results from the division of labour in the household.

Even though first- and second-wave feminism contributed immensely to the development of discourse and advocacy with regard to advancing gender equality, the most notable contribution of third-wave feminism lies in its emphasis on identity. Third-wave feminism critiques second-wave feminism's lack of attention to the differences amongst women (race, ethnicity, class, nationality, religion, context, etc.), and emphasises identity as a site of gender struggle. It recognises the differences in the experience of sexism by women, for instance the intersection of race and identity and how this profoundly affects the degree and experience of gender discrimination (Guerrero, 2003; Walker, 2003, 2005,

Cannon et al, 2005). As recognised by Acker (1999: 191), "gender cannot be torn from its social contexts without risking distortions, including privileging gender over other components of social relations and identities and denying their importance in creating inequality and domination". It is thus important to be aware of, and sensitive to, the differences between women, although our main focus is exposing gender inequality inherent in the institutional structures and organisational culture of a profession, experienced by women as a group. Feminist theory, usefully summed up by Howell, Carter and Schied, is "an inquiry focused on agency, power relations, shifting positionalities, voice, individual experience, and socially constructed knowledge" (2002: 113). I use this definition as an organising tool for the following discussions on and review of concepts within feminist and power theory that are relevant to this study.

2.3.1.1 Agency and power relations

A gender focus will need to consider the issue of power: "its nature, location, operation, distribution and circulation" (Banerjee, 1995: 32). In accordance with the concept of intersectionality[15], and also to some degree the assertions of standpoint theory, one would expect female doctors' access to and advancement and experiences in the medical profession to be a function of their positioning in the societal power structure (based on race, class, culture, etc.). Thus it is pertinent to understand how these gender roles and accompanying power, or lack thereof, permeate behaviour, even in professional roles. Although the power theory approach in this study will concentrate on the structural embeddedness of power (Foucault, 1980) rather than on power relations played out between individuals, interpersonal relationships as a way to institute and maintain power will not be ignored. This aspect will essentially be considered in terms of illustrating attempts by individuals (as narrated by the respondents in this study) to maintain male advantage in the profession in an effort to keep intact their relative power in comparison to women.

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[15] Intersectionality suggests that various socially and culturally constructed categories of discrimination interact on multiple and often simultaneous levels, contributing to varying degrees of social inequality. Based on this reasoning, and in terms of a reflection on how it relates to power, it would assert, for instance, that although women as a group may be discriminated against and have less power than men within a specific context, within a group of women, black women are likely to be more disadvantaged and have less power within that context.

We thus know that power can be structurally embedded, as well as individually exerted, but also notable is the issue of power that is specifically exerted by groups, sometimes referred to as closure. Closure is the process through which social groupings enact methods of exclusion, serving to monopolise "societal chances, privileges and resources…" (Koch, 2003: 5). Theorists focusing on exclusionary 'methods' as the reason for women's non-advancement argue that, through the retention of patriarchal organisational cultures, institutional structures present 'uncomfortable' working environments for women (Witz, 1990). Moreover, "professional projects are embedded in and mediated by patriarchal structures that lend resources for the mobilization of male power" (Witz, 1990, cited in Davies, 1996: 662). This is also where a consideration of the gendering of professions and organisations becomes important, as this gendering can underpin the differential access to power and networks for certain individuals within a profession.

2.3.1.2 Shifting positionalities (Intersectionality)

The vantage point of intersectionality[16] is very important to my analysis, as it recognises the intersection of race, class and identity and how this profoundly affects the degree and experience of gender discrimination. This concept also informs the research methodology in the sense that my data collection method not only considers women as a group, but also the differences between them based on their different contexts. Collins (1998: 201 - 228) articulates intersectionality as the "ability of social phenomena, race, class, and gender to mutually construct one another…but always within keen consideration for power and structural relations". The aspect of mutual construction of relations amongst social identities is very central to an understanding of this concept (Collins, 1998; Shields, 2008). Illustrating the complexity of patriarchy, and thus the necessity to analyse outcomes from this system as such, Mojab and Gorman (2001: 287) sum it up as "a network of networks of power that is tied to economy, religion, law, culture, language, arts, media, education, and state power". This will remain an important thread throughout the study, as it is considered a central tenet of feminist thinking and greatly impacts on

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[16] Recognising the importance of this aspect, many theorists have even shied away from the term feminism to move to a more inclusive notion of 'womanism' (Walker 1990, 1999; Guerrero, 2003; Cannon, Johnson & Sims, 2005).

how gender is conceptualised in research (Shields, 2008). The concept of intersectionality encompasses many of the aspects (for instance the differential impact of race and gender on specific women's experiences in the profession) that I will have to consider in an attempt to better understand and explain the phenomenon of attrition in the South African medical profession.

2.3.1.3 Voice

As this research is essentially a feminist investigation, it is important for me to also incorporate in the research methodology a consideration of voice, and allow for and find ways in which to express women's voices. Thus, I felt strongly that it would be imperative for qualitative responses to be incorporated into the data collection (refer also to the nature of the interviews, discussed in Chapter 3).

Furthermore, I am fully aware that, in some instances, the interview process might illustrate women's disadvantage in the medical profession. Many authors are sceptical of any kind of representations of structural disadvantage, as these may in fact perpetuate women's minority status. However, I identify strongly with Hartsock's assertions that women's experiences may provide them with a "particular and privileged knowledge that reflects both oppression and women's resistance" (Denzin & Lincoln, 2003). So, I agree that, by allowing women's voices to be heard through the interviews it not only will serve the purpose of my investigation, which is to illuminate discriminatory structures in the profession, but also will give us insight into how women are conceptualising, reconceptualising and challenging their position in the profession.

2.3.1.4 Individual experience and socially constructed knowledge (standpoint theory)

Related to the concept of intersectionality is standpoint theory (Harding, 1991, 1997), which essentially is a method to analyse or conceptualise data as situated within inter-subjective discourses and which will also form part of the approach to the data analysis. I elaborate on this concept here, as opposed to discussing it later in the data analysis section, as I feel it is important to illustrate to the reader that there is a clear synergy between the theoretical vantage point of this investigation and what is needed in terms of the practical analysis of data. This perspective recognises, amongst other things, that

"neither knowers nor the knowledge they produce are or could be impartial, disinterested, [or] value-neutral… the challenge is to articulate how it is that knowledge has a socially situated character…. and to work through the transformations that this conception of knowledge requires of conventional notions such as objectivity, relativism, rationality and reflexivity" (Harding, 1991:11).

Therefore, what I essentially aim to do in my analysis, in support of this approach, is to think of the location of my research in terms of the gender, race and class relations from which it originates (Harding, 1991). The implications this has for my consideration of the responses of the study population is that they each experience gender differently because of their different racial, economic and class backgrounds. Moreover, there might also be a difference in the way in which they experience gender in the professional environment, and in their social environment. As Harding indicates, "nor are gender relations between men and women in any particular group shaped only by the men and women in that group, for those relations too are always shaped by how men and women are defined in every other race, class, or culture in the environment" (1991:13 – 14).

Other feminist contributions are also relevant for a consideration of women in the medical profession (these themes include literature on productive and reproductive work, also linking to 'women's work', the private/public dialectic, the feminist ethics of care, and feminism and science). Central to the project of patriarchy, and common to these concepts, is the aim of separation, which historically "was generally associated with subordination, deteriorating status, and the victimization of women by men" (Kerber, 1988: 14). I will briefly consider each of these important feminist contributions in more detail.

2.3.1.5 Public/private dialectic

Kerber importantly tracks the historical development of this concept (public/private divide), stating that in the late 1960s and early 70s it was

"marked by an effort to identify separate spheres as a theme central to women's historical experience…the second stage – in the later 1970s – encompassed an effort to refine the

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definition and identify complexities, introducing the liberating possibilities of a 'women's culture'. By 1980, historians had devised a prism through which, to view the diaries, letters, and organization records" (1988: 17).

She states that when historians used the metaphor of separate spheres, they referred, often interchangeably, "to an ideology imposed on women, a culture created by women, a set of boundaries expected to be observed by women" (Kerber, 1988: 17). As Thornton (1991) notes, the centrality of the dichotomy, regardless of changes in the relations between men and women, maintains a separate sphere of domestic life, which remains the primary site of inequality for women.

Kerber remarks that "the habit of contrasting the worlds of men and of women, the allocation of the public sector to men and the private sector (still under men's control) to women is older than western civilization" (1988: 18). Arguably, the most important separating device has been the concept of the private/public dialectic/divide. The private realm refers to those 'dark' and natural rhythms of biology (Prokhovnik, 1998), "defined by the limitations imposed upon us by the needs of biological life, which preclude choice, [contrasted by] the public realm of action and choice" (Kerber, 1988: 18).

Boyd (1997: 9) asserts that this public/private dichotomy is highly gendered, and that men tend to "prevail over women in the public spheres of politics and work, which con-sequently gave them power in the private sphere of home/family". This has also become a central concern within the fields of law (see, as an example, Fudge, 1987) and politics, as the state's control over the public sphere and inattention or disregard for the private sphere profoundly impacts the sets of issues deemed appropriate for consideration and policing. For instance, in cases of domestic violence, which is considered a private affair, little government attention and regulation is afforded and, because of this, there still are various continued violations of women's rights.

This public/private divide relegates women and their associated roles to the private sphere, where they were "said to live in a distinct world engaged in nurturant activities,

focused on children, husbands, and family dependents" (Kerber, 1988: 10). The values thus traditionally associated with women are those of "domesticity (the others were piety, purity, and submissiveness); home was referred to as women's proper sphere" (Kerber, 1988: 11). This separation kept women subordinate and denigrated them, and operated to "exclude women and undervalue the experience of women" (Prohovnik, 1998: 86).

This kind of thinking was reinforced by various systems. For example, many argue that separation was linked to the Industrial Revolution[17], which "broadened the distinctions between men's and women's occupations and certainly provoked new thinking about the significance and permanence of their respective spheres" (Kerber, 1988: 12). It is clear that many structures and ideologies across history supported this distinction, and therefore it is such a pervasive concept (for instance, various historians, academics and theorists grounded the separation of spheres in psychology[18], culture or property relations).

2.3.1.6 Productive vs. reproductive work, 'women's work'

Also very central to creating and maintaining this separation between the private and public spheres is the split between the value of productive and reproductive work[19]. This concept fundamentally separates women into the sphere of reproduction (private) and men into the sphere of production (public), where reproductive work is considered as those tasks and roles "performed in the home primarily not for pay… as part of family life" (Culkin, 1999: 43 - 46).

The importance of a critique of this thinking is made explicit in Kerber's (1988:13) assertion that "the exclusion of women from production… is the root cause of the

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[17] As Kerber for instance indicates, the "description of women's sphere as separate from, and subordinate to, that of men was congruent with Marxist argument" (1988: 13).

[18] Like Erikson, who, when reporting on the play patterns of girls and boys in 1964, where the former used blocks to construct enclosed interior spaces, and the latter used blocks to construct exterior spaces, concluding that "the differences between inner and outer space corresponds to the male and female principles in body construction" (Kerber, 1988: 11).

[19] Some authors caution against the use of these terms, as "the very notion of who defines what productive work is, as well as how that work is rewarded, become central to any understanding of work" (Howell et al, 2002), and thus this concept's relevance in the present discourse, to act as a descriptive tool, should be questioned.

contemporary social definition of women as natural beings". Many feminists emphasise the importance of this separation as fundamental to patriarchy. Thus, it is asserted by many prominent feminist writers (Firestone, 1971; O'Brien, 1981; De Beauvior, 1989) that women's functions in reproduction are central to their domination by men. This is because "women's reproductive functions inextricably connect women to nature" (Carter, 2009: 122).

According to this reasoning, one of the main functions of patriarchy is that it "enables them (men) to claim ownership of the products of women's reproductive labor" (Carter, 2009: 121). Thus, across history it is not surprising to find various examples of men's attempt at simultaneous control[20], and alienation, of women, from the means of reproduction. Both these strategies are aimed at negating the positive aspects of reproduction for women's consciousness (power, connectedness).

This dialectical separation of the sphere of production and reproduction is central to the economic value assigned to tasks/roles, and thus the general level of value society assigns to those tasks/roles. It therefore is understandable that many feminist projects focus on, and attempt to, assign value, economic[21] or otherwise, to roles and tasks performed by women, to make these tasks visible and relevant in the 'public sphere', and thus to make them more valued by society.

This separation of men's and women's work and the devaluation associated with the latter are also supported by biological discourses used to maintain sexual segregation in the workplace. This is very relevant in the case of medical specialisation, where we find women doctors concentrated in specialisations that are more easily sex-typed feminine. This links partly to the importance of using a feminist analysis, as Messing, Lippel, Demers and Mergler (2000: 21) point out that "resistance to integrating women has…

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[20] As illustrated, for example, by the rise in obstetric medicine, which, "with its associated language and reproductive technologies, has made reproduction a predominantly male, rather than female enterprise (Carter, 2009: 121).
[21] Perrons (2005: 389) thus highlights the importance of "a broader and more holistic conceptualization of the economy in order to secure greater gender equality".

little to do with biological differences and must be overcome by political action". This biological discourse, as shown by Messing et al (2000: 21), can occur in three contexts;

- Women's physical capacities (size, shape, strength)[22]
- Women's occupational illnesses may be thought to be due to their physical and psychological specificity[23]
- Women's reproductive specificity is considered to render them unfit to work more often than men [24]

This devaluing of work traditionally performed by women has fed into the discourse surrounding the concept of 'women's work' (Reskin, 1988; Park, 1996), which devalues those tasks and roles conventionally performed by women. For instance, roles such as caring, and thus 'care work', have also traditionally been devalued. Due to the way that society deals with caring responsibilities, women are rendered vulnerable because they are considered primarily responsible for caring (Sevenhuijsen, Bozalek, Gouws & Minnaar-McDonald, 2003).

2.3.1.7 Feminist ethics of care

As Gouws (2009: 64) shows in her discussion of the liberal state and care, the discourse around care is conventionally based on rights and not on needs, and thus care is provided in "the spirit of charity and not in the recognition of interdependence". This renders care a charity role, and relegates it to the private sphere. However, there is encouraging research that advocates for a reconceptualisation of care, which does not place either those giving or receiving care in a vulnerable position. A feminist ethic of care "has to be understood in its relationship to those who are cared for and in terms of the need to restructure broader social and political institutions to make care a reality for everyone in society" (Gouws, 2009: 62).

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[22] This is usually the argument advanced against women trying to enter the specialisation of Orthopaedics, where it is said that physical strength is very important for the successful completion of tasks.
[23] Draper (1993) illustrates the gendered construction of suitable work.
[24] Stellman (1977) and Stellman and Henifin (1983) importantly contributed to this debate by evaluating the realities and myths surrounding occupational hazards in relation to pregnancy, and illustrate these exclusionary employment practices.

This concept's main contribution is the recognition of the relationality and interdependence of an ethic of care and, as Sevenhuijsen et al (2003) argue, an understanding of the politics of needs interpretation. Thus, "when an ethic of care is used the care giver will evaluate the needs of those who are care dependent and will give care according to her/his understanding of the contextuality of the needs" (Gouws, 2009: 63). This kind of discourse on care reclaims the autonomy of, and space for, care in both the private and public spheres of society. In so doing, this discourse approximates Tronto's (1995) contribution to the definition of an ethic of care as "a moral disposition and a set of moral sensibilities, issues and practices that arise from taking seriously the fact that care is a central aspect of human existence" (as cited in Sevenhuijsen et al, 2003: 314).

2.3.1.8 Debating the usefulness of separation

Although noting the negativity associated with the historical separation of spheres (traditional male-public/female-private), others have argued the importance of this separation in female institution building and the viable political strategy it can present to women at certain historical junctures (Freedman, 1979). Acknowledging the importance of the separation of spaces in female institution building, I remain cautious to applaud the value of this concept, as I view it as having the propensity to perpetuate the dichotomy and devaluation associated with the separation. These networks used for female institution building can simultaneously be supportive and oppressive.

Considering the relevance of this concept for the present, specifically in South Africa with its rich cultural diversity, we "need to locate the spatiality of networks historically and culturally" (Ruwanpura, 2008: 416). Ruwanpura, in her study of Sri Lankan women's agency in everyday life, also very importantly highlights the cultural biases inherent in this public/private metaphor. Her study supports arguments that binary categories are a hallmark of the more modernist period and thinking (Harding, 1986; Longino, 1990). She concludes that this separation disguises the fact that "people's embodied negotiation of the social world is far more diverse, complex, and nuanced than a simple public/private binary suggests" (Ruwanpura, 2008: 421).

Ruwanpura's (2008) assertions link to more recent discourse, which advocates that feminist thought should not be focused on liberating women from the private sphere, but on acknowledging that "women – and men – already undertake responsibilities of citizenship in both the public and the private realms" (Prohovnik, 1998: 84). This move attempts to recognise that separation does not have to mean devaluation, but rather difference, which should not be framed in dichotomous terms.

2.4   THE INFLUENCES FROM MESO-LEVEL THEORY

2.4.1   Theories on gender in professions and organisations

Sociologists of professions became interested in structural changes in the medical profession in the mid-1980s (Starr, 1982). The debates at that time, which have been replayed in more recent literature, were centred around the impact that the increasing entrance of women would have on the status of the profession's authority, knowledge and even income (Notzer & Brown, 1995). Riska (2008: 4) notes that, although extensive, this "scholarly discussion within mainstream sociology of professions did not recognize the changing gender composition of medicine or the new stratification of gender in these processes".

Instead, we find that research on the increasing numbers of women entering the labour market, and considerations in terms of the impact this would have on existing work arrangements, "appeared later in the sociology of occupations and organizations" (Riska, 2008: 4). Thus, in this dissertation, the reader will note frequent use of constructs that would be seen as based in the sociology of organisations, according to earlier, stricter boundaries between fields. However, these concepts very accurately explain various phenomena associated with the increasing feminisation of a profession in general, and which I apply to the medical profession specifically as well.

More recently, the sociology of professions has been recognised as a multidisciplinary field that encompasses various theories on organisations, sociology, political science, etc. The way I would like the reader to reconcile this seeming disjuncture between the

constructs used to describe an organisation and those used to describe a profession is to view a profession (with its associated values, traditions, etc.) as the broader umbrella under which we have an organisation of processes, tasks, institutions, roles, etc. Following this logic, the profession can be seen as providing and prescribing the ideological description of what it is to be a 'professional acting professionally' at any given time, but, within that, the specific day-to-day tasks and processes are organised in a specific way. It thus follows that, although a profession can prescribe gender neutral processes and institutional structures, it is often in the day-to-day organising processes, enactment of roles and tasks that gender inequality is experienced and exposed.

Based on the aforementioned, I thus find it necessary to draw on theories that will describe the organisational culture and structure that these women find themselves in, although this essentially takes place in a professional role. This is an important consideration, as many studies do not consider this factor. Its importance is also alluded to by Chiu and Leicht (1999) when they advocate that a consideration of the context within which feminisation of a profession takes place greatly impacts on the extent and nature of that feminisation.

As a starting point it thus is important to understand what an organisational culture is. Edgar Schein (1985) explains it as a pattern of basic assumptions that have worked well enough to be considered valid and, therefore, are taught to new members as the correct way to perceive, think and feel in relation to problems. Furthermore, he distinguishes amongst three different cognitive levels through which this culture is established, enforced and reinforced:

- Artefacts: These would be visible aspects, such as technology, art, annual reports, newsletters, etc.
- Values: These are intangible aspects deemed important to the individuals belonging to that organisation (in other words, their conscious desires or wants).
- Basic assumptions: These are taken-for-granted, invisible aspects that guide individual behaviour in the organisation. They tell the individual how to perceive,

think and feel about work, performance, human relations and the performance of others within the organisational context.

Johnson (1988) builds on the framework established by Schein (1985) and identifies the elements of organisational culture as being:

- The paradigm: what the organisation is about, what it does, its mission, etc.
- Control systems: the process in place to monitor what is happening in the workplace.
- Organisational structures: reporting lines, hierarchies, etc.
- Power structures: who makes decisions, how widely spread is power, and on what is power based?
- Symbols: organisational logos and designs, parking spaces, executive washrooms
- Rituals and routines: management meetings, board reports.
- Stories and myths: built up about people and events, and which convey a message about what is valued within the organisation.

Considering the definitions offered by Schein (1985) and Johnson (1988), it is clear that organisational culture is what individuals perceive, and how that perception informs a pattern of beliefs, expectation and values (Gibson, Ivancevich & Donnely, 2000). Rao, Stuart and Kelleher (1999) recognise that constraining gender roles and ideologies influences organisational structures, values, behaviour and outcomes. Thus, of importance for the analysis in this study, being particularly concerned with illustrating how different aspects of an organisational culture can contribute to gendered outcomes within a profession, is what Rao et al (1999) identify as the gendered substructure of organisations, which consists of four elements:

- In *valuing heroic individualism,* many organisations tend to "value the hero who works day and night against tremendous odds to solve a crisis".
- The *split between work and family*, where "the ideal worker excludes and marginalizes women who cannot, almost by definition, achieve the qualities of a real worker because to do so is to become like a man".
- *Exclusionary power*, consisting of

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1) positional power, derived from the authority of an office or title,

2) agenda-setting power, where one often finds that what is not important to men does not surface on the agenda, although it might be important to women,

3) hidden power, where certain ideas are supported and put forth as normal, and thus people do not question them,

4) power of dialogue, as through discussion one will become aware of the exercise of power and expose how it builds or prevents equity, and the

5) power of conflict.

- *Monoculture of instrumentality*, which is an organisational cultural focus that excludes people, perspectives and processes not directly related to the accomplishment of the narrow goal.

The macro- and meso-level theories explained above inform the use of a feminist-organisational approach in this study. The advantages of bringing these macro- and meso-level theories together to form a theoretical vantage point are numerous. Firstly, the use of feminism and power theory allows us to investigate gender inequality by considering issues such as the body, class and work, disability, the family, globalisation, human rights, popular culture, race and racism, reproduction, science, the self, and sexuality. Furthermore, approaching this analysis from an organisational standpoint, drawing also on the profession's literature, allows us to deconstruct institutions by gender by identifying gendered outcomes, and proceeding from there to understanding how these outcomes "are actually constituted by gender difference" (Goetz, 1997: 10).

Bringing the two together, in other words a feminist-organisational approach[25], focuses on the power relations between men and women, and the hierarchical structure of organisational cultures that tend to reinforce these unequal power relations at institutional level. In this approach we recognise institutions and organisations as deeply gendered in their structure (Goetz, 1997). Essentially, this type of analysis, by focusing on "norms, values, beliefs and ways of behaving can generate insights into how workplace practices

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[25] Although there has been quite extensive literature using this approach, it has not yet been used as an approach to studying women's entry into the South African medical profession.

within professions become discriminatory" (Helms Mills & Mills, 2000, cited in Mills, 2002: 287), as well as address the "persistence of male advantage" (Acker, 1992: 248).

The above discussion provides a sense of how I have theoretically conceptualised my approach, and the following sections will document the literature and debates relevant to this more specific investigation on the reasons behind the attrition of women medical doctors in the South African medical profession:

- The feminisation of male-dominated professions
- The history of the medical profession
- The feminisation of medical schools
- The feminisation of the medical profession

2.5   INFLUENCES FROM THE MICRO-LEVEL LITERATURE

2.5.1   Feminisation of male-dominated professions

It is important to consider the literature on the feminisation of various male-dominated professions so that we can have some insight into the discourses and debates around the feminisation of the medical profession specifically. We can examine whether certain theories apply to the medical profession, and then take our analysis even further by examining whether these theories would shed some light on the reasons for noticed sex trends in our own medical schools and in the profession.

The feminisation of professions can be defined as either 1) simply the increased entry or movement of women into a particular occupation or field (Abercrombie, Hill & Turner, 2000), or 2) a more fundamental transformation of a specific occupation, where women do not only become the majority within that profession, but the profession undergoes a shift in sex-typing, and thus as a product of this shift is seen as 'women's work'[26] (Jary & Jary, 1995).

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[26] Refer to the previous discussion on the public/private and productive and reproductive work dialectic, which can have a potentially negative impact on the perceptions surrounding the status of a profession.

We know that, over the years, women have been moving more rapidly and more frequently into formerly male-dominated professions. This is true to different degrees in engineering, computer science, dentistry, etc. The literature on the feminisation of different professions examines the potential impact this might have on the relevant profession (Muzzin et al, 1994; Muzzin et al, 1995; Frize, 1997; O'Keefe, 2000; Riska, 1993, 2001). The discourse and debate in this area covers a wide range of issues (negative and positive), such as stress, sexual harassment and gender discrimination (CEJA, 1993), changes in values and career plans, structural inequalities, occupational closure (Loudon, 1999, Harden, 2001, Bickel, cited in Searle, 2001), debt and career choices, specialisation preferences and choices, marriage and the family (Dedobbeleer, Contandriopoulos & Desjardins, 1995; Thorne, 2004), working conditions (Darves, 2005; Kotulak, 2005; Davies, 2006) and environment (rural/urban), pregnancy and part-time training[27], career satisfaction (Barnett, Gareis & Carr, 2005), earnings, and the importance of mentoring (Mobley, Jaret, Marsh & Lim, 1994; Wallace, 2001; Deech, 2009).

There are two main tenets, namely that women's increased entry will either 1) alter the nature of the profession, and/or 2) alter the status of the profession. Both these tenets would assume some implications for 1) service provision, 2) the future trajectory of professions, and 3) occupational segregation and gender inequality (Adams, 2005). Let us examine each of these propositions separately.

2.5.1.1 Women's increased entry will alter the nature of the profession

Much of the literature on the feminisation of professions sees women as the potential force for professional change in a specific profession (Adams, 2005). This view is based on a more essentialist or individual-oriented conception of gender and its associated roles, linked to a person's sex and based on socialisation. This view would purport that women have essentially different qualities from men and thus women will be drawn to more gender-specific tasks within a profession. Furthermore, their more empathetic nature will

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[27] "In the South African context…many training programmes ha[ve] no formal plans for coping with pregnancies among interns" (Hudson et al, 1997:1514).

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eventually change the nature and practice of that profession. For instance, some are of the view that women doctors specifically, are more likely, in comparison to male doctors, to engage patients as active partners in their care (Jovic et al, 2006). This is similar to the internal segregation trends experienced to different degrees within various professions, such as academia (Kulis, 1997; Knights & Richards, 2003).

There are some studies that support these assertions of essential gender differences to some extent. We find that, on average, women work for fewer hours than men (Tanner & Cockerill, 1996, McMurray et al, 2002), and work in certain specialisms that are deemed 'softer' and more predictable. These specialisms are often more easily sex-typed as being feminine, and women furthermore usually earn less than their male counterparts (Notzer & Brown, 1995). However, whether these factors are all strictly related only to the sex of the doctor has not been proven convincingly.

For instance, as can be seen in Adams's (2005: 71) study on the feminisation of dentistry in Ontario, there were

> "very few differences between male and female dentists in terms of practice characteristics and attitudes towards practice, and although men and women tend to differ in their practice type and average income, they, on average, resemble one another in terms of working hours, practice location and professional attitudes".

Furthermore, it seems that other than sex differences in working hours, income and speciality, there is no real, substantial evidence of other differences being present. Some studies have provided evidence that gender differences exist in the motivations of individuals to enter professional practice, but whether these motivations necessarily translate into gender differences within the practice of the profession is not clear. On the other hand, Adams (2005) concludes that, because many studies have found that women's goals do not differ substantially from men's goals related to a specific profession, and because in many cases the same characteristics (such as job status, security, knowledge, fulfilling work) of a job may attract women, it is not necessarily

clear whether women's entry into a profession will change or challenge the traditional ideals of professional practice.

There are studies that suggest that many "male-dominated professions were gendered male and organized by men for men" (Adams, 2005: 90). Linking also to the debate surrounding masculinities, and women conforming to these masculinities in male-dominated professions (such as medicine), it appears that, although this gendering makes it difficult for women to participate in these roles on the same terms as men, there is little evidence "that women are much more likely than men to reject this socialization, or seek to practice in a manner different from their male colleagues" (Adams, 2005)[28].

2.5.1.2 Women's increased entry will alter the status of the profession

Carol Black, president of the Royal College of Physicians, controversially asserted in the popular media that the feminisation of the medical profession could lead to a loss in its status and, moreover, that women do not reach the higher ranks of the profession or enter more 'demanding' specialisations in sufficient numbers (Hall, 2004; Akbar, 2004; Frayn, 2004; Phillips, 2004; The Lancet, 2004; Scullion, 2004; Hilton, 2004; Levinson & Lurie, 2004; Miqueo, 1999; Allen, 2005). This statement has sparked vigorous debate in academic and media circles alike. This is not a new idea, as this issue has been raging for decades and much academic debate and sociological discourse has revolved around its resolution. This debate, of course, can be linked back to the various discourses aimed at devaluing women's work.

When we examine the more academic literature, it is evident that there is no concrete answer to this question either. It is not clear whether the chicken came before the proverbial egg in this case! Many studies have been considering whether the status of a relevant profession changed after normal occupational change (such as job growth/shrinkage, increasing/declining wages, etc.) and whether more female entered due to more males leaving, or whether it was occupational change brought about by the feminisation of that occupation? As Adams notes, "there is little convincing evidence that

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[28] See also Guinier, Fine and Balin (1997).

the entrance of women into professions has (in and of itself) led to, or resulted from, a decline in professional status" (Adams, 2005: 73).

However, most of the literature agrees that gender differences do indeed exist, but none are quite certain of the relevance, extent and significance of these differences. Of course, if one is not certain of the extent of the influence of these differences, how can one make any predictions about the change in nature or status of a profession based on these differences?

However, this investigation does not view gendered trends in a profession as a natural outcome, viewing these differences as problematic if they act as a structural constraint, and thus debate terms such as gender segregation rather than difference. According to Reskin and Roos (1990), increasing feminisation of a profession can lead to three main outcomes, namely re-segregation, internal segregation and genuine integration (elaborated on below):

- **Re-segregation**
  This is where professions previously dominated by men gradually change and become dominated chiefly by women (Reskin & Roos, 1990). It is a situation in which women come to numerically present the majority in a profession. As alluded to before, this phenomenon is often linked to the status of a profession, where one finds that either the increasing exodus of males or the increasing entrance of females is perceived to lower the status of that profession.

- **Internal segregation**
  This is where women and men with the same professional titles work in different fields in the same profession, and those specialties have lower status (Reskin & Roos, 1990). It is also referred to as ghettoisation, and is an illustration of the way in which structural inequality can still occur, even though equality of access has been ensured. For instance, Wright and Jacobs (1994: 517) find in the case of computer work that "men predominate in high-status specialties, such as electrical engineering, while women are concentrated in low-status occupations, such as

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data entry". This is quite a common occurrence in various profession and is an indication of the continuing inequality between men and women, as illustrated by phenomena such as 1) gender stereotyping[29], 2) gender discrimination[30], and/or 3) occupational closure[31].

- **Genuine integration**

  This is where women are accepted on an equal footing with men. This "requires integration in all specialties within an occupation as well as occupational equity between female and male coworkers of equivalent experience" (Reskin & Roos, 1990: 71). However, it is recognised that this is an ideal situation. Many organisations create the image of this state of affairs through phenomena such as tokenism, where women or men are employed at certain levels in a profession to create the illusion of professional equity. Many are of the opinion that gender mainstreaming, although it has honourable intentions and roots, has fallen into this trap[32].

Wright and Jacobs (1994), on the other hand, motivates for a less stringent view of the possible outcomes of the feminisation of a profession, and argue that these outcomes should not be seen as final points on a spectrum, as proposed by Reskin and Roos (1990). These phenomena should be viewed as continuously moving, and consequently Reskin and Roos (1990) discusses rather a ghettoising, integrating, or segregating profession.

2.5.2 The history of the medical profession

It is necessary to provide some background in terms of the evolution of the medical profession so that one can have insight into the ways in which it has become perceived to be and classified as male oriented.

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[29] This is when some professions, or some tasks and roles within a profession, are associated with a specific sex.

[30] This is when an individual is denied equal opportunity based on their sex.

[31] This is where groups within a profession enforce methods of exclusion, which serve to limit entrance to specific occupational networks, and/or sex-related discriminatory employment practices, which have become ingrained in a company's institutional culture.

[32] As noted by Perrons (2005:390), "gender mainstreaming has become normalized as a 'technical project' and has been divorced from its feminist political roots, which challenge equal power relations".

In the writing on the history of the evolution of the medical profession, in such varied countries as the United States of America, Egypt and England and Italy, we find that, in trying to reconcile this apparent contradiction, many prominent women doctors, like Elizabeth Blackwell[33] and Elizabeth Garret[34], continued to "embrace sympathy as a female virtue that rendered women better physicians" (Tuchman, 1999: 126). Most text discussing women in the medical profession start doing so from mainly a documentary vantage point[35] (Walker, 1997)[36], which is evident in the biographical accounts of the writings of Phelps by Wegener (2005). These writings were concerned mainly with lauding women doctors in the early 1800s, when they were still viewed very negatively. As Phelps (1968: 916) notes, "the history of women in medicine is filled with examples of hostility and outright persecution". The arguments relied on the feminine traits of women and argued that, because of these characteristics, they were very able and in some cases perfectly suited for the job of a physician. However, other female doctors of that time, like Marie Elizabeth Zakrewska and Mary Putnam Jacobi, recognised early on the "barriers women would confront if they sought entry into the medical profession by emphasizing their nurturing abilities" (Tuchman, 1999: 122).

The discussion above illustrates the difficulties women doctor pioneers experienced during their entrance into this male-dominated profession. Realising that they were entering a solely male domain, they were struggling with a conceptualisation of their worth, or what they could add to the profession in order to justify their entrance. Unfortunately, those feminine attributes thought to be advantageous for the conceptualisation of women's contribution to the profession also maintained their difference from the male norm. To some extent, this is still the disjuncture experienced by many women trying to conceptualise their belonging in the profession today.

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[33] She was the first woman to qualify as a doctor in the USA.
[34] She was the first woman doctor in the United Kingdom.
[35] This refers to when literature relates factual information about women in the medical profession without interpretation or clinical engagement.
[36] See also Phelps (1968), Matthews (1970), Bowers (1966), Powers, Rexford and Wiesenfelder (1969) and Davidson (1978).

Medicine has traditionally been conceptualised as a very technical science, requiring a high level of skill and knowledge. The definition of the practice of medicine as a science is what seemed to remove its values and characteristics from all things feminine, and thus the female doctor was viewed as something of an anomaly. As shown by Tuchman (1999: 122)

> "the increased use of scientific instruments, a greater reliance on sophisticated surgical techniques, and the growth of hospitals and laboratories as the sites of medical training and care all contributed to an image of medicine that glorified everything exact and scientific, while ignoring the caring, more human side of medicine".

It has been argued that this classification, as is evident in the record of science, continues to reproduce gender-based exclusion in the sciences even today. Therefore, we now turn to a discussion of feminism and science.

2.5.2.1 Feminism and science

Feminist critiques of science and medicine are varied and established (Keller, 1982; Hubbard, 1990, 2003; Eichler, Reisman & Manace-Borins, 1992; Fausto-Sterling, 1992). Hubbard's contribution concentrates on the production of science as a social process that is reflective of the interest of predominantly white men, while Fausto-Sterling attempts to illustrate the connections between gender, race and science. In sum, on the most basic level this literature criticises the predominance of men in science, and at the more radical level it challenges the objectivity of science itself (medical, psychological, behavioural, etc.), and, through a consideration of both of the aforementioned, it shows how the exclusion of women from science is legitimated. Thus the more radical view requires the actual paradigms of science to be challenged, while the less radical view is concerned with women's representation in medical science.

The literature on feminism and science therefore challenges these "baseless paradigms in medicine and the behavioural sciences [as] pretexts for subordinating women" (Schiebinger, 2000: 1171). It bases its critique on evaluating the extent to which science, and medical science and research specifically, conform to one of its most basic premises

– objectivity. This set of literature focuses on how medicine and medical research, which purport to be objective and scientific as opposed to feminine and subjective, are found to be biased. Through such studies, medical research and science were found to contain 'gender distortions' in their actual content. Schiebinger (2000: 1172) thus asserts that "regimes of inequality produced and reproduced gender in the substance of science". For instance, women were historically not included in clinical trials. In studies in which they were included, "the male body typically represented the normal human, the female body has traditionally been studied as a deviation from that norm" (Rosser, 1994, cited in Schiebinger, 2000: 1172). For an example of how women or women's problems were conceived as deviant, see McCrea (1983), who discusses the representation and definition of menopause as a deficiency disease, which contributed to its stigmatisation.

Some have thus argued for the outcomes and findings of medical trails to be understood in the context within which they occur, and that the concept of total objectivity should be questioned[37]. It is then not surprising that following from this conceptualisation of medical science, and the association of science with objectivity (and thus men), opposite to everything that is subjective (thus women), caused a great deal of difficulty for women's conceptualisation of their belonging in the medical profession.

Although the link between medicine and science is clear, the critique of science through a feminist lens, as explained in the previous paragraphs, can uncover "certain masculinist distortions of the scientific enterprise [referred to as] the intermingling of masculine bias with what purports to be objective, scientific statement" (Keller, 1982: 589).

2.5.3   Feminisation of, and attrition in, medical schools

The increasing feminisation of medical schools is widely documented (Howell, 2003; Hay & Jama, 2004; Wong, 2004; Breier & Wildschut, 2006). A case in point is Canada, where female enrolment has risen from 50% (2004) to roughly 65% (2007) (Gulli & Lunau, 2008). In America, the most recent available data at the time of writing (2004)

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[37] This has led to "a bias in the choice and definition of problems with which scientists have concerned themselves" (Keller, 1982: 590).

illustrates that medical school classes were 51% female (AMSA, 2005). In the UK, the number of women entering medical school has increased from 24% of total admissions in the 1960s, to about 56% of total admissions in 2008/9 (Deech, 2009). This increase can be attributed, amongst other things, to women's heightened expectations as a result of better education, which is the case in many countries across the globe. Medicine has always epitomised the highest academic achievement, and better education for women has also meant that they strive to realise these higher goals.

When we look at national figures we find that the same trend is evident in South African medical schools, where women comprised 46% of medical student graduations in 1996, and 56% in 2005. When we examine these figures more closely we find that this phenomenon is even more pronounced at certain medical schools; for example, women's proportional representation at UCT was 63% in 2005. Furthermore, we also find that in the past two decades women started to outperform males in medical schools. Hay and Jama's (2004) study confirmed this phenomenon in a South African medical school, and the trend was also anecdotally confirmed in Breier and Wildschut's (2006) study on medical education and the profession in South Africa. The feminisation of medical schools is thus quite widely documented internationally, and has also been established in South Africa.

Considering the issue of attrition from medical schools (at the undergraduate level), the body of literature firstly finds that some aspects of training might have negative effects on students' mental and emotional health, in turn suggesting that this might contribute to attrition (Dyrbye, Thomas & Shanafelt, 2005). Furthermore, attrition is seen to be linked mostly to academic[38], financial and, occasionally, personal reasons (Simpson & Budd, 1996; Huda & Agha, 2004). The higher attrition rate of minorities is emphasised specifically in the South African case (Moomal & Pick, 1998; Lehmann & Sanders, 1999), and has been borne out in the cohort data findings of this study as well (see Chapter 4).

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[38] In the case of South Africa, the continued high attrition rates, particularly of black students, have resulted in critiques of the necessity of science-oriented pre-clinical years (Lehmann & Sanders, 1999).

Most studies, however, agree that women do not struggle particularly in undergraduate medical education, although there is some evidence that this might not be the case in postgraduate training[39]. The importance of mentoring for female residents is thus highlighted. Although I acknowledge the importance of the attrition occurring at this level, this aspect was seen as outside of the scope of this study. The decision to exclude an analysis of the aforementioned attrition, was based on the difficulties associated with isolating, and being able to compare the highly differential pathways of individuals and women medical practitioners into and out of post-graduate training, at the present juncture.

2.5.4   Feminisation of, and attrition from, the medical profession

The concept of the 'feminisation of the medical profession' has most recently, and usefully, been problematised by Riska (2008) as the "feminization thesis", identifying three discourses underpinning the literature on this specific phenomenon; 1) research discourse, 2) medical discourse and 3) public discourse:

- The research discourse can be identified by "an effort to illuminate the implications of an increasing number of women on changes in medical work" (Riska, 2008: 4).
- The medical discourse tends to "reconstruct medicine as a gender-neutral organization by signaling the gendered character of women" (Riska, 2008: 4).
- The public discourse is exemplified by a mixture of the medical and research discourses that recaptures themes in both.

Riska (2008) asserts that the aims and objectives associated with each of these discourses are distinctly different, and thus the use of the term 'feminisation' should not be assumed but should be defined clearly in the relevant text. She thus, challenges the use of the concept of the feminisation of the medical profession, as the "most frequent and general meaning of the term feminization implies a shift in the numerical gender composition of

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[39] Walker, Janssen and Hubbard (1993: 182), for instance, found in their study on attrition from orthopaedic surgery residency that "female residents had a statistically higher attrition rate than male residents".

the practitioners" (Riska, 2008: 4). I would also like to challenge this notion, which assumes that female enrolments translate uniformly into numbers in the profession. Importantly, Riska also alludes to the fact that, although the term is most commonly used with a numerical reference, it also "contains predictions about qualitative changes in the practice of medicine" (Riska, 2008: 3).

I see my investigation as identifying most explicitly with the research discourse, as it is also an effort "to illuminate the implications of an increasing number of women" (Riska, 2008:4) in the South African medical profession. I do not position my investigation within the medical discourse or the public discourse. Although I identify most with the research discourse, my investigation differs slightly from Riska's assertion that this is done solely to investigate changes in medical work due to feminisation. By investigating the reasons behind attrition, I am also interested in identifying the aspects militating against women's 'genuine integration' (Reskin & Roos, 1990) in the profession in SA.

The preceding discussion offers an adequate theoretical framework for our discussion on the feminisation of the medical profession. It seems that much of this literature presents very plausible explanations for the various sex trends we have noticed in the profession. We thus can now evaluate whether, in our investigation, the following arguments would hold when applied to the medical profession.

If we consider the international context, we see that the feminisation of the medical profession is quite an established phenomenon. For example, in Norway, 30% of all professionally active doctors in 1999, were women, and this number has risen to 34% more recently (Gjerberg, 2002); in England, where women accounted for less than a fifth of the medical workforce in 1948 and now account for approximately 41% (Deech, 2009); and in Russia[40], where women account for around 77% of the medical workforce and this has been the case since the 1950s (Riska, 2001).

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[40] To this day, medical doctors are among the lowest paid jobs in Russia (Arsenault et al, 2009).

2.5.4.1 Will increasing feminisation change the nature of the medical profession?

As was noted in the section on history, the debate on whether increasing feminisation will change the nature of the medical profession remains unresolved until today. Some authors suggest that this is true, because women are more nurturing, have a different approach to patient care, etc., while others hold that women enter and practice medicine exactly on the same grounds and quality as men. As Shiebinger (2000: 1173) points out, a "refusal to acknowledge politics [here referring to feminism]… has led to a simple equating of women entering the profession with change in science".

Gjerberg (2001: 342), however, notes that "in spite of the relatively rapid increase in the number of women, the medical profession is still in many ways a gender-segregated professional group, although important changes are taking place". In support of this, Williams (1999, cited in Adams, 2005: 90) also asserts that "while gender differences in practice are apparent, women are not so much changing the profession, as they are taking part in a profession that is, for other reasons, undergoing change". It is thus unclear whether women have indeed altered the profession of medicine.

2.5.4.2 Will increasing feminisation change the status of the medical profession?

In general, we find that "women's participation is not evenly spread across specialties, but tends to concentrate in those that are somewhat lower-status and perhaps more easily sex-typed feminine" (Adams, 2005: 74). Thus, this specific configuration of women's participation might impact on the conceptualisations of the status of the medical profession.

It is well known, based on various studies on the subject, that "women in medicine work disproportionately in general practice, and as obstetricians and gynaecologists, while they are underrepresented in the high status specialities of surgery and internal medicine" (Hinze, 1999; Armstrong & Armstrong, 1992; Riska, 2001; Gjerberg, 2002[41]). One thus will find various studies showing women's substantial under-representation in high-status

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[41] For an earlier consideration of this phenomenon, see also Martin, Arnold and Parker (1988).

medical surgery specialties[42]. Whether it is their entrance into these specialities that has caused the drop in status, or whether the specialties already had a low status before their entrance, remains debatable. What is factual, however, is that women are definitely found to be concentrated in the lower status specialties and practice types.

Various studies (Heilegers & Hingstman, 2000; Gjerberg, 2003; Harden, 2001) have reported the difficulties faced by female physicians in terms of specialisation, and that they tend to specialise to a lesser degree than their male counterparts. This is also supported by the findings of the UCT case study in the HSRC medical profession study (Breier & Wildschut, 2006), as well as by national figures comparing the sex distribution of general practitioners and specialists in SA. However, Gjerberg (2002, 2001), in her study of the speciality choices of Norwegian doctors, found that, contrary to popular assertions around speciality trends among female medical doctors, women were found to specialise to a high degree and just as much as their male colleagues. Their specialisation choices were spread over more disciplines than their predecessors, and more male and female doctors seemed to be choosing general practice. However, in support of more mainstream findings, her study also found women doctors to increasingly enter and concentrate on disciplines such as obstetrics, gynaecology and paediatrics.

However, most importantly, Gjerberg (2002) and Hinze (1999) assert that the gendering of medical specialities creates both implicit barriers for women and explicit structural barriers that prevent women from participating in professions on the same terms as men. Importantly, any investigation into the gendered trends in professions will not be complete without a consideration of the socio-political context within which these changes are taking place. Thus, specifically important in the South African context is the racialised character of professionalisation (mentioned before, and elaborated upon later), which has had an impact on the course and trajectory of the feminisation of the medical

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[42] There also is a quite a large set of literature on women's specific difficulties in academic medicine (Tesch et al, 1995; Whiting & Bickel, 1990, Carr et al, 1993, Conley, 1993), for example with the requirement of publishing, which other studies have shown to also present certain gendered barriers (Prozesky, 2006).

profession, and consequently on the specific nature of the gendered construction of the profession.

Chiu and Leicht (1999) add that the context within which feminisation occurs has a significant impact on the trends in, and thus on the perceived changes in the nature and status of, that profession. For instance, a profession that is feminising within a context of favourable conditions, such as occupational growth, rising wages, etc., will move more towards the favourable type of outcomes (such as genuine integration). Conversely, an occupation feminising within unfavourable conditions will result in the less favourable outcomes (such as occupational segregation). Chiu and Leicht (1999) assert that "it is the nature of the profession itself, and particularly the context of occupational change in which feminization occurs, that determines its impact – specifically whether it leads to ghettoization and a continuation of gender inequality, or whether the feminization is successful and more integrative" (cited in Adams, 2005: 75).

In an effort to comprehensively consider the factors associated with the increasing feminisation of the medical profession, particularly in South Africa, it would be a mistake to ignore the historical inequality of healthcare provision in the country, as well as the inequality in the production of healthcare providers, especially doctors. As pointed out by Breier (2006: 1), "when the first democratically elected government came into being in South Africa in 1994 it inherited a health system with gross inequalities". Thus, the apartheid legacy has contributed to a very unequal medical profession in terms not only of gender but, very significantly, also of race. It therefore is no surprise that, in the case of UCT, a historically white institution (HWI), the issues surrounding racial equality have often been considered paramount.

Furthermore, there has been a significant shift in the South African healthcare context, from curative, hospital-based care to an emphasis on primary and community-based health care. This is a major focus in medical curricula across SA at present, and arguably might have had an even greater impact than the increasing feminisation on the nature of healthcare provision.

Relating these findings to the debates on the attrition of women from the medical profession and science in general,

- There is considerable literature on attrition in the medical profession in general (Berhan, 2008; Chankova, Muchiri & Kombe, 2009), as well as literature considering the attrition of women in science professions (Andrews, 2002; Holmes et al, 2008). The latter finds similar to those of medicine that women leave mainly because of factors linked to the structure of that profession, the role of time lag, and the more biological determinist assumptions of women's inherent preferences. In terms of establishing the attrition rates of women doctors, data from Singapore suggest that, although the attrition rate of women doctors from the profession generally is higher than that of male doctors, this situation is increasingly changing. In comparing data from 1979, when the attrition rate of women doctors was about 11% higher than that of males, more recent data (1994) suggests only a 5% difference (Sadasivan, 2003).

- Most literature alludes to the subject of attrition, but does not comprehensively interrogate the reasons behind this attrition. What I do find encouraging, in reviewing the more recent literature, is that there is an increased realisation of the importance of further studies to ascertain the reasons underlying attrition in the medical profession (Rittenhouse et al, 2004[43]; Moschos & Beyer, 2005; Cropsey et al, 2008[44]; Deech, 2009), as well as suggesting the importance of innovative retention strategies (Berhan, 2008[45]). However, as explained in the introductory chapter, there are very limited evaluations of the attrition of women from medicine, and the attrition of women from South African medicine more specifically. However, a review of the literature on the feminisation of the SA

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[43] Rittenhouse et al (2004) in their consideration of the reasons for medical practitioner attrition, question the factors used to predict attrition.

[44] Cropsey et al (2008:1111), in their study of women in academic medicine, assert that "the majority of reasons for faculty attrition are amenable to change. Retaining high-quality faculty in medical settings may justify the costs of faculty development and retention efforts".

[45] In a study of the attrition of medical doctors in Ethiopia, Berhan (2008), remarks that concrete retention mechanisms should be put in place, for example providing land for physicians, low-cost housing, low-cost or interest-free loans for housing and automobile procurement, improving the staff taxation system for academic staff, dual employment options, etc.

medical profession touches on some of the issues relevant to attrition (reviewed below).

2.5.5 Feminisation of the South African medical profession

An examination of the formation of the South African Society of Medical Women (SASMW) presents the most comprehensive account of women's entry into the South African medical profession. The SASMW was established in 1952. The formation of this body not only illustrated the racialised character[46] of medical professionalisation in South Africa, but also the fact that gender discrimination and inequality within the profession were experienced to such an extent that women doctors felt it necessary to mobilise and organise as a group.

The first women doctors to graduate in South Africa did so in the 1920s (Wits archives), which was also the time during which the first group representing medical women in SA was formed. After the outbreak of the war in the late 1930s, this group broke up. Dr Alice Cox started the Johannesburg branch of the reformed SASMW in 1952, while Dr Ethel Barrow re-formed the Cape Town branch. These first pioneers described the medical profession in South Africa as "a profession that was closing doors and we had to do something about it" (Walker, 1997a: 1505). When the SASMW was re-established in the 1950s, "it was in response to discrimination and so we began to lobby for change" (Walker, 1997a: 1506). Some of the restrictions and barriers to the advancement of women medical doctors in the profession were:

- The retirement age of women doctors, which was 53 in comparison to male doctors' 60 years;
- The marriage bar, in terms of which some women were either dismissed when they got married, or were refused employment based on their marital status;
- The fact that only temporary positions were available to married women doctors, which were challenged by the association, and thus married women doctors have been employed in a permanent capacity in the public sector since 1955;

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[46] This refers to the continued discrimination against people of colour in terms of entering the medical profession, although white women were increasingly gaining access to the profession.

- Unequal salaries and conditions of service, against which the SASMW "waged successful campaigns for equal salaries and improved conditions of service for medical women in part-time employment" (Walker, 1997a: 1506);

- The issue of specialisation through part-time study, which was the organisation's major focus during the 1960s and 1970s, in an effort to meet the "needs of women with young families who were not specializing because of the difficulties involved in raising a family and studying full-time" (Walker, 1997a: 1506). The main tenets of resistance against part-time specialisation, remains concern by the medical fraternity that standards would be compromised if this occurs, and thus "this issue remains one of contention and is currently not offered by all specialties" (Walker, 1997a: 1506), even today.

What Walker importantly notes in her article on the formation of the SASMW is the need for "further research on the medical profession's attitude to gender and racial issues" (1997a: 1507). Through critically evaluating the gendered outcomes in the profession, and analysing the possibility of a gendered organisational culture in South African medicine, it might be possible to illustrate these discriminatory tendencies. Considering the series of issues this organisation lobbied for, and for which it managed to achieve some kind of gender parity in certain instances, even a decade later, some of these issues are remain a problem for women doctors in the South African medical profession.

As I have mentioned before, in-depth discussion and critical analysis of women in the SA medical profession is not very extensive. However, some studies have been valuable. Levinson and Lurie (2004) evaluate the effects that increasing feminisation will have on the SA profession, falling in line with the essentialist conceptions of women's increasing entry into a male-dominated profession. The core question in their study is, will women's entry change the nature of the medical profession? Some authors have included a consideration of the influence of race on medical professionalisation and training (Breier & Wildschut, 2006). Unterhalter (1985) looked at discrimination against female medical students, but this aspect has not been followed up very extensively by any other study to date, or carried through to an investigation of experiences in the profession.

Walker (2003, 2005) and Wynchank (nd) present probably the most extensive consideration of the influence of race, gender and culture, and how they impact on medical professionalisation in South Africa. They also refer to the possible disjuncture between a westernised work culture and the beliefs and traditions adhered to by female doctors from non-western cultures (Vidyasagar & Rea, 2004; Wynchank, nd; Pausawasdi, 2004). The remaining reports have tried to establish at least a quantitative account of medical education and the profession in SA (Brink et al, 1991; Hay & Jama, 2004; Breier & Wildschut, 2006; Breier, 2009), elaborating less extensively on the qualitative issues.

Deficiencies in research on this broad subject area thus are noted as a lack of focus on: women in the SA medical profession specifically[47], how feminisation of the profession will affect patient care and health care systems (Brink, 1991), the profession itself (Levinson & Lurie, 2004), and the issue of race (Wynchank, nd; Reay, 1998). Even less has been written on how SA women doctors themselves affect and are affected by the organisational culture of medicine. This study therefore would make a valuable contribution to the field by aiming to create a deeper understanding of the possible gendered substructure underlying the experiences of women doctors in SA, which could shed some light on attrition.

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[47] In addition to the studies already mentioned, the author found only two studies related to SA women doctors in the NRF Nexus database on current and completed research projects in South Africa (Walker, 1999 and Vries, current).

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

As shown in the objectives, the research methodology needed to encompass the use of both qualitative and quantitative research methods[48]. The quantitative investigation will be used to establish and illustrate the sex trends in the data, while the qualitative investigation aims to provide some explanation of the reasons behind the existing trends. The trends identified by the quantitative analysis will inform the qualitative research, indicating issues that are most relevant to explore among this sample of women.

This chapter is concerned mainly with two things: firstly, to describe the sample in order to contextualise, for the reader, the findings and conclusions drawn from the data in later chapters. Secondly, it will describe the research methods used in an effort to meet the three objectives of the research.

First, I start by considering the original problem statement in an effort to explain the decision to use the specific research design as being the most appropriate for this research project. It is very important to accurately describe the research methodology, and it is equally important to consider the relevance of this methodology against the original objectives of the research (which will be elaborated on later when we discuss issues concerning validity and reliability).

The purpose of the problem statement in the introduction was to identify and make explicit the gender-specific institutional and societal factors influencing the attrition of women medical practitioners from the South African medical profession. Reflecting on

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[48] Onwuegbuzie and Leech (2005) have commented on the pragmatism of using both quantitative and qualitative research methodologies.

this problem statement as my premise, it became apparent that I would have to attempt to meet three objectives:

- Objective 1: Describe the trends in the attrition of women doctors from the SA medical profession between 1996 and 2005
- Objective 2: Establish the reasons underlying the attrition trends of female doctors in the SA medical profession between 1996 and 2005
- Objective 3: Provide recommendations on the retention of women doctors in the SA medical profession

Before considering each objective more specifically, it is first necessary to describe the selection of the sample.

3.2   DESCRIBING THE SELECTION OF THE SAMPLE

The envisioned total sample of 25 respondents, were to be compiled by three samples. The selection of samples 1 and 2 was based on whether the probable respondents were women doctors who had graduated from the UCT medical school in the period 1996 to 2005. The selection of sample 3 was based on whether probable respondents were women medical doctors and lecturers at the UCT medical school.

These possible respondents were first approached by sending out a letter of invitation to contribute to this study. In the letter of invitation I set out the reasoning for the interviews, which was an attempt to illustrate the more nuanced experiences of practising and non-practising female medical doctors, as well as lecturers in the profession during a specific period. The samples were comprised as follows:

- Sample 1: 10 respondents. This sample consisted of female medical doctors still in medical practice. These women were selected to provide information on, and experiences of, women currently practising in the medical profession.
- Sample 2: 10 respondents. This sample consisted of non-practising female medical doctors. These women were selected to provide us with information on, and experiences of, non-practising female medical doctors in order to establish

their reasons for no longer being in the medical profession. I set out to provide a profile of women who had left the profession in an attempt to show the factors that impacted specifically on their decisions to leave, assuming that these women would be significantly different to those women who chose to remain in the profession.

- Sample 3: five respondents. This sample consists of female medical doctors who are currently lecturers in medicine. These women were selected to provide us with information on, and experiences of, lecturers in medicine in order to obtain their insights into factors impacting on attrition. These women are expected to have longer tenure in the profession, and to be able to provide a wealth of knowledge and experience in terms of their own training and the training of doctors today. The latter is especially important, as aspects of training have been shown to have an effect on attrition in the medical profession. Also, there are issues of attrition that are relevant specifically to academic medicine (although not the focus of this study) on which it would be possible for these women to reflect.

The sampling method used was purposive sampling. The reason for choosing this method is that each respondent was chosen on the basis of the extent to which that respondent could address the key questions to be asked. The first stage involved gathering as much contact information as possible for each sample. This involved investigating all the publicly available contact details of doctors in the hospital groups in the Western Cape (Medi-Clinic, Life HealthCare, New Groote Schuur, etc.), obtained from the websites of the respective hospital groups, and selecting all the UCT graduates (who graduated in the period under investigation). Fifty-one possible respondents were identified through this method and invited to participate in the study. The method of contact was either by e-mail, fax or telephone. The respondent was provided with a brief description of the project, and then sent an official letter of invitation, which again explained the project and the envisioned sample, and requested a personal interview with the prospective respondent.

Once a respondent agreed to an interview, a suitable time and date for the interview were agreed upon. Before the actual tape-recorded interview commenced, the respondent was asked to read through the informed consent form and to ask any questions she might have.

3.3 OBJECTIVE 1

To meet Objective 1, I would need to investigate and answer my first research question: What was the difference between the graduation rate of men and women medical students compared to their entry rates into SA medical practice between 1996 and 2005?

3.3.1 Secondary data collection

In this part of the research project, I will be using secondary data, which involves the collation and exploration of existing datasets, as well as an extensive review of data gathered in previous studies on the subject.

Stated differently, this part of the research concentrated on the review of data, including:

- Data on the numbers and distribution of medical practitioners in South Africa from 2002 to 2006, and in 2008[49], as supplied by the *Health Professions Council of South Africa (HPCSA)*

- Data on medical school enrolments and graduations in 1996[50], and from 1999 to 2006, as supplied by the *Department of Education's[51] Higher Education Management Information System (HEMIS)*

- Data relating to the numbers and distribution of healthcare practitioners from the *Health Systems Trust (HST) 2000 – 2008* and *Labour Force Survey*

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[49] I have repeatedly attempted to obtain gender disaggregated professional data from the HPCSA, but have not received this data.

[50] I had access to gender and race disaggregated medical student data from HEMIS for the period 1999 to 2005 (the period of investigation for this study). However, I wanted to extend this analysis in a few tables to report on a trend over 10 years, and thus only requested data for 1996. The years in between would not have made a difference, as the formula used in the relevant tables only took into account the start (1996) and end (2005) years.

[51] This department has subsequently (since 2008/9) been divided into two: the Department of Higher Education and Training (DHET), and the Department of Basic Education (DBE).

- Data on medical student enrolment and graduation in 1996 and from 1999 to 2005, as well as medical student cohort data from 1996 to 2005, will be used, as obtained from the *Institutional Planning Department* for the UCT case study.

I will briefly discuss how the UCT case study will be used in an effort to meet Objective 1, and will later elaborate on how it will be used in an effort to meet Objective 2.

UCT was chosen as a suitable case for further investigation into gendered trends observed in national medical school and profession data for two reasons. Firstly, as explained in the introduction, this case was part of the HSRC's study on the medical profession in SA, and I already had access to a large amount of data from this university that had not been explored to assess the reasons behind the gendered trends observed. Secondly, the cohort data of the larger study was not disaggregated by sex, and my study offered a vehicle by which to specifically explore the reasons behind the possible gendered trends. Again, my analytical position was from an intersectional perspective, and thus my interest was not only to establish the factors impacting on women doctors, but also to highlight the intersection between race and gender. UCT's medical school was a perfect case to explore race and gender transformation in medical education, as it is "a historically white English-speaking university that has undergone considerable change in the composition of its student body and curriculum in recent years" (Breier & Wildschut, 2006: 7).

Thus, in an effort to meet Objective 1 I would use UCT enrolment and graduation data, as well as cohort data. This assisted in establishing the sex trends in attrition at UCT's medical school, thus making possible an in-depth exploration of specific outcomes for medical students within a specific context.

3.3.2 Secondary data analysis

The quantitative data analysis involved the secondary analysis of existing data sets (HEMIS, HPCSA, HST, LFS and UCT cohort data), referred to previously.

This part of the study thus involved an analysis of national enrolment and graduation trends (DoE HEMIS database) and their comparison with cohort student data from the UCT medical school. It will also involve a comparison with data from the Health Professions Council of South Africa (HPCSA) to establish the rate of attrition between graduation and registration as a general practitioner. The former will be undertaken in order to identify and describe the national trends in attrition for males and females, while the latter will focus on identifying the sex trends in attrition evident specifically at UCT medical school. Professional data disaggregated by race and sex were also requested from the HPCSA to allow an investigation of how these variables might influence attrition.

Furthermore, the UCT case study will highlight whether the broader national trends are also evident and experienced in the same way. This most closely approximates Denzin and Lincoln's (2003: 137) description of an instrumental case study where "a particular case is examined mainly to provide insight into an issue". Thus, the case plays a supporting role in the sense that it is supposed to give us insight into a phenomenon. As Mason (2002: 175) points out, qualitative research is particularly good at supporting arguments that focus on "how social phenomena and processes operate or are constituted". This will also give us a sense of the extent to which this case study might be illustrative of the national population, although, because of the small sample size, it cannot be considered appropriate for empirical generalisation purposes.

However, there is an opportunity for theoretical generalisation based on two claims. Firstly, it would be possible to generalise because I have no reason to assume that my sample, and thus my analysis, are atypical (Mason, 2002). Secondly, UCT was selected specifically because it had the highest proportion of women medical students at any medical school in South Africa, and thus would present the most appropriate case to investigate issues associated with the feminisation of medical education in SA. In this way it constitutes a pivotal case (Mason, 2002), which is important not only for exploring, but offering an explanation of, issues (such as attrition and discrimination) underlying the feminisation of the medical profession in SA. The only way that I would be able to make stronger claims to theoretical generalisability would be if I could

establish that the sample of respondents in this study is representative of the wider population to which they belong. However, as established before, and based on the poor quality of racial and sexual disaggregated professional data, I cannot establish representivity accurately.

3.4   OBJECTIVE 2

In order to meet Objective 2 I would need to investigate and answer my second research question: *What are the reasons underlying the attrition trends of women doctors in the SA medical profession between 1996 and 2005.*

This part of the study has both qualitative and quantitative aspects and involved the use of semi-structured personal interviews[52], conducted with three purposively selected samples of women who had graduated from the UCT medical school. The selection of the sample has already been described, and we now discuss the primary data collection method (semi-structured interviews) and tool (interview schedule) used in an effort to answer research question 2.

3.4.1   Primary data collection method (semi-structured interviews)

The decision to use semi-structured interviews as the primary data collection method was based on the advantages that this method could offer in terms of allowing for the inclusion of both closed-ended and open-ended items. The former items produce data that can be processed and analysed easily with quantitative analysis tools, such as the Statistical Package for the Social Sciences (SPSS), while the latter provide space for the respondents to provide a sense of their own, personal experiences and produce data that allows one to ascertain why one might see trends in the quantitative data. I strongly agree with Buzek's (1978) assertion that "women are located structurally and in changing

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[52] This type of interview schedule is aimed at "trac[ing]…historical, political, economic, social and cultural forces in order to clarify how and why these differential impacts… have come about" (GMSH, 1999). It therefore utilises predefined, open-ended questions, as well as some questions that arise naturally during the course of the interview.

organizational and personal contexts that intertwine with subjective assessment to produce knowledge" (cited in Denzin & Lincoln, 2003: 131). Thus, open-ended questions were included because I regarded it as important for women to express themselves through the interview process, as their own understanding of the phenomenon under investigation would be brought to the fore, rather than simply imposing my understanding on the issue. This objective links very well to the theoretical underpinnings of this investigation, as described in Chapter 2, specifically the approach of intersectionality, standpoint theory and voice. Closed-ended questions alone would not have provided this space, and a purely open-ended interview would limit the extent to which one could quantitatively analyse the interview data.

The advantages of using semi-structured interviews are further illustrated and expressed by Mason (2002: 62) as being the space they provide for:

- *an interactional exchange of dialogue* (thus, interviewees would not perceive me as trying to impose my own assumptions on them, but rather letting them speak for themselves);
- *a relatively informal style, with the appearance of a conversation or discussion, rather than a formal question-and-answer format*;
- *a thematic, topic-centred approach* (thus, I could still keep track of the direction of the interview, while ensuring that certain key themes and issues to be investigated are indeed spoken about);
- *allowing the production of situated knowledge* (thus, I could reflect on each respondent's, as well as my own, impact on the creation of knowledge, and consider their idea of, and specific context within which they understand, the issues) (see also Harding's 'feminist standpoint theory' as discussed on pages 27-28 and 33).

The use of the interview as data collection method does not only hold advantages, and in my analysis I will be very careful and critical when evaluating the participants' responses at face value. I will have to be very mindful that the "interview method is heavily

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dependent on people's capacities to verbalise[53], interact, conceptualise and remember" (Mason, 2002:64). Any disadvantage is clearly outweighed by the extent to which interviews consisting of more open-ended than closed-ended questions (see below) would allow me to attain my research objectives, i.e. to establish the reasons behind trends in the quantitative data, which cannot be gleaned from statistical analysis alone. The data thus collected illustrates the ways in which social explanations and arguments can be constructed, and how this emphases the "depth, nuance, complexity and roundedness in data, rather than the kind of broad surveys of surface patterns which, for example, questionnaires might provide" (Mason, 2002: 65). I therefore sacrificed the wider generalisability that a survey questionnaire with predominantly closed-ended questions would have provided, for a more complex explanation and understanding of the social phenomenon under investigation.

3.4.2 Primary data collection tool (interview schedule)

The interview schedule consisted of a total of 51 items, of which four were closed-ended, 29 were open-ended and the remaining 18 were statements. In the latter case, the respondents were asked to use Likert response categories[54] indicating to what extent they agreed or disagreed with each statement, with strongly agree coded as 1, and strongly disagree as 5. The interview schedule was designed to collect a wide range of data on themes related to, or associated with, attrition and women in the medical profession. These themes were identified from the relevant theoretical and empirical literature reviewed in Chapter 2, as well as from previous research (Breier & Wildschut, 2006; Breier, 2009).

A slightly different interview schedule was drafted for each sample of respondents, as some questions were not relevant to all women across all samples. For example, asking

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[53] Although it would seem highly unlikely that medical school graduates would lack the capacity to verbalise, some respondents, specifically those for whom English is a second language, did struggle to express themselves.
[54] The Likert scale was developed by Rensis Likert in 1932. Items forming part of Likert scales usually take on a format in which respondents are asked to strongly agree, agree, disagree, or strongly disagree, or perhaps strongly approve, approve, and so forth.

respondents in sample 2 what the implications would be of moving from public to private practice would not make sense, as the women in that sample had left medical practice altogether (refer to Section 3.2 for a description of the sample selection).

3.4.2.1 Nature of the interviews

The interview schedule does not adequately reflect the nature of the actual interviews conducted for this study. In this regard it is very important to highlight a few points:

Firstly, an examination of the interview schedule might have the reader presuppose a very structured question-and-answer procedure, while the actual interviews proceeded in a much more organic manner. Miles and Huberman (1984) (cited in Creswell, 1994) suggest that researchers conducting qualitative research should consider four parameters: 1) the setting, 2) the actors, 3) the events, and 4) the process. I find these parameters useful to describe the nature of the interviews conducted for this study.

In terms of the setting, most of the interviews were conducted in the respondents' offices. Three were conducted after hours at the respondents' homes, and one in a public coffee shop. Because the date, time and venue for the interview were chosen on the basis of what the respondents considered as most suitable, the interviews arguably occurred in a setting in which the respondents felt comfortable and in control.

In terms of the actors involved in the process, the respondents were all medical graduates and I did not perceive them as being intimidated by my presence. These were highly professional and goal-directed people. I was very aware of the limited time they had available for the interview, and how difficult it was for them to secure time for me to interview them. One respondent stated that, although she felt the research was important, the interview further reduced the already limited 'free time' she could spend with her children.

When we consider the fieldwork process, it is relevant that the interview took place in a setting suggested by the respondents, as well as at a time most suitable for them. It was

encouraging that only one interview had to be postponed, and although these women were clearly very busy, they were very interested in the research and felt that their narratives would make a strong contribution to what they considered to be an important and worthwhile research topic. After completing the interview, I sent each respondent an official e-mail to thank them for their participation in my research. Many were very interested in receiving feedback after the completion of the research project.

A process of 'member checking' (Babbie & Mouton, 2001: 275 – 276) was also agreed upon at the end of the interview. This is where I assured the respondents that I would provide them feedback on quotes that I wanted to use within a specific context in the dissertation. The respondents could then indicate whether this was an accurate reflection of what they had communicated in the interview (refer to Section 3.5.2 for an explanation of the motivation underlying this procedure).

Lastly, it is important to consider the process of the interviews. The actual process of interviewing was determined by the type of individual that was being interviewed. Some respondents were very straightforward and kept to the point, and these interviews lasted roughly an hour, while others were quite passionate about women's issues in general and were very keen to comment at length on issues concerning women in the medical profession. During the pilot interviews, as well as during the interviews conducted for this study, it became clear that the interview process needed to occur in a much less structured fashion than had been anticipated.

In sum, I used the schedule as a way to keep track of all the issues on which I considered it important to probe the respondents, and to ensure that the questions asked would provide the data necessary to answer my research questions, while at the same time attempting to conduct the interview in a less structured, conversational manner. For example, in order to relax the respondent at the start of the interview, I asked her what initially motivated her to pursue a career in medicine. In most cases, this question resulted in a historical overview of the person's entrance into the profession, including obstacles faced and opportunities that presented themselves. In this introductory section,

many respondents already started reflecting on the issues of importance to this particular research project, and their narratives resulted in very rich, in-depth qualitative data. Similarly, at the end of the interview I would ask the respondents to reflect on issues they experienced as problematic in the profession, especially if they felt that these factors were not (adequately) dealt with in the preceding sections of the interview. This also resulted in highly valuable and insightful comments made by the respondents, as it provided them with a space to reflect on issues about which they felt particularly strongly.

In some interviews it was easier to keep to the sequence of questions as per the interview schedule, but sometimes the conversation took other, unexpected turns and the researcher felt it important to explore the issues mentioned. We would then return to the original sequence of questions once the respondent felt an issue had been dealt with adequately. Thus, the researcher and the respondents were allowed to "develop unexpected themes" (Mason, 2002: 62). This also very aptly approximates Burgess's (1984) (cited in Mason, 2002) description of semi-structured interviews as "conversations with a purpose". I wanted the respondents to feel comfortable and that any perspective they wanted to share was important for the research. As a result, some interviews lasted well over an hour, and in one extreme case continued for two hours! The average length of the interviews, however, was approximately one-and-a-half hours.

3.4.2.2 Pilot study

The interview schedules were piloted with five respondents (who were excluded from the analysis for this study): two for the sample 1 interview schedule, two for the sample 2 interview schedule, and one for the sample 3 interview schedule. Some items were modified after this process. The interview schedule was divided into four main sections. The first was designed to gather personal data. The second section focused on gauging the respondents' perceptions of the institutional factors that might affect attrition in the medical profession. The third section focused on gathering data on the societal factors that may influence the attrition of women medical doctors from the profession. The final section attempted to assess the respondents' views and recommendations on how women

medical doctors could be retained in the South African medical profession (see Appendix 4 for the full interview schedule).

Both public sector and private sector doctors were included in the sample; however, it proved very difficult to differentiate between the two, as it became evident in the interviews that most doctors were active in both sectors.

It was also interesting that it proved difficult to differentiate clearly between lecturers in medicine and those active in practice, as many lecturers were still active in practice although the majority of their time was spent as lecturers. Lecturing responsibilities were seen as being part of their roles as doctors. This almost amorphous type of doctor was thus difficult to categorise, but it is possible that it could be a product of women doctors trying to find ways in which to create some flexibility in their practice of the profession.

3.4.3   Primary data analysis method

Before moving on to a description of the way in which the primary data was analysed, I need to explain how the data was coded. The data, of course, includes all the responses to the open-ended and closed-ended items in the interview schedule, as well as instances where the respondents answered the Likert scale of a closed-ended question, but then continued to elaborate, as well as questions and responses that evolved naturally from the interview.

Seidel (1998) says that the coding of qualitative data basically entails the acts of 1) noticing, 2) collecting and 3) thinking, but importantly explains this process as iterative and progressive, and further indicates the importance of expressing the relationship of quotes numerically (in a quantitative manner) as well as qualitatively (in a qualitative manner). Thus, I firstly found it important to use SPSS so that I could achieve the former (in Chapter 5), but also found the manual colour-coding process important, as it allowed me achieve the latter (in Chapter 6).

3.4.3.1 Expressing responses to open-ended items quantitatively

The coding of the data firstly involved assigning case numbers to each interview. Thus, simply put, the first interview I conducted was named case 1, and the respondent became respondent 1. This resulted in the following table of interview information.

Table 3.1: Distribution of respondents across the three samples

Sample 1	Sample 2	Sample 3
Respondent 1	Respondent 3	Respondent 4
Respondent 2	Respondent 16	Respondent 9
Respondent 5	Respondent 17	Respondent 10
Respondent 6	Respondent 18	Respondent 12
Respondent 7	Respondent 19	Respondent 15
Respondent 8	Respondent 20	Respondent 23
Respondent 11	Respondent 21	
Respondent 13	Respondent 24	
Respondent 14	Respondent 25	
Respondent 22	Respondent 26	
	Respondent 27	

Coding essentially involves the reduction of information, in this case the data from the interview transcripts, into manageable data chunks. In my study this involved the following steps:

1. Firstly, all interviews were transcribed verbatim. As indicated earlier, all interviews were tape-recorded. This approximates a mixed-methods approach in that the interview schedule was used to capture answers to specified questions, but that, as mentioned, the interviews were conducted in a conversational manner and many questions therefore arose during the actual interview. In order to capture all this rich data it was important to tape-record the interviews and transcribe them.

2. The interview schedule was already structured according to four themes, creating a provisional 'start list' of codes before starting with the fieldwork (Basit, 2003). As already explained, these four themes (biographical and personal information; perception of the impact of institutional factors on attrition; perception of the impact of societal factors on attrition; recommendations for retention of women

doctors) were selected as categories based on previous literature and studies of women in the medical profession. Basit (2003: 145) asserts that codes can come from "the conceptual framework, list of research questions, hypotheses, problem areas and/or key variables that the researcher brings to the study".

3. As a first sweep, I selected six interview transcripts at random, two for each sample, and categorised the various possible responses that could be elicited from each open-ended question. Thus, my coding essentially involved grouping responses into already defined themes and then, through the process of reading the responses to each open-ended question, identifying further relevant subthemes in the responses. For instance, in relation to the question asking the respondent how she felt that her marital status influenced her experience of the profession, the range of responses were grouped as 1 - Positively, 2 - Negatively, 3 - Has not influenced, 4 - Unmarried, 9 - No comment[55]. This is supported by Basit, who says that "category names can come from the pool of concepts that researchers already have from their disciplinary and professional reading, or borrowed from the technical literature, or are the words and phrases used by informants themselves" (2003: 144). I thus viewed my process of coding as informed by theory, but I also entered into a reflexive process by editing and reviewing themes and categories emerging from the data. For a complete view of how each question was coded, please refer to the codebook in Appendix 5. This process allowed a numerical representation of the types of responses to open-ended questions by the three samples of respondents.

3.4.3.2 Expressing responses to open-ended items qualitatively

In order to express the responses to open-ended items qualitatively, I proceeded with the following steps.

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[55] This process of reducing qualitative data into a quantitative format involves a qualitative analysis, in which the open-ended responses are coded on the basis of the general theme of the response to the relevant item.

1. I read through the transcripts manually[56], colour coding and arranging quotes for use in my analysis. I read and reread the entire interview transcripts and highlighted the relevant quotes that would be useful to illustrate themes and debates already identified in the literature, but that were grouped under the four themes or sections as in the interview schedule (Biographical and personal information - Black, Impact of institutional factors - Green, Impact of societal factors - Red, Recommendations on retention - Blue).

2. Lastly, after chunks of data were organised under these four themes, I further divided the quotes relating to each theme into those that were constitutive and those that were illustrative (Mason, 2002) of the phenomenon I was asking about. Essentially, I chose for inclusion in my analysis those "textual data [that] illuminate questions of importance to social science" (Ryan & Bernard, 2010: 4). In my case, I was interested in ascertaining whether these data chunks indicated the presence/absence of a gendered organisation of medicine (referred to by Rao et al (1999) as the "deep structure"). I made use of Spradley's suggestion to search transcripts "for evidence of social conflict, cultural contradictions, informal methods of social control, things that people do in managing impersonal social relationships. Methods by which people acquire and maintain achieved and ascribed status, and information about how people solve problems" (1979: 199).

3.4.4 Primary data analysis

3.4.4.1 Using meso-analysis

Because I wanted to focus both on women's individual experiences, but also how these experiences were influenced by culture and the institutional structures of medicine, I felt that a meso-analysis would be appropriate. This level of analysis is not only concerned with individual cases, but refers to how societal and institutional forces mesh with human activity (Maines, 1982 cited in Denzin & Lincoln, 2003).

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[56] This method was chosen due to the small size of the overall sample, which had only 27 respondents. As Basit (2003: 143) espouses, "the choice will be made dependent on the size of the project, the funds and time available, and the inclination and expertise of the researcher".

3.4.4.2 Using thematic analysis

Thematic analysis, as explained earlier in the section on coding, essentially starts with the accurate transcription of the data. It simply involves reading through the interview transcripts, identifying units of meaning in the data, and then grouping these units into a theme or themes, which one uses to analyse the data.

3.4.4.3 Using SPSS

The Statistical Package for Social Sciences (SPSS version 17) was used to identify the main patterns in the data through analysing the interview responses. As a preliminary organising step, I coded the open-ended questions into a quantitative form (see codebook), although, as explained before, I analysed mainly the closed-ended items through SPSS as a way in which to identify patterns in the data. The analysis of the responses to the closed-ended questions is important to describe the possible status quo and to allow the investigation of probable and possible relationships between variables. After the general patterns had been established, it was possible to have a better idea of which aspects to explore further and deeper in the qualitative analysis (thematic analysis of the interview transcripts). SPSS is also useful in that it allows the identification of possible constructs that might be useful in studying the attrition of women medical doctors on a larger scale.

It is very important to check the data files for errors before beginning the statistical analysis. By printing out the frequency distributions and codebook of all the closed-ended items I could assess and correct out-of-range cases. To do this, I obtained descriptive statistics on each of my variables and checked for out-of-range cases by comparing the output with my codebook, as well as considering the distribution of the scores.

One is limited, however, in the level of complexity with which one will be able to analyse the data, as the variables are measured primarily on a nominal and ordinal level.

Consequently, it is important, before we proceed, to briefly explain the scale created to measure the impact of the culture[57] of the medical profession on the respondents.

3.5 IMPORTANT ISSUES REGARDING DATA ANALYSIS

The analysis was conducted both quantitatively and qualitatively. Through the use of SPSS, the former coded and analysed the responses arising from the interviews, and thereby expressed the open-ended data numerically. The latter, through meso- and thematic analysis of the open-ended data, and the use of Rao et al's (1999) description of the four elements constituting a gendered substructure in an organisation, considered whether such a gendered organisation of medicine is indeed evident in South Africa. After establishing whether a gendered organisation of medicine is evident within the South African context, I considered, through the narratives of these respondents, whether this can be linked to attrition.

3.5.1 Reliability and validity of quantitative analysis

The validity of the measurement tool was ensured through piloting and amending the interview schedule according to input from the pilot sample of women. I have attempted to ensure face validity of the quantitative analysis by clearly linking my findings and deductions to the issue we were trying to investigate. Content validity in the quantitative analysis was attempted through linking my research methodology to the objectives and research questions of the research project.

3.5.2 Trustworthiness and authenticity of qualitative analysis

A much more difficult task was to maximise the reliability of our qualitative data and analysis. I attempted to ensure reliability through accurately reporting on each step of the research process, in order to ensure possible repeatability. Creswell (1994: 156) refers to "a detailed protocol for data collection". In our analysis, achieving validity is attempted through the accurate representation of the utterances of the respondents. This is my

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[57] This term is conceptualised as representing a combination of those sets of institutional structures and organisational cultural influences that impact on a woman's experience of the medical profession.

attempt at ensuring objectivity, understood by Smaling (1992: 77) as the "endeavour both to let the object speak and not to distort it… doing justice to the object of study".

The reader might be aware that reliability and validity are contested terms in qualitative research. Early qualitative researchers might have felt more "compelled to relate traditional notions of validity and reliability to the procedures in qualitative research", but later and more recent qualitative researchers "developed their own language to distance themselves from the positivist paradigms" (Cresswell, 1994: 157). Thus, the use of terms such as 'trustworthiness' (Babbie & Mouton, 2001) and 'authenticity' (Erlandson, Harris, Skipper & Allen, 1993, cited in Creswell, 1994: 157).

As discussed earlier, I use member checks as a way in which to increase the 'internal validity' (as the accuracy of the information and whether it matches reality) of the findings. The presentation of interview quotes as said by the respondents, without altering their responses, is another method to attempt validity and reliability within the qualitative context. This lets the "respondents speak freely without distorting what they say while we interview them" (Babbie & Mouton, 2001: 275). Also, through a process of triangulation I attempted to overcome many of the barriers usually associated with qualitative research. Triangulation is considered as one of the best ways to enhance validity and reliability in qualitative research (Babbie & Mouton, 2001). As triangulation can involve comparisons and investigations across paradigms, methodologies, methods, researchers, etc., I felt it acceptable to do this by combining various methods (as explained in the research methodology sections). In terms of traditional conceptions of 'external validity', it is important to be aware that we are limited in terms of the empirical generalisability of findings from the study (as discussed before). However, "the intent of qualitative research is not to generalise findings, but to form a unique interpretation of events" (Creswell, 1994: 158-159).

It might also be considered appropriate here to consider the limitations or difficulties associated specifically with conducting feminist research, as experienced in this investigation. In the first place, feminist research centres on and attempts to make explicit

the experiences of women and, secondly, it also highlights the different experiences of women. The former implies the need for the collection of rich and in-depth data, whereas the latter would imply the need for a disaggregation of data. These two central concerns in feminist research, thus might in the case of small sample sizes (like in my study) lead to difficulties in analysing and drawing findings, from data that are disaggregated to the point of presenting difficulties in the identification of clear overarching trends.

3.6 IMPACT OF CULTURE OF MEDICAL PROFESSION (ICMP) SCALE

I constructed this scale to measure whether, and to what degree, the respondents felt that the culture of the medical profession had a negative impact on women doctors' experiences of the profession. I did this to investigate how this factor might relate to women's decisions to leave the profession. Thus, if a respondent achieves a low score on this scale, the respondent does not perceive the culture of the medical profession to have a negative impact on experience of the profession, and vice versa.

The scale includes
- Item 26, which measures whether the respondent feels that a woman doctor's advancement is affected by her location in the organisational power structure (strongly agree = 5 and strongly disagree = 1)
- Item 27, which measures whether the respondent feels that workplace structures present uncomfortable working environments for women (strongly agree = 5 and strongly disagree = 1)
- Item 28, which follows from the previous question (variable 27) and requires the respondent to clarify whether she feels that this has been her own personal experience in her workplace (always = 5 and never = 1)
- Item 30, which measures whether the respondent feels that the typically hierarchical structure of organisational cultures reinforces the unequal power relations between men and women (strongly agree = 5 and strongly disagree = 1)

Once all the response codes had been reversed correctly and combined into a scale, the respondents' responses to these questions were scored from a minimum of 4 to a maximum of 20 points. The scores were grouped into three categories, namely low (4-8 points), medium (9-15 points) and high (16-20 points)[58]. Each respondent thus was "assigned an overall score representing the summation of the scores he or she received for responses to the individual items" (Babbie & Mouton, 2001: 154). Therefore, if the respondent fell into the low category, she would feel that the culture of the profession did not impact negatively on a women doctor's experience of the profession. If a respondent fell into the medium category, this meant that she felt that the culture of the profession sometimes impacted negatively on her experience of the profession. Lastly, if a respondent fell into the high category, this meant that she felt that the culture of the profession always impacted negatively on her experience of the profession. The next two sections report on the reliability and validity of the scale.

3.7.1 Reliability and validity of the ICMP scale

Firstly, having chosen the four relevant items to put into the ICMP scale, I evaluated the mean inter-item correlation, which is shown to be adequate at a value of .508. Yaffee (1998) states that, if the average inter-item correlation is > .6, then it would be appropriate to standardise items and add them together as an index.

Table 3.2: Summary item statistics

	Mean	Minimum	Maximum	Range	Maximum / minimum	Variance	N of items
Inter-item correlations	.508	.353	.702	.349	1.988	.022	4

The reliability analysis is important to test the consistency of this specific measuring instrument. The scale, made up of four selected items (explained above), shows good internal consistency, with a Cronbach's alpha of .803, and can thus reliably be used to

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[58] Cut-offs were established on the basis of the percentile distribution of the sample across the categories used, where the 25th and 75th percentiles were known as the first (Q1) and third (Q3) quartiles, and the 50th percentile corresponds with the median (Foxcroft & Roodt, 2009).

measure the construct we are investigating (impact of the culture of the medical profession). A further test of reliability is provided by examining the inter-item correlation matrix. As shown below, the values in the matrix are all positive, which indicates that the items are measuring the same underlying characteristic.

Table 3.3: Inter-item correlation matrix

	Item 26	Item 27	Item 28	Item 30
Item 26*	1.000	.353	.517	.683
Item 27	.353	1.000	.702	.361
Item 28	.517	.702	1.000	.429
Item 30	.683	.361	.429	1.000

*Note: Please refer back to page 92 for the complete definitions of items 26, 27, 28 and 30.

Factor analysis is another method to ascertain the reliability of a scale, and essentially investigates the extent to which the items selected to be combined into a scale are indicative of one underlying construct. As shown in the correlation matrix (Table 3.6), the factor loadings of each item on one principal component were very good, with the lowest loading being .756 and the highest .839. Furthermore, as shown in Table 3.7, the scale explains 63% of the variance in the principal component.

Table 3.4: Component matrix/factor analysis

	Component
	1
Item 27*	.756
Item 30	.775
Item 26	.806
Item 28	.839
Extraction method: principal component analysis	
a. 1 component extracted.	

*Note: Please refer back to page 92 for the complete definitions of items 26, 27, 28 and 30.

Table 3.5: Total variance explained

Component	Initial Eigenvalues			Extraction sums of squared loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	2.526	63.161	63.161	2.526	63.161	63.161
2	.875	21.866	85.027			
3	.352	8.805	93.832			
4	.247	6.168	100.000			

Extraction method: principal component analysis

The findings of the bigger study from which the idea for this investigation originated allowed careful selection of the questions and themes thought to influence the attrition of women doctors from the medical profession. On this basis, therefore, the strength of content validity, as well as the quality of the measurement of the interview schedule, was ensured (William et al, 2007). The validity of the measurement tool was ensured through piloting and amending the interview schedule according to input from the pilot sample of women.

3.7   OBJECTIVE 3

Objective 3 aims to provide recommendations for the retention of women doctors in the medical profession in South Africa. Of course, this can only be achieved through the analysis of data produced by meeting both the preceding objectives. Thus, I will consider this objective in the concluding chapter.

3.8   ETHICAL CONSIDERATIONS

As the extent of ethics can only be judged on the basis of knowledge of the larger research design, it is appropriate at this stage to consider the ethics of this study. This investigation formed part of a bigger study on the Profession and Education of Medical

Doctors, which received full ethical clearance from the HSRC Research Ethics Committee (see Appendix 1). The respondents were all informed of the objectives of and background to the study through a brief synopsis in the invitation to contribute to the study, as well as in the informed consent form provided before the commencement of the interview. It was explained to each respondent that their participation in the study was completely voluntary and that there would be no negative consequences or penalisation following withdrawal from or refusal to participate at any time during the interview.

It was also explained that all information would be kept confidential and that the respondents could choose to be completely anonymous, be mentioned by name and designation, or by designation only. It was explained to them that this decision was completely voluntary. As a further measure to ensure the reliability of the responses, if the respondents were unclear about the meaning of a term or concept used in an item during the interview process, they could ask for clarification (William, 2006).

Now that the reader has an understanding of the research design underlying the collection and analysis of the data, we turn to Chapter 4, which attempts to meet Objective 1.

CHAPTER 4

AN EFFORT TO MEET OBJECTIVE 1 - THE DIFFERENCE BETWEEN MALE AND FEMALE PROGRESSION IN THE PROFESSION

4.1 INTRODUCTION

As explained in the previous chapter, the quantitative analysis was conducted in an effort to meet Objective 1, which essentially sought to establish the following: *What was the difference between the graduation rate of men and women medical students compared to their entry rates into the SA medical practice, between 1996 and 2005?*

In order to answer this question I needed to do two things (elaborated on below), which included a comparison with the trends in the UCT medical school case study:

1. *Establish the difference between the graduation rate of men and women medical students between 1996 and 2005*

   Firstly, by using Department of Education (DoE) Higher Education Management Information System (HEMIS) data (macro-level trend data), I could provide a sense of the national medical student enrolment and graduation trends between 1996 and 2005 (to establish a picture in terms of the national throughput context, taking sex and race into consideration). Secondly, by using UCT medical student enrolment and graduation data (micro-level trend data) during the same period, I could give a sense of the context of the case study.

2. *Compare the results of the above investigation with entry rates into the SA medical practice between 1996 and 2005*

   Firstly, by using Health Professions Council of South Africa (HPCSA) data, which reflects the number of medical doctors registered, and HEMIS data, I could compare national graduation data with the total number of registered medical practitioners from 2002 to 2007 (to get a sense of national sex attrition trends). Secondly, by using UCT cohort data between 1996 and 2005, I could establish the sex trends in attrition

in the UCT medical school (to investigate whether some of the sex trends in the attrition of graduate professionals are reflected in the UCT case study).

In this chapter, I will make use of the national data sets mentioned above (see Chapter 3 for more detail), as well as explore the above two issues (sex differences in graduation rates, and sex differences in attrition) in the national context and in the UCT medical school case study. Although I will be illustrating trends in enrolment and graduation by evaluating the relevant HEMIS datasets, the UCT cohort data provides an advantage in that it is a better reflection of graduation rates. This data follows a cohort of students, and the graduation rates reflect those of actual students, rather than just the conventional way of establishing graduation rates (although an accepted measure used by the Department of Education [DoE]), which involves dividing graduation numbers of a particular year by the enrolment numbers for the same year. The cohort data I am using here is disaggregated by race as well as sex, making it possible for me to investigate whether the graduation rates differ substantially between men and women medical students, as well as to investigate racial differences. Being able to consider the impact of gender as well as race links well to the overall approach of intersectionality (see Chapters 2 and 3).

Before I attempt to do any of the above, it is important to understand the nature of the samples upon which the analysis will be based.

4.2   DESCRIBING THE SAMPLE

The envisioned samples were as follows: sample 1 (S1), consisting of 10 women doctors in medical practice; sample 2 (S2), consisting of 10 non-practicing women medical doctors; and sample 3 (S3), consisting of five women lecturers in the UCT medical school. The realised samples, however, included two additional respondents, and I thus had an actual sample 1 of 10 respondents, sample 2 of 11 respondents, and sample 3 of six respondents (see Table .1 below). This was purely because of the number of positive responses received on the invitations sent out, and not based on any purposive sampling for specific sample numbers. Sixteen of the respondents gave permission to be identified by designation only, six by name and designation, while five remained anonymous.

Table 4.1: Envisioned and realised samples

Envisioned samples	Realised samples
Sample 1: 10 respondents	Sample 1: 10 respondents
Sample 2: 10 respondents	Sample 2: 11 respondents
Sample 3: 5 respondents	Sample 3: 6 respondents

A description of the sample of women interviewed follows below.

4.2.1 Age

Usually one would include a description of sex, but in this case it will not be necessary as all the interviewees were women. The age distribution showed quite a large range of age between the three samples, with the median age of respondents at 46 years, and still quite a high mean age of 44.67. However, the high mean age is probably due to the inclusion of a retired lecturer in sample 3, which skewed the distribution to the maximum age of 73.

I also offer here the age distribution excluding the lecturers to give a better sense of the distribution of the women that would have been affected directly by choices in terms of attrition from the medical profession. Thus, when we analyse choices and influences, we know this reflects a specific age range and group of individuals. Here we see a much more reduced mean age in sample 1 of 43 (rounded off), and 41 in sample 2.

Table 4.2: Sample distribution on age

Age	N	Mean
Sample 1	10	42.60
Sample 2	11	41.18
Sample 3	6	54.50

4.2.2 Race

Race was used as a variable as we needed to include this as a variable because of my focus on intersectionality. This distribution is completely random, as cases were not

selected on the basis of their race, but on whether they were a female medical graduate from the UCT medical school during a specific period. The pie chart below indicates the racial distribution for the entire sample. The majority of the respondents were white (78%), followed by Indians (11%) and Africans (7%), with a minority of respondents being coloured (4%).

It is impossible to know the extent to which this sample might be representative of the broader SA medical profession. When compared to 2008 HPCSA data on the racial distribution of medical practitioners on the register (as sex and race disaggregated data was not available at the time of writing), the distribution would be as follows: African/Black 16%, coloured 1.5%, Indian/Asian 13%, white 24%, and unspecified 24%. Thus, my realised sample would not be considered representative of the racial distribution of the registered medical practitioners in the broader SA medical practice (although the racial distribution is for males and females, and because we do not have sex and race disaggregated data, we cannot say whether this possibly is representative of the racial distribution of women doctors in the South African medical profession).
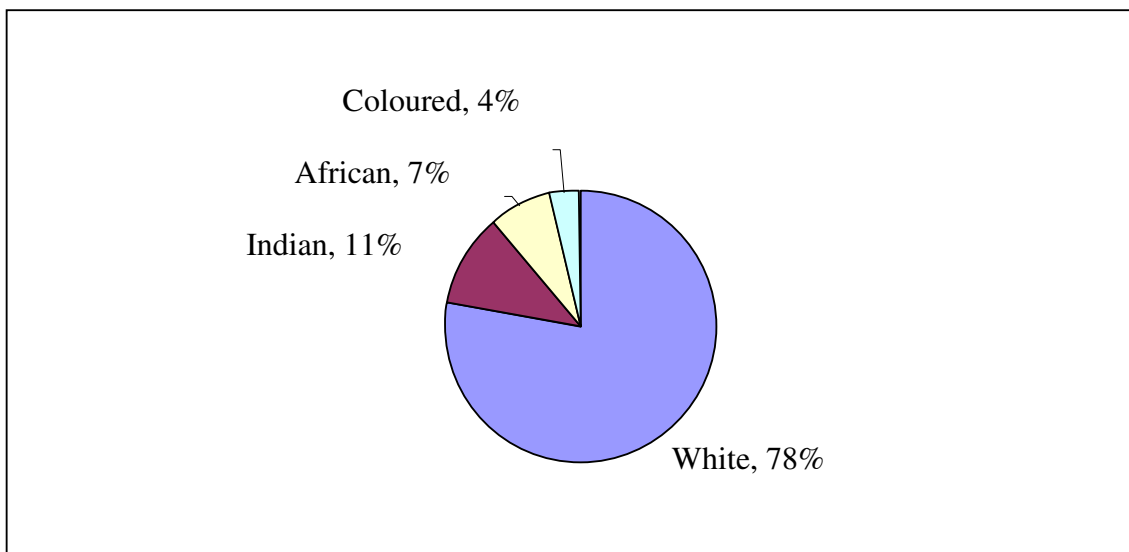
Figure 4.1: Racial distribution across three samples (all respondents)
N = 27

To get a sense of the profile of those respondents that have remained in the profession and those that have left the profession, I also include the racial distribution of samples 1 and 2 respectively.

From the two pie charts of sample 1 and 2, it is evident that, in this sample of respondents. the majority of the people who stayed in the profession (sample 1) were white (60%), with the minority being coloured and African. Whites were also the majority of the people I interviewed who had left the profession (82%), with no coloureds in my sample having left the profession. However, these figures are expected, as whites formed the majority of the overall sample.
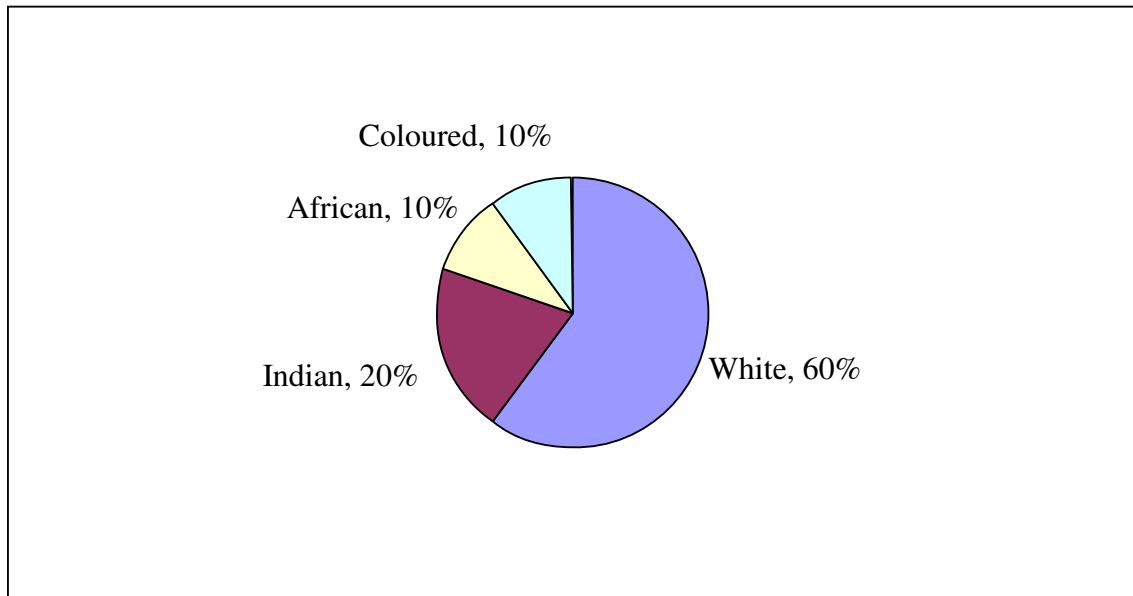
Figure 4.2: Racial distribution of sample 1
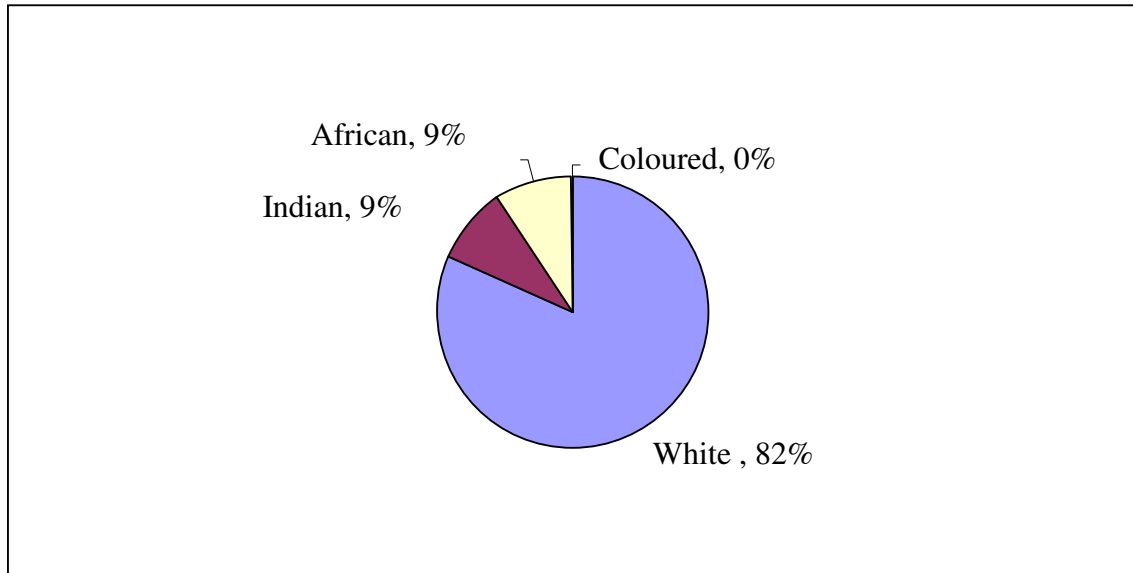
Figure 4.3: Racial distribution of sample 2

4.2.3   Marital status[59]
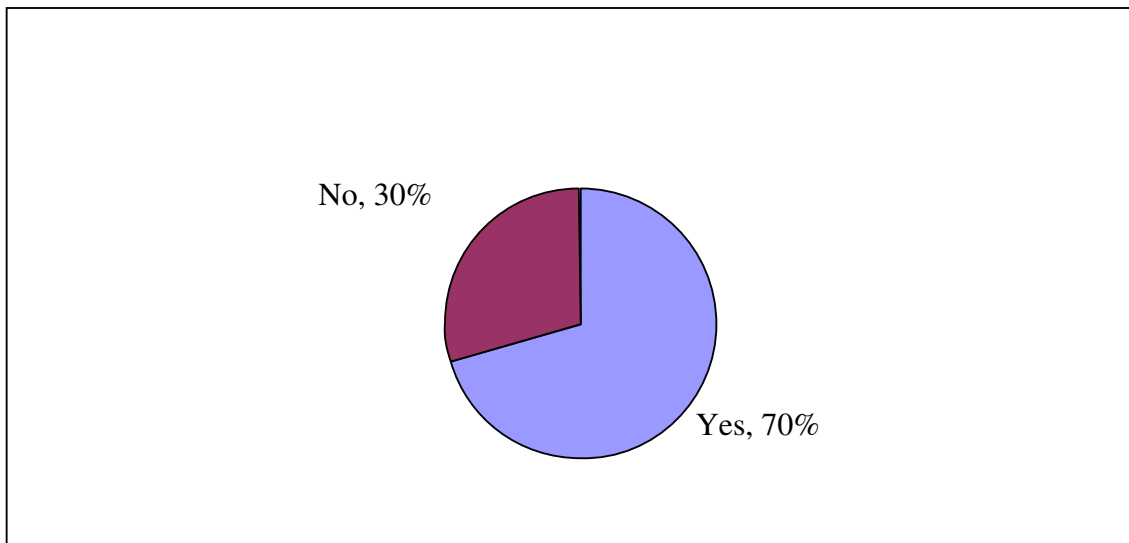
Figure 4.4: Marital status across three samples (all respondents)

N = 27

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[59] Although having only these two response categories can rightly be considered as too simplistic, all the respondents elaborated further when they stated no. Thus, some indicated that they were separated and therefore answered no. Two respondents indicated that this was a second marriage, and another indicated that she was not married at the time, but that she was divorced. However, this item was not used extensively in the analysis. It is only relevant in the description of the sample.

As the pie chart above indicates, the majority of my sample was married at the time of the interviews and, to get a better sense of the marital status of those who had left and those who stayed, I will illustrate the marital statuses of sample 1 and sample 2 in two further pie charts respectively.
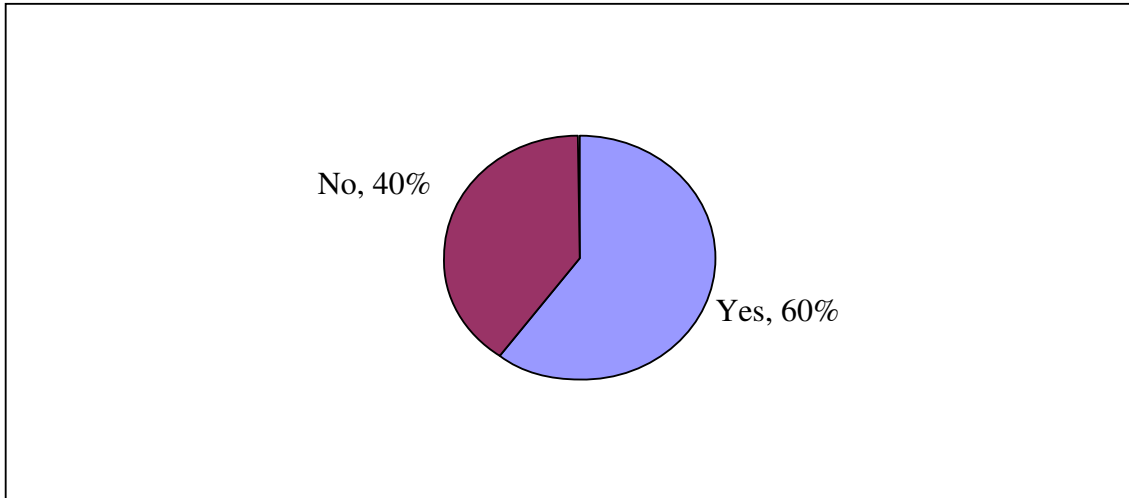
Figure 4.5: Marital status of sample 1
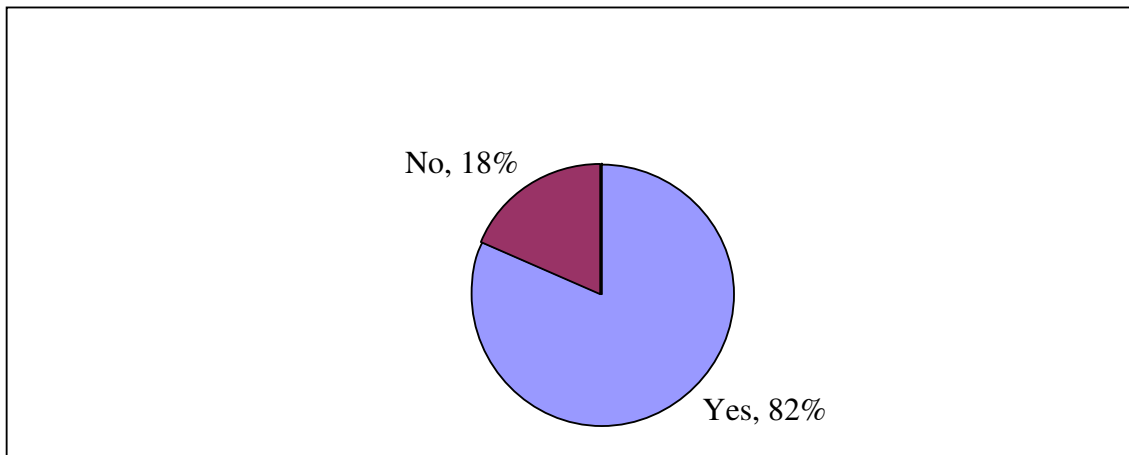
Figure 4.6: Marital status of sample 2

These pie charts indicate that the majority of women in both samples were married, but, more importantly, we notice that a bigger majority of women were married in the sample of women who had left the profession. It will be important to consider the respondents' answers on whether they felt that their marital status influenced their experience of the profession.

4.2.4   Children
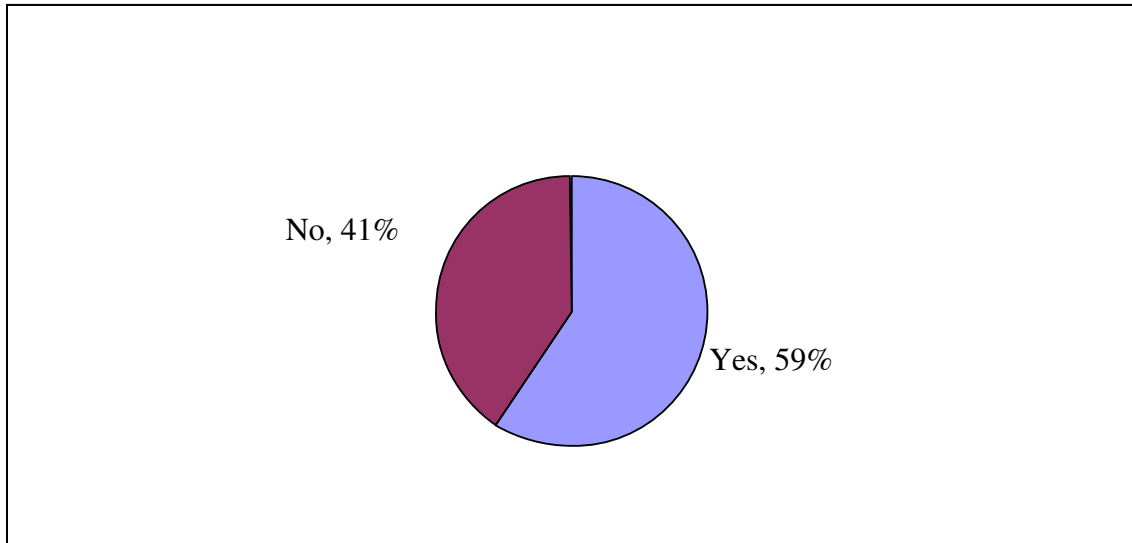
Figure 4.7: Whether respondents (samples 1, 2 and 3) had children

N = 27

From the pie chart above it is evident that the majority of the respondents had children, and it therefore would be very important to consider their answers to the question on whether they felt that this aspect influenced their experience of the profession. We compare sample 1 and 2 in relation to this variable below.
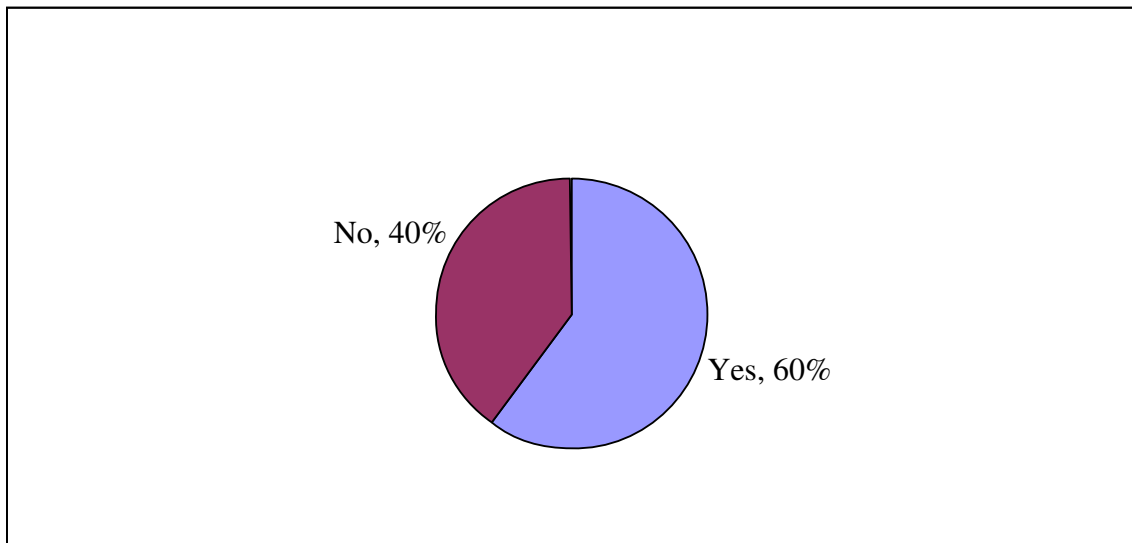
Figure 4.8: Whether respondents in sample 1 had children
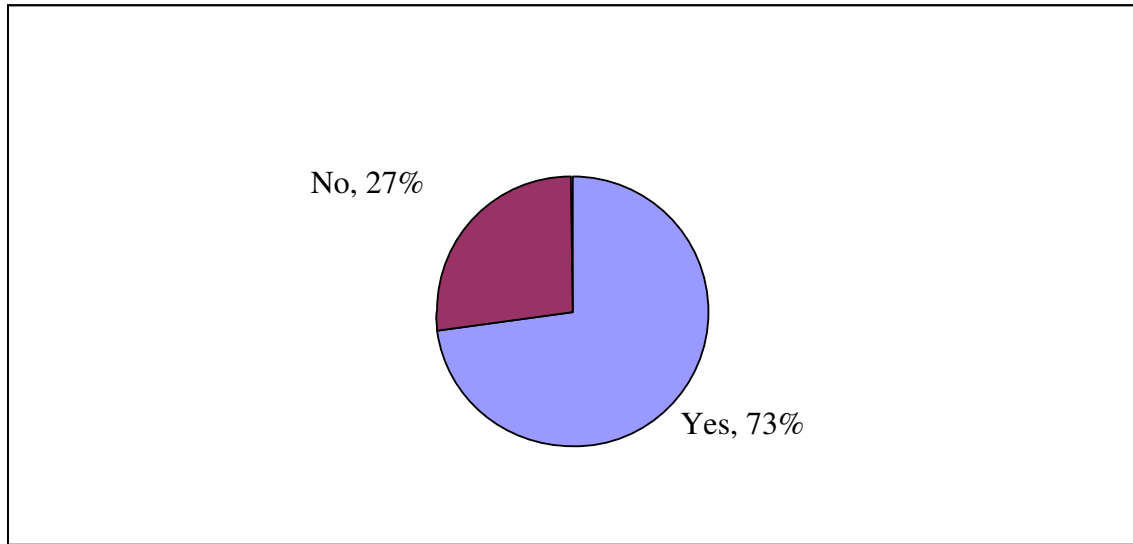
Figure 4.9: Whether respondents in sample 2 had children

The pie chart for sample 1 indicates that the majority of women who stayed in the profession had children, whereas a majority of the sample of women who had left the profession also had children (73%). It is quite surprising that a majority of sample 1 had children, as various studies report on the difficulties associated with remaining in this profession while also having to carry the primary responsibility of child care (for example Riska, 2001).

The descriptive analysis above has described the sample upon which the findings are based. The reader is thus again cautioned to consider the findings in the later sections within this context (please refer back to Chapter 3 for a comprehensive description of the sample selection). I have already indicated that the purpose of this study was not generalisability, but rather highlighting the findings in relation to this sample of women as a *possible* indication of what might be the case generally. Further analyses clearly are needed, and the following two chapters will explore the reasons impacting on these women's propensity to exit or stay in the profession. We now move to a discussion of the national medical student data.

4.3   ESTABLISH THE DIFFERENCE BETWEEN THE GRADUATION RATES OF MEN AND WOMEN MEDICAL STUDENTS BETWEEN 1996 AND 2005

4.3.1   National medical student enrolment and graduation trends (1996 and 2005)

Table 4.3: Enrolments between 1996 and 2005, by sex, race and institution

| Institution | Year | Male | | | | Total male | Female | | | | Total female | Grand Total |
		Afn	Col	Indian	White		Afn	Col	Indian	White		
	1996	134	80	93	329	**636**	113	80	73	337	**603**	**1239**
	2005	152	52	73	129	**408**	232	142	94	227	**699**	**1107**
Cape Town	**% change**	13%	-35%	-22%	-61%	**-36%**	105%	78%	29%	-33%	**16%**	**-11%**
	1996	43	23	8	545	**619**	26	11	3	385	**425**	**686**
	2005	112	18	13	168	**311**	98	24	7	226	**355**	**666**
Free State	**% change**	161%	-22%	63%	-69%	**-50%**	277%	118%	133%	-41%	**-17%**	**-3%**
	1996	944	16	249	79	**1288**	482	11	106	32	**631**	**1719**
	2005	702	7	52	30	**791**	536	9	42	21	**608**	**1399**
Medunsa	**% change**	-26%	-56%	-79%	-62%	**-39%**	11%	-18%	-60%	-34%	**-4%**	**-19%**
	1996	276	22	326	72	**696**	185	19	303	31	**538**	**1234**
	2005	341	23	108	11	**483**	405	45	217	34	**701**	**1184**
UKZN	**% change**	24%	5%	-67%	-85%	**-31%**	119%	137%	-28%	10%	**30%**	**-4%**
	1996	22	14	32	624	**692**	17	6	37	549	**609**	**1301**
	2005	117	17	53	322	**509**	212	34	62	468	**776**	**1285**
Pretoria	**% change**	432%	21%	66%	-48%	**-27%**	1147%	467%	68%	-15%	**27%**	**-1%**
	1996	13	67	15	666	**761**	13	67	9	552	**641**	**1402**
	2005	34	101	37	279	**451**	54	184	79	314	**631**	**1082**
Stellenbosch	**% change**	162%	51%	147%	-58%	**-41%**	315%	175%	778%	-43%	**-2%**	**-23%**
	1996	111	2	11	1	**125**	96	0	6	1	**103**	**228**
	2005	188	10	27	2	**227**	206	2	41	0	**249**	**476**
Transkei	**% change**	69%	400%	146%	100%	**82%**	115%	/	583%	-100%	**142%**	**109%**
	1996	212	25	285	598	**1120**	91	32	268	599	**990**	**2110**
	2005	239	7	133	164	**543**	204	17	226	294	**741**	**1284**
Wits	**% change**	13%	-72%	-53%	-73%	**-52%**	124%	-47%	-16%	-51%	**-25%**	**-39%**
	1996	1755	249	1019	2914	**5937**	1023	226	805	2486	**4540**	**10477**
	2005	1885	235	496	1105	**3723**	1947	457	768	1584	**4760**	**8483**
Totals	**% change**	7%	-6%	-51%	-62%	**-37%**	90%	102%	-5%	-36%	**5%**	**-19%**

Source: DoE HEMIS (1996 – 2005)

What the table indicates clearly is the general growth in medical student enrolment by women, with a concomitant decrease in male medical student enrolment in the period from 1996 to 2005. The enrolment of women medical students experienced a percentage increase of 5%, while male enrolment experienced a percentage decline of 37%. Furthermore, the table also indicates that this trend of the increasing enrolment of women holds for half of the South African medical schools (four out of eight). The trend is most pronounced at the University of Transkei (142% increase), and the least pronounced at the University of Cape Town (with only a 16% increase) during the period. The university with the biggest decline in the enrolment of women was the University of the Witwatersrand (a decline of 25%), while the University of Stellenbosch had the smallest decline over the period (a decline of 2%).

A more extensive examination of the case within the category of women results in the following findings. Although women nationally have experienced growth in medical student enrolments, this is not true for all race categories. Both Indian and white women showed a decline in enrolments, with white women experiencing the biggest decline (-5% and -36% respectively). Coloured and African women both experienced increases in enrolment, with the greatest growth found for coloured women (102%), followed by African women (90%).

The decreasing trend in male enrolment is a much more consistent trend across universities, however, as it holds in all but one case (seven out of eight universities). At the University of Transkei there actually was growth of 82%. In line with the overall decreasing trend in male medical student enrolment, however, the university showing the greatest decline over the period was the University of the Witwatersrand (-51% decline), and the institution showing the smallest decline was the University of Pretoria (-27%).

Furthermore, examining the national race differences within the male category, the trend of decreasing enrolment holds for all men, except African men, who actually experienced an increase in enrolment over the period (7%). The smallest decline in enrolments was

found for coloured men (-6%), followed by Indian men (-51%) and, lastly, white men, who experienced the biggest decline (-62%).

In terms of national medical student enrolments, I found a trend of increasing female enrolment compared to a much stronger trend of decreasing male medical student enrolment. Furthermore, during the period one notes the differences experienced within groups, with the greatest decline in enrolments found for white men, and the greatest increase in enrolments found for coloured women.

Moving to an exploration of the trends in graduation, I find the following, as shown in Table 4.4 below.

Table 4.4: Graduations between 1996 and 2005 by sex, race and institution

Institution	Year	Male				Total male	Female				Total female	Total
		Afn	Col	Indian	White		Afn	Col	Indian	White		
	1996	8	18	12	58	96	4	17	7	70	98	194
	2005	15	2	10	21	48	34	17	11	40	102	150
Cape Town	% change	88%	-89%	-17%	-64%	-50%	750%	0%	57%	-43%	4%	-23%
	1996	0*	1	1	99	101	4	0	0	66	70	171
	2005	8	2	2	30	42	11	4	1	48	64	106
Free State	% change	/*	100%	100%	-70%	-58%	175%	/	/	-27%	-9%	-38%
	1996	124	4	15	11	154	54	0	3	4	61	215
	2005	151	3	14	6	174	109	2	5	4	120	294
Medunsa	% change	22%	-25%	-7%	-46%	13%	102%	/	67%	0%	97%	37%
	1996	28	1	39	3	71	27	4	64	5	100	171
	2005	59	7	40	4	110	79	12	89	8	188	298
UKZN	% change	111%	600%	3%	33%	55%	193%	200%	39%	60%	88%	74%
	1996	1	0	1	112	114	2	0	0	104	106	220
	2005	12	4	8	60	84	18	5	11	79	113	197
Pretoria	% change	1100%	/	700%	-46%	-26%	800%	/	/	-24%	7%	-11%
	1996	0	6	0	99	105	0	12	0	76	88	193
	2005	1	7	8	52	68	2	15	9	56	82	150
Stellenbosch	% change	/	17%	/	-48%	-35%	/	25%	/	-26%	-7%	-22%
	1996	18	0	0	0	18	9	0	0	0	9	27
	2005	24	3	7	1	35	30	1	3	0	34	69
Transkei	% change	33%	/	/	/	94%	233%	/	/	/	278%	156%
	1996	18	2	34	79	133	7	8	25	116	156	289
	2005	29	1	35	37	102	16	3	56	70	145	247
Witwatersrand	% change	61%	-50%	3%	-53%	-23%	129%	-63%	124%	-40%	-7%	-15%
	1996	197	32	102	461	792	107	41	99	441	688	1480
	2005	299	29	124	211	663	299	59	185	305	848	1511
Totals	% change	52%	-9%	22%	-54%	-16%	179%	44%	87%	-31%	23%	2%

Source: DoE HEMIS (1996 – 2005)

*Note: In the cells in which there is a forward slash (/), this denotes that a percentage change could not be computed in the relevant case, as the 1996 figure is equal to 0. The formula includes a division into the 1996 figure, and of course a division by 0 is not possible.

When examining the graduations, I find that women experienced an overall growth of 23%, accompanied by a decline in male medical student graduations (-16%). Unlike the situation at enrolment, the trend of increasing female graduations over the period holds for the majority of universities (five out of eight). The University of Transkei experienced the highest increase (278% growth), and the University of Cape Town experienced the smallest growth (4% growth).

Looking at the graduation trends for women, I find the trend of increasing graduations holds for all but one category, as white women actually experienced a 31% decline. African women experienced the greatest increase (179% growth), followed by Indian women (87% growth) and coloured women, with the smallest increase in graduations (44% growth).

The trend in decreasing male medical student graduations holds for all but three universities, the University of KwaZulu-Natal (with 55% growth), the University of Transkei (94% growth) and Medunsa (13% growth). The biggest decline in male graduations is noted at the University of the Free State (with a 58% decline), and the smallest decline is noted at Wits University (a decline of 23%).

Furthermore, examining the trend for men, I find that, although males overall experienced a decline in graduations, African and Indian men actually experienced an increase of 52% and 22% respectively. The biggest decline in graduations is seen for white men (-54%), followed by coloured men (-9%).

In sum, in terms of graduations I thus find a stronger trend of increasing female graduations, accompanied by a decrease in male graduations. Within race categories I find that white men showed the biggest loss in graduations, while African women have reaped the biggest rewards in terms of graduation growth over the period.

Table 4.5: National medical student enrolments and graduations (1996 and 2005)

National	Year	Male				Total male	Female				Total female	Grand Total
		Afn	Col	Indian	White		Afn	Col	Indian	White		
	1996	1755	249	1019	2914	5937	1023	226	805	2486	4540	10477
	2005	1885	235	496	1105	3723	1947	457	768	1584	4760	8483
Enrolments	**% change**	7%	-6%	-51%	-62%	-37%	90%	102%	-5%	-36%	5%	-19%
	1996	197	32	102	461	792	107	41	99	441	688	1480
	2005	299	29	124	211	663	299	59	185	305	848	1511
Graduations	**% change**	52%	-9%	22%	-54%	-16%	179%	44%	87%	-31%	23%	2%

Source: South African Department of Education (DoE) (HEMIS, 1996 and 2005)

Considering the sex trends in enrolment and graduation, we find an overall increase in enrolment (5%) and graduation (23%) of women, accompanied by an overall decrease in enrolment (37%) and graduation (16%) of men over the period. Within the female category, while coloured women have shown the greatest growth in enrolments (102%), they also have the smallest growth in graduations (44%). Within the male category, African men were the only ones to show an increase in enrolment (7%), and also had the greatest growth in graduations (52%). Significantly, the greatest decline in both enrolments and graduations was seen for white men.

Not only was this examination important in providing the national context within which to consider the sex trends uncovered in the UCT case study, but it shows how gains or losses are not shared equally within race and institution categories. These trends illustrate and highlight the importance of an investigation into, and evaluation of, what and how different factors impact or influence women or men in their efforts to succeed. Next we briefly consider the enrolment and graduation trends at the UCT medical school, before moving on to an investigation of national trends in attrition between graduation and registration as a medical practitioner.

4.2.2 UCT medical student enrolment and graduation trends between 1996 and 2005: illustrating the local context

The previous section presented an overview of the sex and race profiles of medical student enrolment and graduation in South Africa during the period from 1996 to 2005. This should provide very necessary and helpful background for the consideration of the sex trends to be assessed in the UCT case study during the same period. This national evaluation highlighted that, in terms of enrolments and within the context of increasing female enrolment at half of SA medical schools, the trend is least pronounced at the University of Cape Town. Also, in terms of a national trend of increasing female graduation at the majority of SA medical schools, UCT showed the smallest growth. However, at the latest point of evaluation (2005), UCT has the highest proportion of both women medical student enrolments and graduations, and thus still presents the most appropriate case for an investigation of women at medical school in the South African context.

The two tables below reflect the main national trends of increasing female enrolment and graduation, as illustrated by the increase in proportional share of both enrolments (49% in 1996 to 63% in 2005) and graduations (50.5% in 1996 to 68% in 2005). This is accompanied by a decrease in male enrolment and graduation, reflected in the decrease in proportional representation of male enrolment (51% in 1996 to 37% in 2005) and graduation (49.5% in 1996 to 32% in 2005).

Table 4.6: MBChB enrolments at UCT by sex, 1996 – 2005

Year	Male		Female		Total	
	No.	% of total	No.	% of total	No.	%
1996	636	51	603	49	1239	100
1999	470	43.5	610	56.5	1080	100
2000	435	41	635	59	1070	100
2001	450	41	651	59	1101	100
2002	393	38	647	62	1040	100
2003	386	37	658	63	1044	100
2004	394	37	677	63	1071	100
2005	408	37	699	63	1107	100
All	**3572**	**41**	**5180**	**59**	**8752**	**100**

Source: DoE HEMIS (1996, 1999 - 2005)

Table 4.7: MBChB graduates at UCT by sex, 1996 - 2005

Year	Male		Female		Total	
	No.	% of total	No.	% of total	No.	%
1996	96	49.5	98	50.5	194	100
1999	90	49	92	51	182	100
2000	47	35	87	65	134	100
2001	83	51	79	49	162	100
2002	72	43	95	57	167	100
2003	68	44	87	56	155	100
2004	60	38	99	62	159	100
2005	48	32	102	68	150	100
All	564	43	739	57	1303	100

Source: DoE HEMIS (1996, 1999 - 2005)

The tables also illustrate that, over the relevant period, women constituted the majority of medical student enrolments (59%) as well as graduations (57%) at UCT. Men thus formed the minority of both enrolments (41%) and graduations (43%) during the period. Looking at the tables in this way shows that, while men formed only 41% of enrolments, they formed 43% of graduations during the period. On the other hand, while women comprised 59% of enrolments during the period, they actually formed only 57% of graduations. This superficial analysis is obviously not sufficient, as the graduations do not refer to the same enrolments, and thus we will use cohort data in our later discussions and analysis in order to establish attrition in the medical school. However, these two tables are useful to indicate some level of disparity between sex trends in enrolment as well as graduation at this medical school.

Even though there is awareness that these trends are to some extent informed by historical disadvantage due to racial and gender discrimination in the South African medical education and professional landscape, they need further investigation to establish other influencing factors. A deeper investigation into the nuances within the data is clearly needed, and will be the focus of the next chapter. However, before moving on to investigating the underlying factors impacting on these gendered trends, let us briefly consider the nature of attrition from the South African medical profession, as well as the extent to which the UCT medical school case study might reflect these trends.

4.3 ESTABLISHING SEX TRENDS IN ATTRITION

4.3.1 National attrition between graduation and registration between 1996 and 2005

This section, as explained before, involves a comparison of data from the Department of Education's (DoE) HEMIS database and data from the Health Professions Council of South Africa (HPCSA) to establish the rate of attrition between graduation and employment in the profession as a general practitioner. Sex disaggregated professional data was obtained from the HPCSA to allow us to investigate how sex might influence attrition.

Furthermore, to completely meet Objective 1, I would need HEMIS and HPCSA data disaggregated by race. Unfortunately, this exercise resulted in unusable data. Not only is the HPCSA racial categorisation not directly comparable to the HEMIS racial categorisation, but after calculating the data I found large numbers of medical practitioners falling into the unspecified category[60], which would make any racial trend analysis futile. Thus any fluctuations in numbers might rather be an indication of fluctuations in the number of people during the relevant period who were willing to classify themselves as falling into a specific racial category, rather than an actual change in a specific number of people of a specific race. This, in effect, acts as missing data. Moreover, at any given time, the unspecified category makes up roughly 50% of the total number of medical practitioners, and thus has a big impact on any trend analysis and the reliability thereof. Unfortunately the data disaggregated by race could not be used reliably to indicate any trends in terms of race and sex in the profession over time. Due to the large proportion of registered medical practitioners unspecified in terms of race, it was not possible to investigate how these trends might play out in terms of the cross-cutting of gender and race.

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[60] This category comprises three sub-categories of people – those indicating 'other', those leaving that aspect blank, and those indicating unknown in relation to that aspect.

In an effort to present some kind of indication as to the racial translation into the profession, I turned to Labour Force Survey (LFS)[61] data, kept by the Department of Labour (DoL), which indicates the percentages of different races that are in employment in the profession. This differs from the HPCSA data, which includes all the people registered with the professional council. Although this has its own limitations, it is seen as the best indication of what might be the situation in reality, since it measures the number of people in active employment.

Therefore, evaluating the table below in terms of race, African doctors increased from 11% of the workforce in 1996 to 50% in 2005. There also was an increase in Indian doctors, from 3% in 1996 to 11% in 2005. Both coloured doctors (from 8% in 1996 to 2% in 2005) and white doctors (79% in 1996 to 36% in 2005) showed declines.

Table 4.8: Employed medical practitioners by race in percentages, 1996 - 2005

	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
African/Black	11.0	19.6	3.6	14.2	19.1	27.2	24.3	16.6	32.5	50.3
Coloured	7.6	18.9	19.9	5.3	0.0	1.3	8.5	2.3	0.2	2.1
Indian/Asian	2.8	0.0	9.2	8.4	16.6	10.8	8.9	18.1	11.1	10.6
White	78.5	61.5	67.4	69.8	64.3	60.7	58.3	61.6	56.2	36.1
Unspecified	0.0	0.0	0.0	2.3	0.0	0.0	0.0	1.5	0.0	0.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: Labour Force Survey (1996 – 2005)

The LFS data on sex, although different from the HPCSA data (as explained before), reflects very similar trends. The table above reflects quite a steady racial transformation,

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[61] As a result of the transition from one survey dataset to another (from the former October Household survey to the new Labour Force Survey), some discontinuity may be expected between trends expressed in the OHS data from 1996 to 1999, and trends expressed in the LFS data from 2000 to 2005. Thus, in an effort to have a more standardised presentation of data, it is common practice to use percentages rather than raw numbers. Another challenge arising from the data is the high annual fluctuation in the number counts for the key occupational categories. This is a product of the process of weighting raw data obtained through a sample to approximate national parameters. Both of the surveys on which this analysis depends – the OHS and the LFS – are based on samples of the national population (Paterson & Roodt, 2008). The fluctuations are particularly evident when one disaggregates national employment totals by another category, such as province (x 9 sub-categories) or race (x 4 categories) (Paterson & Roodt, 2008).

but below one finds a much slower sex transformation. Although there have been fluctuations during the period, we find that male doctors still form the majority in the profession (71.4%), while women are still in the minority (28.6%).

Table 4.9: Employed medical practitioners by sex in percentages, 1996 - 2005

	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Male	72.2	59.0	65.3	63.9	70.5	61.6	73.2	61.1	52.4	71.4
Female	27.8	41.0	34.7	36.1	29.5	38.4	26.8	38.9	47.6	28.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: Statistics South Africa (StatsSA), Labour Force Survey (LFS) (1996 – 2005)

The trends in the sex and race composition of medical practitioners in the South African medical profession have been illustrated, and it now is important to establish the nature and extent of attrition between graduation and registration.

To be able to present the trends in attrition during my period of investigation (1996 to 2005), I firstly need to compare the numbers of medical student graduates from 1996 to 2002 with increases in medical practitioner registrations from 1999 to 2005. The two-year gap in the comparison is because graduates had to do a one-year internship and one year of community service before registering (the internship period has since been raised to two years[62]). However, after numerous unsuccessful attempts to obtain sex disaggregated profession data for 1999 to 2001 from the HPCSA, I could not extend this analysis to include the entire period of investigation. However, I did have access to professional data for 2006 and 2007 and decided to include these years in my analysis, as it is useful to indicate the possible future direction in the trends after 2005. The table below thus presents and compares the numbers of graduates from 1999 to 2006 with increases in registrations in 2002 to 2007 respectively.

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[62] Traditionally, the MBChB was a six-year degree, followed by a one-year internship. Since mid-2004, the regulations were changed, allowing for a five-year degree with two years' internship. Six-year degrees were permitted to continue with a single year's internship until mid-2006, when the requirement was fully instituted that all internship training would be of two years' duration (HPCSA, 2004).

The calculation below firstly indicates an increase in male graduate progression (calculated as the actual increase in numbers on the register, as a percentage of the relevant graduates) into the profession, from a dismal 39.3% in 2004 to 81.4% in 2007. The progression of women into the profession started off much better than men in 2004 (63.9%), and shows a smaller increase in progression, to 77% in 2007. Also, if we consider the percentage change in progression into the profession for males and females respectively, we find that, between 2004 and 2005, men experienced a bigger increase in progression into the profession than women (32.7% compared to 26.6%). Furthermore, if we consider the same percentage change in progression between 2005 and 2006, we find that males show an increase (6.2%), while females show an 11% decline despite having a higher progression compared to males over this period. Lastly, considering the progression between 2006 and 2007, we find that although a smaller percentage change is noted in comparison to the previous period (2005 – 2006), men showed a 3.2% increase in progression, while women still continued to show a decline, albeit smaller in comparison to the previous period (2005 – 2006), of 1.7%.

Table 4.10: Comparison between graduates and growth in numbers of medical practitioner registrations to establish attrition

Years	Number of MBChB graduates		Number of medical practitioners on HPCSA register		Increase in MPs registered in numbers		Increase in MPs registered as a percentage of graduates two years previously		Percentage change	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
1999	699	610								
2000	577	554								
2001	608	621								
2002	618	594	21881	8022						
2003	639	657	22066	8512	185	490				
2004	629	770	22305	8909	239	397	39.3%	63.9%		
2005	792	688	22750	9447	445	538	72.0%	90.6%	32.7%	26.6%
2006	541	655	23250	9966	500	519	78.2%	79.0%	6.2%	-11.6%
2007			23762	10561	512	595	81.4%	77.3%	3.2%	-1.7%

Source: Compiled from HEMIS and HPCSA data

On the basis of the above data, it seems that there might in actual fact be some cause for concern. The great increases for women at enrolment and graduation would indicate that the feminisation of medical education in South Africa is a reality. To varying degrees, women are increasingly forming the majority of both enrolments and graduations at medical schools. However, by looking at the numbers and percentages of females in the profession, it is evident that women are not well represented. The case has been made on various fronts (for instance by Breier & Wildschut, 2006 and Deech, 2009) that this is to be expected, as women's later entrance into medical schools would translate into quite a time lag in terms of their entrance into the profession. However, the above table indicates that the time lag might not be the only explanation, as we still see definite sex differences in progression into the profession.

If women doctors show poor progression into the profession, we might be facing a critical shortage of medical practitioners to effectively support our national health system, as women are the majority of our pool of graduates. Again, this supports my suggestion that it is imperative to investigate why women exit the profession in an effort to get a sense of the issues that might prevent women from progressing into the profession more effectively. This is where my UCT case study will aim to fill the gap. In the next chapter we will be grappling with the factors influencing attrition by analysing the interview data gathered.

However, before we do that it first is necessary to investigate the UCT medical school case study so that, when we move to a very specific analysis of why attrition occurs in the profession in the next chapter, we also will have a sense of the extent to which the reasons for attrition in this sample of women might be a reflection of their medical school performance.

4.3.2   UCT medical student attrition[63] between 1996 and 2005[64]

The period of examination initially proposed, was from 1996 to 2005, a 10-year period that translates effectively into graduation data of six cohorts of students; 1996–2000, 1997–2001, 1998–2002, 1999–2003, 2000–2004, and 2001–2005. It covers the 10-year period I initially wanted to investigate between 1996 and 2005. An additional advantage of using cohort data to investigate attrition is the opportunity it provides to consider graduation rates more comprehensively, as it includes three categories of graduates (those that graduated in the minimum time, those that graduated in the minimum time + one year, and those graduating in the minimum time + two years[65]).

4.3.2.1 MBChB at UCT: Cohort 1996 – 2001

Looking at the table below, illustrating first-time medical student entrants in 1996, I find the following trends. Firstly, of those who graduated in the minimum time, the graduation rates for women (68%) are actually higher than those for men (67%). African men are struggling in particular, as their graduation rate is only 50%, and also coloured women, with a graduation rate of 47%. At the minimum time, the highest graduation rate was for African and Indian women and coloured men, but these reflect low absolute numbers (for African women, for instance, two enrolled and two graduated).

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[63] When we evaluate medical student attrition, it would be important to consider the possible impact of changes in curriculum assessment, together with gender-related influences, although a justified consideration of the impact of curriculum changes is outside the scope of this study.

[64] The reader is cautioned here that this cohort data reflect small numbers, and thus percentages might be inflated in many instances. This data is useful, however, as different from the macro-level trend data that was analysed earlier, this data reflects the enrolment and graduation of specific individuals (micro-level trend data).

[65] It has been asserted in some studies (Breier, 2009; Deech, 2009; Huda & Agha, 2004) that previously disadvantaged individuals (women, black) usually struggle to complete the MBChB programme in the minimum time due to their poor educational backgrounds, and in the case of women in particular, their absence during pregnancy and childbirth (Jagsi, Tarbell & Weinstein, 2007). Those with poor education often have to be diverted into bridging programmes, especially in the first few years of the MBChB degree. These students thus take longer to complete the degree, although the quality of the eventual graduate might be the same as any other medical student graduate. It thus is an important indicator of the increased quality of medical school enrolments, as well as of the overall reduction in discrimination, if we find that increasing numbers of students are managing to graduate in the minimum time.

Table 4.11: First- time entering students in the six-year programme, 1996

Sex	Race	Total entering	Graduated in minimum time	Graduated in M + 1	Graduated in M + 2	Min. time graduation rate (A)	M+1 graduation rate (B)	M+2 graduation rate (C)	% change between A and B	% change between B and C	Total people not having completed MBChB (D)	D as a % of total entering
Male	African	2	1	0	0	50.0%	50.0%	50.0%	0.0%	0.0%	1	50.0%
	Coloured	10	9	0	0	90.0%	90.0%	90.0%	0.0%	0.0%	1	10.0%
	Indian	19	12	5	1	63.2%	89.5%	94.7%	26.3%	5.3%	1	5.3%
	White	23	14	2	0	60.9%	69.6%	69.6%	8.7%	0.0%	7	30.4%
Total male		54	36	7	1	66.7%	79.6%	81.5%	13.0%	1.9%	10	18.5%
Female	African	2	2	0	0	100.0%	100.0%	100.0%	0.0%	0.0%	0	0.0%
	Coloured	19	9	5	1	47.4%	73.7%	78.9%	26.3%	5.3%	4	21.1%
	Indian	10	9	0	0	90.0%	90.0%	90.0%	0.0%	0.0%	1	10.0%
	White	32	23	2	0	71.9%	78.1%	78.1%	6.3%	0.0%	7	21.9%
Total female		63	43	7	1	68.3%	79.4%	81.0%	11.1%	1.6%	12	19.0%
Grand total		**117**	**79**	**14**	**2**	**67.5%**	**79.5%**	**81.2%**	**12.0%**	**1.7%**	**22**	**18.8%**

Source: University of Cape Town Institutional Planning Department (1996 medical student cohort data)

Furthermore, looking at the trends within groups, the additional years considerably increased the graduation rates, so that graduation rates for men (from 67% to 81.5%) were now marginally better than for women (from 68% to 81%). Also notable is that the additional years did not make any difference to the graduation rate of African and coloured men, but indeed did so for Indian and white men. The additional years made some difference to the graduation rates of white and coloured women. Furthermore, the biggest percentage change in graduation rates for both men and women occurred within the category of minimum + one year, rather than minimum + two years.

Also interesting is the percentage of dropouts/non-completions[66], where it seems that the percentage is quite similar for both men (18.5%) and women (19%), although the latter had a slightly higher dropout rate. For men the highest dropout rate is found in the African category (50%), with the smallest dropout rate for Indian men (5%). For the women, the smallest dropout was found for African women (0%), because all of them passed in the minimum time, and the largest dropout was for white women (22%).

4.3.3.2 MBChB at UCT: Cohort 1997 – 2002

The 1997 cohort reflects the following trends: I find drastically lower levels of attrition compared to the previous years' cohort of students, with the overall dropout rate decreasing from 19% to 13%. Women overall had a very low attrition rate, of 9%, compared to men with 20%. White men had the highest attrition rate within the male category (33%), while no coloured men dropped out in this cohort. African women were struggling in particular, with the highest attrition rate (29%), with white women exhibiting the smallest attrition (2%). In terms of the minimum time graduation rate, white men and Indian women in particular were struggling to graduate.

Examining the trends within groups, considering an additional two years favourably increased graduation rates for both men (67% to 80%) and women (75% to 91%). Furthermore, in line with the trends in the previous cohort of medical students, and much more pronounced, is the fact that the percentage increase between minimum + one and minimum time is greater than between minimum + one and minimum + one, suggesting that an additional one year might impact more significantly on graduation rates than an additional two years.

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[66] This percentage reflects a combination of all those students who graduated in another faculty/programme, dropped out in good academic standing in the current faculty, dropped out in good academic standing in another faculty, were excluded on academic grounds from the FHS, excluded on academic grounds from another faculty, those that were still registered in the FHS, and those that were still busy in other faculties.

Table 4.12: First- time entering students in the six-year programme, 1997

Sex	Race	Total entering	Graduated in minimum time	Graduated in M + 1	Graduated in M + 2	Min. time graduation rate (A)	M+1 graduation rate (B)	M+2 graduation rate (C)	% change between A and B	% change between B and C	Total people not having completed MBChB (D)	D as a % of total entering
Male	African	0	0	0	0	/	/	/	/	/	0	/
	Coloured	10	10	0	0	100%	100%	100%	0%	0%	0	0%
	Indian	15	9	4	0	60%	87%	87%	27%	0%	2	13%
	White	21	12	2	0	57%	67%	67%	9.5%	0%	7	33%
Total male		46	31	6	0	67%	80%	80%	13%	0%	9	20%
Female	African	7	5	0	0	71%	71%	71%	0%	0%	2	29%
	Coloured	17	12	3	0	71%	88%	88%	18%	0%	2	12%
	Indian	14	6	6	0	43%	86%	86%	43%	0%	2	14%
	White	43	38	4	0	88%	98%	98%	9%	0%	1	2%
Total female		81	61	13	0	75%	91%	91%	16%	0%	7	9%
Grand total		**127**	**92**	19	**0**	**72%**	**87%**	**87%**	**15%**	**0%**	**16**	**13%**

Source: UCT Institutional Planning Department (1997 medical student cohort data)

4.3.3.3 MBChB at UCT: Cohort 1998 - 2003

In the 1998 cohort, I find a similar trend of women (27%) again having a lower attrition rate than men (28%). However, compared to the previous year's cohort data, the drop-out rate has dramatically increased for women (from 9% to 27%), as well as for men (from 20% to 28%).

Table 4.13: First- time entering students in the six-year programme, 1998

Sex	Race	Total entering	Graduated in minimum time	Graduated in M + 1	Graduated in M + 2	Min. time Graduation rate (A)	M+1 graduation rate (B)	M+2 graduation rate (C)	% change between A and B	% change between B and C	Total people not having completed MBChB (D)	D as a % of total entering
Male	African	4	2	0	0	50%	50%	50%	0%	0%	2	50%
	Coloured	6	3	0	0	50%	50%	50%	0%	0%	3	50%
	Indian	13	10	0	0	77%	77%	77%	0%	0%	3	23%
	White	23	18	0	0	78%	78%	78%	0%	0%	5	22%
Total male		46	33	0	0	72%	72%	72%	0%	0%	13	28%
Female	African	10	8	0	0	80%	80%	80%	0%	0%	2	20%
	Coloured	13	10	0	0	77%	77%	77%	0%	0%	3	23%
	Indian	11	6	0	0	54.5%	54.5%	54.5%	0%	0%	5	45.5%
	White	43	32	0	0	74%	74%	74%	0%	0%	11	26%
Total female		77	56	0	0	73%	73%	73%	0%	0%	21	27%
Grand total		**123**	**89**	**0**	**0**	**72%**	**72%**	**72%**	**0%**	**0%**	**34**	**28%**

Source: UCT Institutional Planning Department (1998 medical student cohort data)

Furthermore, in this cohort, additional years did not make any impact on the graduation rate at minimum time. Considering the drop-out rate however, specifically African and coloured men have experienced the highest drop-out (50%), while white men have

experienced the smallest drop out (22%). For women, the highest attrition is seen for Indians (45.5%), while the smallest drop-out noted for Africans (20%).

4.3.3.4 MBChB at UCT: Cohort 1999 – 2004

In 1999 I find the same trend, with attrition for women (15.5%) being approximately half of that of men (29%). The highest attrition within the male category is seen for African men (73%), with Indian men faring the best, with no attrition. African women have the highest attrition (35%), with white women showing the lowest attrition (6%).

Table 4.14: First- time entering students in the six-year programme, 1999

Sex	Race	Total entering	Graduated in minimum time	Graduated in M + 1	Graduated in M + 2	Min. time graduation rate (A)	M+1 graduation rate (B)	M+2 graduation rate (C)	% change between A and B	% change between B and C	Total people not having completed MBChB (D)	D as a % of total entering
Male	African	11	1	1	1	9%	18%	27%	9%	9%	8	73%
	Coloured	9	6	1	0	67%	78%	78%	11%	0%	2	22%
	Indian	9	7	2	0	78%	100%	100%	22%	0%	0	0%
	White	16	10	3	0	62.5%	81%	81%	19%	0%	3	19%
Total male		45	24	7	1	53%	69%	71%	16%	2%	13	29%
Female	African	23	4	10	1	17%	61%	65%	43.5%	4%	8	35%
	Coloured	23	13	6	2	56.5%	83%	91%	26%	9%	2	9%
	Indian	16	9	3	1	56%	75%	81%	19%	6%	3	19%
	White	35	29	3	1	83%	91%	94%	9%	3%	2	6%
Total female		97	55	22	5	57%	79%	84.5%	23%	5%	15	15.5%
rand total		**142**	**79**	29	6	**56%**	**76%**	**80%**	**20%**	**4%**	**28**	**20%**

Source: UCT Institutional Planning Department (1999 medical student cohort data)

For both the men and women in this cohort, the additional two years makes a substantial difference to their graduation rates. Men show a positive growth, from 53% to 71%, and women show an even bigger growth, from 57% to 84.5%, indicating that the additional

two years more favourably affected graduation rates for women. Reiterating the previous trend, the increases in graduation rate are also more substantial between minimum time and minimum + one 1 year in this cohort of students.

4.3.3.5 MBChB at UCT: Cohort 2000 – 2005

In the 2000 cohort of students, as observed in previous cohorts, attrition for women (11%) is smaller than that for men (17%), although the highest attrition for women was again found to be African women (32%), while no attrition was noted for Indian women. The highest attrition in the male category was found for African men (23.5%), with coloured men showing no attrition.

In terms of looking at what effect the additional years had on graduation rates, I find that they had a great impact on the graduation rates of men and women in this cohort. The graduation rates of men grew from 55% to 83%, and the graduation rates of women from 64% to 89%. Here one notes that the only percentage increase in graduation rate occurred between minimum time and minimum + one, indicating that, in this cohort of students, minimum + two years had no effect on the graduation rates of either sex.

Table 4.15: First-time entering students in the six-year programme, 2000

Sex	Race	Total entering	Graduated in minimum time	Graduated in M + 1	Graduated in M + 2	Min. time graduation rate (A)	M+1 graduation rate (B)	M+2 graduation rate (C)	% change between A and B	% change between B and C	Total people not having completed MBChB (D)	D as a % of total entering
Male	African	17	5	8	0	29%	76.5%	76.5%	47%	0%	4	23.5%
	Coloured	2	0	2	0	0%	100%	100%	100%	0%	0	0%
	Indian	12	8	2	0	67%	83%	83%	17%	0%	2	17%
	White	16	13	1	0	81%	87.5%	87.5%	6%	0%	2	12.5%
Total male		47	26	13	0	55%	83%	83%	28%	0%	8	17%
Female	African	22	10	5	0	45.5%	68%	68%	23%	0%	7	32%
	Coloured	19	10	7	0	53%	89.5%	89.5%	37%	0%	2	10.5%
	Indian	12	6	6	0	50%	100%	100%	50%	0%	0	0%
	White	38	32	5	0	84%	97%	97%	13%	0%	1	3%
Total female		91	58	23	0	64%	89%	89%	25%	0%	10	11%
Grand total		**138**	**84**	36	0	**61%**	**87%**	**87%**	**26%**	**0%**	**18**	**13%**

Source: UCT Institutional Planning Department (2000 medical student cohort data)

4.3.3.6 MBChB at UCT: considering cohorts over time (1996 and 2005 cohorts)

Examining this data over time provides insights into how the different categories of medical students have performed during the entire period. However, the following tables should not be interpreted as anything but an indication of the trends in graduation rates within each category of graduation. For instance, a percentage decrease in women graduating in the minimum time + one year should not be seen as a negative trend, as it might be indicative of more women graduating in the minimum time, which is a positive outcome. However, of concern is the fact that there had been an overall drop of 6.7% in graduations in the minimum time during this period (shown in table below).

Table 4.16: Graduation rate based on those graduating in the minimum time

Sex	Race	1996			2000			Percentage change
		Total entering	Graduated minimum time	Graduation rate	Total entering	Graduated minimum time	Graduation rate	
Male	African	2	1	50.0%	17	5	29.4%	-20.6%
	Coloured	10	9	90.0%	2	0	0.0%	-90.0%
	Indian	19	12	63.2%	12	8	66.7%	3.5%
	White	23	14	60.9%	16	13	81.3%	20.4%
Total male		54	36	66.7%	47	26	55.3%	-11.3%
Female	African	2	2	100.0%	22	10	45.5%	-54.5%
	Coloured	19	9	47.4%	19	10	52.6%	5.3%
	Indian	10	9	90.0%	12	6	50.0%	-40.0%
	White	32	23	71.9%	38	32	84.2%	12.3%
Total female		63	43	68.3%	91	58	63.7%	-4.5%
Grand total		**117**	**79**	**67.5%**	**138**	**84**	**60.9%**	**-6.7%**

Source: UCT Institutional Planning Department (1996 – 2000)

Men experienced the biggest drop in graduations (-11.3%), with women showing the smallest drop (-4.5%). This is interesting, as when I investigated the graduation figures and examined the trends over time, I noticed an increase in proportional representation of women's graduation rates. The trends examined over time in the cohort data, however, suggest that the gains might not have been as positive for each institution. Thus, although the data in the above table indicate a bigger drop in the graduation rate of men, contrary to expectations based on previously considered graduation data, the table actually indicates a decrease in the minimum time graduation rate for women during the period. This example illustrates how cohort data might be able to illuminate more nuanced trends, which would bring one closer to a comprehensive understanding of a phenomenon and also equip one better to address it.

Investigating the male category more carefully I found that coloured men experienced the biggest drop in graduations (-90%), followed by African men, with a percentage drop of

20.6%. Indian and white men both experienced increases in graduation, with white men showing the most growth (20.4%) compared to the growth for Indian men (3.5%). For women the most drastic drop in minimum graduation rate was seen for African (-54.5%) and Indian women (-40%). Coloured and white women both experienced increases in the minimum graduation rate during this period, with white women experiencing the most growth (12.3%), followed by coloured women (5.3%).

If one considers the same picture, but looks at the graduation rate based on an additional year, there seems to be an increase in the percentage of students graduating in the minimum time + one year. Men have a smaller percentage increase in graduation rate, of 3.3%, with African men having the biggest increase (26.5%), followed by white men (17.9%) and coloured men (10%). Indian men experienced a decrease in graduation rates (-6.1%) in this category.

Table 4.17: Graduation rate based on those graduating in minimum time + one

Sex	Race	1996			2000			Percentage change
		Total entering	Total graduating	Graduation rate	Total entering	Total graduating	Graduation rate	
Male	African	2	1	50.0%	17	13	76.5%	26.5%
	Coloured	10	9	90.0%	2	2	100.0%	10.0%
	Indian	19	17	89.5%	12	10	83.3%	-6.1%
	White	23	16	69.6%	16	14	87.5%	17.9%
Total male		54	43	79.6%	47	39	83.0%	3.3%
Female	African	2	2	100.0%	22	15	68.2%	-31.8%
	Coloured	19	14	73.7%	19	17	89.5%	15.8%
	Indian	10	9	90.0%	12	12	100.0%	10.0%
	White	32	25	78.1%	38	37	97.4%	19.2%
Total female		63	50	79.4%	91	81	89.0%	9.6%
Grand total		**117**	**93**	**79.5%**	**138**	**120**	**87.0%**	**7.5%**

Source: UCT Institutional Planning Department (1996 – 2000)

Table 4.14 indicates that, for women graduating in the minimum time + two years, there is an overall increase of 9% during the period. African women experienced a decline in graduation rate (-31.8%) in this category of graduation as well. White women showed a 19.2% increase in graduation rate over the period, followed by coloured women (15.8%) and, lastly, Indian women, with an increase of 10% over the period.

Indian men are the only ones within the male category to show a decrease in the minimum time + two years graduation considered over this period. All other categories of men showed an increase in those graduating in minimum time + two years (17.9% for white men and 10% for coloured men), with African men showing the greatest increase (26.5%).

Table 4.18: Graduation rate based on those graduating in minimum time +two

Sex	Race		1996			2000		
		Total entering	Total graduating	Graduation rate	Total entering	Total graduating	Graduation rate	Percentage change
Male	African	2	1	50.0%	17	13	76.5%	26.5%
	Coloured	10	9	90.0%	2	2	100.0%	10.0%
	Indian	19	18	94.7%	12	10	83.3%	-11.4%
	White	23	16	69.6%	16	14	87.5%	17.9%
Total male		54	44	81.5%	47	39	83.0%	1.5%
Female	African	2	2	100.0%	22	15	68.2%	-31.8%
	Coloured	19	15	78.9%	19	17	89.5%	10.5%
	Indian	10	9	90.0%	12	12	100.0%	10.0%
	White	32	25	78.1%	38	37	97.4%	19.2%
Total female		63	51	81.0%	91	81	89.0%	8.1%
Grand total		**117**	**95**	**81.2%**	**138**	**120**	**87.0%**	**5.8%**

Source: UCT Institutional Planning Department (1996 – 2000)

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The table below sums up the trends in the three tables above, and is thus only a simplification. It indicates that there was an overall decrease in both men and women who graduated in the minimum time, with males experiencing the biggest decline. Men and women showed increases in those graduating in minimum time + one and minimum time + two years. Within the male group, it is worrying that there had been such a large decrease in coloured males graduating in the minimum time during the period, accompanied by increases in their graduation rate for minimum time + one and minimum time + two years. African men also exhibited the same trend, of decreasing percentages of those managing to graduate in the minimum time, and increasing trends for those graduating in minimum time + one and minimum + two years. The trend for Indian men is promising, since they increased their percentage of those graduating in the minimum time, accompanied by a decrease in those that graduated in minimum time + one and minimum time + two years. For white men it is positive to see that they managed to improve their graduation in minimum time dramatically, but that their rates also improved for minimum time + one and minimum time + two years.

Table 4.19: Comparing percentage change in graduation rates, 1996 - 2000

Sex	Race	min time	min + 1	min + 2
Male	African	-20.60%	26.50%	26.50%
	Coloured	-90.00%	10.00%	10.00%
	Indian	3.50%	-6.10%	-11.40%
	White	20.40%	17.90%	17.90%
Total male		-11.30%	3.30%	1.50%
Female	African	-54.50%	-31.80%	-31.80%
	Coloured	5.30%	15.80%	10.50%
	Indian	-40.00%	10.00%	10.00%
	White	12.30%	19.20%	19.20%
Total female		-4.50%	9.60%	8.10%
Grand total		**-6.70%**	**7.50%**	**5.80%**

Source: UCT Institutional Planning Department (1996 – 2000)

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A trend of improved graduation rates across all types (min time, m + 1 and m + 2) is evident for coloured and white women. Indian women show a disappointing decrease in minimum time, while showing increases for m+1 and m+2. The most disappointing is the trend for African women, who exhibit a drop in graduation rate for all types of graduation.

4.4   SUMMATIVE REMARKS

This chapter set out, firstly, to *establish the difference between the graduation rate of men and women medical students between 1996 and 2005, and found:*

- The increasing feminisation of South African medical education, as illustrated by both the increase in the enrolment and graduation of women, accompanied by an overall decline in enrolment and graduation of men.

- More specifically, coloured women showed the greatest growth in enrolments, while African women showed the greatest growth in graduations. Significantly, the greatest decline in both enrolments and graduations is seen for white men.

- Based on the increases in graduation rates, it does not seem that women particularly struggle with the academic programme in comparison to men; however, gains or losses are not experienced unilaterally across categories. One would have to acknowledge the probability that these fluctuations could be an artefact of a small sample size.

- The UCT case mirrors the national case, as seen in the proportional increase in medical student enrolment and graduation by women, accompanied by a concomitant decrease in male enrolment and graduation during the period.

- Considering proportional representation of the total number of enrolments and graduations at UCT, I found a disparity between the proportion of women in enrolment and their proportion of graduations. Men form a bigger percentage of graduations than their proportional share of enrolments. This could indicate a higher medical school attrition rate for women than for men.

Secondly, I set out to *compare the outcomes of the investigation of the sex differences in graduation with entry rates into the SA medical practice between 1996 and 2005, and found:*

- The race transformation in the profession has been much faster than the sex transformation.

- Based on the model of calculation used (please refer back to Table 4.7), and the specific period under review, although women showed a higher rate of progression into the profession in comparison to men (except for the last year of consideration, 2007), when considered over time, this rate has recently been decreasing to varying degrees. Male progression into the profession is actually increasing steadily, which was not an expected outcome given their decreases in national enrolment and graduation. Thus, although men's proportional representation has been declining overall in the profession, their progression into the profession seems much more successful. This supports assertions elsewhere that the increase in enrolment and graduation of women was expected to produce a much greater progression into the profession[67] than has actually been the case.

- At the UCT medical school, sex attrition is not as straightforward or as pronounced as expected from the consideration of general enrolment and graduation data.

- Investigating the UCT cohort data rendered much more specific results, and the attrition of women medical students was found to be generally lower than that of men between 1996 and 2005. In all but one of the cohorts (1996), women actually had a lower dropout rate than males. This confirms results in other studies, which assert that women do not struggle in medical school and have actually been outperforming males in recent years (see Levinson & Lurie, 2004; Hay & Jama, 2004; Burton & Wong, 2004; BMA, 2004; AAMC, 2003).

- African men actually have the overall highest attrition rate, and in three out of the six cohorts, African women had the highest attrition rate in the female category.

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[67] As Deech (2009: 11) notes, reflecting the UK context, "given that women have represented 50% of medical students since 1991 the impact should have been greater by now".

- Furthermore, in terms of the general cohort data trends, there has been an overall decrease in people managing to graduate in the minimum time, with a bigger decrease for men than for women. The trend analysis suggests that one additional year might yield more substantial increases in graduation rate than an additional two years.

Overall, this chapter allowed us to establish the following:

- That, similar to other studies on the issue, both the UCT cohort and HEMIS data show that women do not seem to struggle in medical school. The UCT cohort data actually indicates an overall higher attrition rate for men.

- That a consideration and comparison of HEMIS data and HPCSA professional registration data indicates, disappointingly, that both men and women in South Africa experience considerable attrition between graduation and registration as a professional.

- Lastly, that although it might be premature to suggest (given that the calculations are based on a relatively short time period), because of changing curriculum training times, and because the trend is not consistent, it seems to be clear based on this calculation and time period, that while men have shown an increase in the rate of progression into the profession, women have shown a decrease (please refer back to Table 4.7).

It is necessary to highlight some confounding factors militating against a clearer understanding of the nature of this attrition:

- The changing length of training; in 1998, when a compulsory community service year was instituted, and in mid-2004, when an additional year of internship was required.

- The fluctuating trends in attrition for both men and women, making it very difficult to form a picture of any kind of consistent trend. However, as noted before, this could be attributable to the small sample size.

- The difficulty in verifying 2008 registration data disaggregated by sex[68].

- The inability to obtain medical practitioner registration data disaggregated by sex for 1999 to 2001.

- The paucity of racially disaggregated medical practitioner data, making it impossible to ascertain how the intersection of race and gender interacts and impacts on attrition.

Thus, acknowledging the limitations of the quantitative data in answering the questions surrounding attrition in the medical profession, we turn to the next chapter. Here I aim to offer more concrete reasons for the attrition of women from the South African medical profession, through an investigation of the differences between responses from women who have left the profession and those who have chosen to remain in the profession, as well as reflecting on the view of lecturers in medicine.

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[68] The 2008 HPCSA registration data for medical practitioners shows a very drastic drop in registrations for both men and women. This might be a function of the additional year of internship that is now showing an effect in the 2008 registration data. The single year of internship was allowed to run until mid-2006, and thus there might have been a time lag in its effect on registrations. Also, queries to verify the reasons for this suspected anomaly in the 2008 data received no response from the HPCSA.

CHAPTER 5

IN AN EFFORT TO MEET OBJECTIVE 2 - QUANTITATIVE ANALYSIS OF PRIMARY DATA

Following from the results reported in Chapter 4, I now embark on effort to meet Objective 2, which aims to *establish and explain the reasons underlying the attrition trends of women doctors from the SA medical profession between 1996 and 2005.*

This part of the study concentrates on a quantitative analysis of the interview data from the respondents and describes the factors they perceive to have impacted on their experiences in the profession during the period 1996 to 2005. This chapter thus presents these women's perceptions and views, based on their personal experiences as women medical doctors in the South African medical profession. We do this firstly to obtain the respondents' general views on why women leave the SA medical profession, and secondly and more specifically, we consider the reasons that motivated respondents in sample 2 to leave the profession by comparing results across the different samples (refer to Section 3.2 for a description of the sample selection). Thirdly, I will report the results of the Impact of the Culture of the Medical Profession (ICMP) Scale, to consider whether my respondents perceived the institutional/organisational culture in the profession to play a role in attrition. This is a particularly important aspect of my research and analysis, as one of the main hypotheses is that women are negatively influenced by the "deeply gendered structure" (Goetz, 1997) of the organisational culture in the medical profession.

Thus, I will,

- Firstly, investigate the impact of institutional[69] and societal[70] factors on attrition through examining and comparing the three samples' responses to questions 11 to 23.

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[69] This refers to those institutional factors of the medical profession that have been identified as impacting on the attrition of women. It includes, for instance, the organisational culture that might be discriminatory, the possibility of a glass ceiling (where women can only advance up until a certain professional level within a profession), sexual harassment in the workplace, etc.

[70] This refers to those wider societal factors (as prescribed by general societal norms and values within a given context) that have an influence on women's experiences in the medical profession. It would include

- Secondly, compare the different samples' responses to two important questions asked in the first section of the interview schedule, namely whether medicine was the respondents' first vocational option, and whether they felt that they had appropriate role models in the medical profession (for demographic information and a profile of the samples, refer to Chapter 3). I do this to get a sense of the impact of individual[71] factors on women doctors' decisions to stay in the profession.

- Thirdly, consider and report on the results of the ICMP Scale to ascertain whether this sample of respondents feels that the culture of the profession negatively impacts on a women doctor's propensity to stay in the profession.

These distinctions between individual, institutional and societal factors are based primarily on the necessity of categorisation to facilitate the easier collection and analysis of the primary data. It would be inappropriate to suggest that these factors do not mutually construct one another. However, these categories of collection and analysis were informed by research in this area (Breier & Wildschut, 2006), and proved useful as an organising mechanism. The limitations associated with this organisation of sets of items are mitigated to some extent by the respondents' own distinctions of the source (individual, societal, institutional) of the impact on their various experiences.

5.1 THE IMPACT OF INSTITUTIONAL FACTORS ON ATTRITION

I will first consider the role of institutional factors in attrition, as measured by responses to 15 items in my interview schedule. A general overview of the responses to each of these questions follows below, and where the type of question permits, I elaborate and analyse more extensively.

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factors such as women having primary responsibility for childcare, the division of labour according to traditional gender roles in the home, and women's gender identity through socialization.

[71] These will refer to the more personal characteristics of individuals that might impact on their experiences of the medical profession. Of course, these factors are also profoundly influenced by societal expectations and often coincide WITH WHAT?.

5.1.1 Reasons for attrition from the medical profession

Question 11 is an open-ended question asking, *According to your view, what contributes to attrition in the medical profession in general, and in SA specifically?* The question was designed to obtain a sense of the main reasons for attrition in the medical profession, and resulted in the following responses from the sample of women. From the table below it is evident that the majority (52%) of respondents felt that, in general, doctors leave because of 'poor working conditions and lack of support in the public sector', followed by 'political uncertainty and crime' (15%), and also notably, 'because of having children' (11%). The latter issue is particularly relevant to women doctors, as women continue to carry the primary responsibility for childcare. It is thus encouraging to see recent recommendations from the National Working Group on Women in Medicine (in England) advocating for "additional support with childcare, and improvement in the opportunities for alternative working patterns" (Deech, 2009: 3).

Table 5.1: Reasons for attrition from the medical profession

What contributes to attrition in the medical profession?	Frequency	Percent
Poor working conditions and lack of support in public sector	14	52%
Political uncertainty and crime	4	15%
Having children and needing more time	3	11%
More opportunities abroad	2	7%
I don't know	2	7%
No career path in public sector	1	4%
Difficult profession	1	4%
Total	27	100%

Note: This table illustrates the responses of all respondents

5.1.2 Impact of the institutional power structure

Question 12 is a statement on the degree to which the respondent agrees or disagrees that *A female doctor's advancement is affected by her location in the institutional power structure.* The five-point Likert scale was collapsed into a three-point scale, and the range of responses was cross-tabulated with the different samples of women (see Table 5.2). It is clear that the majority of respondents agreed with this statement (52%). Furthermore,

not only was this agreement the case in general for this question, but at least 50% in all three sub-samples agreed with the statement.

Table 5.2: Perceptions of the impact of the institutional power structure

A female doctor's advancement is affected by her location in the institutional power structure								
Response	Sample 1		Sample 2		Sample 3		Total	
Agree	5	50%	6	55%	3	50%	14	52%
Undecided	1	10%	3	27%	2	33%	6	22%
Disagree	4	40%	2	18%	1	17%	7	26%
Total	10	100%	11	100%	6	100%	27	100%

5.1.3   Institutional structures uncomfortable

Question 13 is also a statement, which measures the extent to which the respondents agree or disagree that the *Institutional structures[72] present uncomfortable working environments for women*. The table below is a cross-tabulation of the responses to this question and the sample within which the respondents fall. The responses on the five-point Likert scale were again collapsed into a three-point scale. This shows a much clearer division in responses, with no respondent being undecided on this question. A very clear majority of all respondents (74%) agreed with this statement, and this is also the case within each sub-sample (60% for sample 1, 91% for sample 2, and 67% for sample 3). The largest percentage of all respondents who agreed with this statement was in sample 2, where only one respondent disagreed with this statement. This might indicate that women who have left the profession feel particularly negatively influenced by the institutional structures within the medical profession.

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[72] The respondents seem to reflect on organisational culture and institutional structures interchangeably, and thus I would suggest that the reader understand these responses to indicate their general perception of the broader work environment and arrangements.

Table 5.3: Perceptions of whether institutional structures are uncomfortable

Institutional structures present uncomfortable working environments for women								
Responses	Sample 1		Sample 2		Sample 3		Total	
Agree	6	60%	10	91%	4	67%	20	74%
Disagree	4	40%	1	9%	2	33%	7	26%
Total	10	100%	11	100%	6	100%	27	100%

5.1.4 Extent to which discomfort with institutional structures reflects own experiences

Question 13.1 is a statement that measures the extent to which discomfort experienced within the working environment (as indicated in the previous interview statement), has been the respondent's *personal experience at her organisation*. This question does not apply to those respondents that disagreed or strongly disagreed with the statement presented in question 13, and thus the table below reflects missing and valid percentages.

Table 5.4 indicates that half (50%) of the relevant respondents stated that discomfort with the institutional structures has 'always' or 'very often' been their personal experience at their place of work. This finding is quite discouraging and does not bode well for the retention of women doctors (Berhan, 2008; Deech, 2009).

Table 5.4: Extent to which discomfort with institutional structures reflects own experience

Responses		Frequency	Percent	Valid percent	Cumulative percent
Valid	Always	5	18.5	25.0	25.0
	Very often	5	18.5	25.0	50.0
	Sometimes	5	18.5	25.0	75.0
	Rarely	2	7.4	10.0	85.0
	Never	3	11.1	15.0	100.0
	Total	20	74.1	100.0	
Missing	Not applicable	7	25.9		
Total		27	100.0		

Note: This table excludes seven missing values (those respondents who indicated that they did not agree with the statement that institutional structures present uncomfortable working environments for women, and thus question 13.1, which asked respondents whether this had been their own personal experience, was not applicable to them).

5.1.5 How discomfort with institutional structures manifests itself

Question 13.2 was an open-ended question asking the respondents to explain how their experience, as noted in the previous question, manifested itself, and the table below indicates a range of frequencies for the different responses for all respondents. The table indicates that the proportional majority of those respondents who felt that discomfort with the institutional structures within the medical profession reflected their own experience, linked this to treatment by other healthcare practitioners or people in associated professions (nurses, midwives) or patients (22.2%).

Table 5.5: How discomfort manifests itself for relevant respondents

Responses		Frequency	Percent	Valid percent
Valid	Treatment by other healthcare or associated professionals or patients	6	22%	32%
	Working conditions and lack of resources in public sector	4	15%	21%
	No separate change rooms/theatre gear for female doctors	3	11%	16%
	Difficulty to juggle both life and work	3	11%	16%
	Men still dominate high ranks in medicine	1	4%	5%
	Inflexibility for women with children	1	4%	5%
	All of the above	1	4%	5%
	Total	19	70%	100%
Missing	Not applicable	6	22%	
	No comment	2	7%	
	Total	8	30%	
Total		27	100%	

5.1.6 Organisational cultures reinforcing inequality

This is a statement that measures the extent to which the respondent agrees or disagrees that *The typically hierarchical structure of organisational cultures reinforces unequal societal power relations at institutional level.* The responses on the five-point Likert scale were collapsed into a three-point scale. The table below reflects a cross-tabulation between the responses to question 14 and the different samples, and reflects that the

majority of respondents agreed with this statement (70%). A minority of respondents were undecided on this statement (7%).

Table 5.6: Organisational cultures reinforcing inequality, across three samples

Responses	Sample 1		Sample 2		Sample 3		Total	
Agree	7	70%	7	64%	5	83%	19	70%
Undecided	1	10%	0	0%	1	17%	2	7%
Disagree	2	20%	4	36%	0	0%	6	22%
Total	10	100%	11	100%	6	100%	27	100%

5.1.7 Reasons why organisational cultures reinforce inequality

The table below indicates the range of issues raised by the respondents as reasons for their responses to the previous question. Unfortunately, and similar to the outcome in question 13, it seems that these women are more willing to agree with the fact that discrimination exists, but are wary to admit to it in their own experience, or to point out exactly where or how these issues manifest themselves. It is quite interesting to note the respondents' reluctance to admit to this inequality, as reinforced by the organisational culture within medicine, being their own experience, although it was made clear to them they could be totally anonymous. This might also be an indication of their internalisation of the culture[73], as well as the endurance of the masculine gendering process of the medical profession. The majority of the relevant respondents indicated that this was the situation, mainly because men still dominate the high ranks of medicine (41%).

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[73] As reported by Mandelbaum (1978: 138), "one of the means of adaptation to minority-group status [has] been the internalization of dominant group norms by women physicians".

Table 5.7: Reasons why organisational cultures reinforce inequality, all respondents

Responses		Frequency	Percent	Valid percent
Valid	Men still dominate the high ranks of medicine	7	26%	41%
	Still a very masculine environment & incompatible structure for women	4	15%	24%
	Difficult to specialise or advance if you want to have babies, male still ideal worker	3	11%	18%
	Tokenism to create illusion of equality	1	4%	6%
	Male still seen as preferable and better employee	1	4%	6%
	Male-dominated specialisms	1	4%	6%
	Total	17	63%	100%
Missing	Not applicable	6	22%	
	No answer	4	15%	
	Total	10	37%	
Total		27	100.0	

5.1.8 Aspects affecting women doctors' attrition from the profession

In an effort to ascertain which aspect the respondents might see as most prominently affecting women doctors' propensity to leave the medical profession, I present Tables 5.8, 5.9 and 5.10 below. The data in these tables essentially encompasses one question, but asked of three different issues. The first table indicates that the majority of the respondents primarily were negative about the extra year of community service (44% of the total respondents), compared to only 22% feeling primarily positive about this aspect.

Table 5.8: Respondents' views on the extra year of community service, across samples

Responses	Sample 1		Sample 2		Sample 3		Total	
Primarily negative	4	40%	5	45%	3	50%	12	44%
Both positive and negative	2	20%	4	36%	3	50%	9	33%
Primarily positive	4	40%	2	18%	0	0%	6	22%
Total	10	100%	11	100%	6	100%	27	100%

The views on community service in rural areas are illustrated below. Here the responses are more mixed, and the proportional majority of respondents conceded that, although it

was a difficult aspect of training, it included both positive and negative aspects (48%). It is also interesting that sample 2 respondents specifically (women doctors who have left the profession) did not experience this aspect in a primarily negative way, and that the majority of them recognised both the positives and negatives of this aspect of training.

Table 5.9: Respondents' views on community service in rural areas, across samples

Responses	Sample 1		Sample 2		Sample 3		Total	
Primarily negative	2	20%	4	36%	2	33%	8	30%
Both positive and negative	5	50%	6	55%	2	33%	13	48%
Primarily positive	3	30%	1	9%	2	33%	6	22%
Total	10	100%	11	100%	6	100%	27	100%

Contrary to the outcomes of the above question, the item inquiring about the respondents' views on the long hours on call, especially for trainee doctors, indicates firmly that 78% of the respondents felt that this was a primarily negative aspect of the professional culture, with a minority of respondents (4%) feeling primarily positive about this aspect of the profession. However, I am not convinced of the extent to which this could be an indication of a doctor's intention to leave the profession, as all the women in sample 1 felt primarily negative about this aspect, but still were practicing[74].

Table 5.10: Respondents' views on long hours on call, especially for trainee doctors, across samples

Responses	Sample 1		Sample 2		Sample 3		Total	
Primarily negative	10	100%	7	64%	4	67%	21	78%
Both positive and negative	0	0%	3	27%	2	33%	5	19%
Primarily positive	0	0%	1	9%	0	0%	1	4%
Total	10	100%	11	100%	6	100%	27	100%

5.1.9 Views on the importance of issues affecting the attrition of women doctors

A question of particular relevance is whether the respondents felt that the extra year of community service, community service in rural areas and the long hours on call,

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[74] The difficulty associated with linking attitudes directly to behaviour has been explored elsewhere (Bagozzi, 1992).

especially for trainee doctors, would affect a doctor's decision to stay in the profession or not.[75] Some of the respondents are of the view that these three issues do not impact on a doctor's decision to stay in the profession. However, these issues were included in the interview schedule, as identified by previous research (Breier & Wildschut, 2006), as well as the pilot study as specific issues of relevance to the attrition of medical doctors. The cross-tabulation below reveals that a very convincing majority of the respondents (93%) agreed that considered together, all three issues affect the attrition of women doctors, and this was true for all samples (100% of sample 1, 91% of sample 2 and 83% of sample 3).

Table 5.11: Respondents' views on the issues affecting the attrition of women doctors, across samples

Responses	Sample 1		Sample 2		Sample 3		Total	
Agree	10	100%	10	91%	5	83%	25	93%
Disagree	0	0%	1	9%	1	17%	2	7%
Total	10	100%	11	100%	6	100%	27	100%

The majority of the respondents thus agree that these three aspects combined most definitely have an impact on a doctors' propensity to stay in the profession. Across the three issues, it is observed that the biggest majority of respondents feels primarily negative about the long hours on call item. This finding could suggest that long hours on call plays the biggest role (in comparison to the extra year of community service, and community service in rural areas) in the propensity of a doctor to leave or remain the profession. This is also a trend that holds for all samples.

In relation to this question I would have to acknowledge the weaknesses associated with asking double-barrelled questions, but I would argue that this weakness is to a large extent mitigated by the fact that I first asked the respondents' perceptions of each aspect separately. I then asked the respondent to reflect on the answers they had given to each

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[75] Although I asked this question without attaching any specific gender, some of the respondents assumed that this was what I meant and thus elaborated on why these issues might be particularly problematic for women. However, because this question was asked without attaching gender, the responses should be considered as applying to both men and women.

item on feminisation, and then, based on these responses, asked for their general assessment of the impact of feminisation as a whole.

5.1.10 The effect of feminisation

Question 16 ascertains whether the respondents felt that the feminisation of the profession had affected patient care, the healthcare system and the profession itself. Each item was assessed separately. Collapsing this five-point item into a three-point item (Agree, Undecided, Disagree), resulted in the following responses: the proportional majority of the respondents agreed that the feminisation of the profession had indeed affected[76] patient care (48%), the healthcare system (48%), and the profession itself (59%).

Table 5.12: All respondents' views on whether the feminisation of the profession has affected patient care

Samples 1, 2 & 3		The feminisation of the profession has affected patient care			
		Agree	Undecided	Disagree	Total
Total	Count	13	5	9	27
	%	48%	19%	33%	100%

Table 5.13: All respondents' views on whether the feminisation of the profession has affected the healthcare system

Samples 1, 2 & 3		The feminisation of the profession has affected the healthcare system			
		Agree	Undecided	Disagree	Total
Total	Count	13	4	10	27
	%	48%	15%	37%	100%

Table 5.14: All respondents' views on whether the feminisation of the profession has affected the profession itself

Samples 1, 2 & 3		The feminisation of the profession has affected the profession itself			
		Agree	Undecided	Disagree	Total
Total	Count	16	2	9	27
	%	59%	7%	33%	100%

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[76] These questions were asked to assess whether the respondents felt that the feminisation of the profession had affected these three aspects separately. The following question then asked them to consider the nature of the impact as a whole, taking into consideration their responses to all three these aspects.

Based on the aforementioned, it is clear that these respondents agreed that the feminisation of the profession has had an impact on the abovementioned three aspects. To get a sense of their perceptions of the nature of that impact, it is necessary to turn to an examination of the responses to question 16.1.

5.1.11 The nature of the impact of feminisation

The responses to open-ended question 16.1 were divided into five categories (Primarily positively, Negatively, Both positively and negatively, No effect and Don't know). The table below indicates that the proportional majority of respondents (41%) indicated that the increasing feminisation had a mainly positive impact on the medical profession. It is also noteworthy that none of the respondents indicated that the impact of the feminisation of the profession had been mainly negative. However, I would have to acknowledge the probable influence of my own perception when coding the results, as it was an open-ended question.

Table 5.15: All respondents' views on the nature of the impact of feminisation on the medical profession

Responses		Frequency	Percent	Valid percent
Valid	Primarily positively	11	41%	65%
	Both positively and negatively	6	22%	35%
	Total	17	63%	100%
Missing	Not applicable	6	22%	
	No comment	4	15%	
	Total	10	37%	
Total		27	100%	

Note: The four 'no comment' responses that are indicated as missing were respondents that, when asked this question, indicated that they did not know.

Having a sense of the institutional factors that impact on women doctors' propensity to stay in the profession, as a result of the interview responses from this sample of respondents, we now move to a discussion of the societal factors that impact on attrition in the SA medical profession. The section on societal factors covers a total of 11 items. Below follows the responses to each question.

5.2 THE IMPACT OF SOCIETAL FACTORS ON ATTRITION

5.2.1 The impact of societal factors on the attrition of women doctors

This question assessed, as a starting point, whether the respondents felt that societal factors[77] (those outside of the immediate institutional structure) influenced the attrition of female medical doctors from the SA medical profession. The majority of the respondents (89%) agreed with question. Looking at the distribution within samples, I find that this trend also holds across all three samples (90% of sample 1, 91% of sample 2, and 83% of sample 3). However, many of the respondents remarked in the interview that it was quite difficult to divorce societal[78] and institutional[79] culture influences, as they often overlap. This is evidenced by one respondent's remarks: "the profession itself does not encourage, based on the assumption of the outside world's patriarchal, um, model in this country…it's that insidious stuff that impacts on how women relate within the workplace" (R14, sample 1).

I will explore this aspect further during the qualitative discussion in the next chapter.

Table 5.16: Respondents' views on the impact of societal factors on the attrition of women doctors, across samples

Responses	Sample 1		Sample 2		Sample 3		Total	
Agree	9	90%	10	91%	5	83%	24	89%
Undecided	1	10%	0	0%	0	0%	1	4%
Disagree	0	0%	1	9%	1	17%	2	7%
Total	10	100%	11	100%	6	100%	27	100%

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[77] The respondents seemed to understand this as referring to the impact of those aspects associated with the traditional perceptions of women's role in society, and how this influences their experiences within the medical profession.

[78]For example, factors such as childcare, division of labour, gender identity, etc.

[79] For example, factors such as organisational culture, glass ceiling, sexual harassment.

5.2.2 Elaborate on the impact of societal factors on the attrition of women doctors

The respondents were asked to elaborate further on how they perceive societal factors to impact on the attrition of women from the medical profession. The table below indicates the range of answers. The majority of valid responses (70%) attributed the most influence to societal factors associated with perpetuating patriarchy (the role of women as inferior to men as prescribed by religion, culture, etc.). This is where the previous discussion on the separation of spheres, the devaluation of women's work, etc. becomes relevant. It again is notable that 15% of the respondents were not willing to comment on this aspect.

Table 5.17: All respondents' elaboration on the impact of societal factors on the attrition of women doctors

		Frequency	Percent	Valid percent
Valid	Primarily prescribed role of women as	14	52%	70%
	Primarily child care responsibilities	5	18.5%	25%
	Both	1	4%	5%
	Total	20	74%	100%
Missing	Not applicable	3	11%	
	No answer	4	15%	
	Total	7	26%	
Total		27	100%	

Note: Those respondents who indicated undecided on disagree were coded as 'not applicable'.

5.2.3 The impact of race on experience of the profession

Illustrating how it is not always easy to differentiate between the impact of societal and institutional factors, the question below indicates whether these respondents felt that race had an impact on female doctors' experiences of the culture of medicine. Again, the table indicates that the majority of the respondents agreed with question (65%), with the minority disagreeing (9%). Looking at the trend within groups, we find that the majority in both samples 1 and 2 agree with this statement, while only half of sample 3 agreed.

Table 5.18: Respondents' views on the impact of race on a woman doctor's experience of the profession, across samples

Impact of race on experience of profession								
Responses	Sample 1		Sample 2		Sample 3		Total	
Agree	7	70%	7	64%	3	50%	17	63%
Undecided	2	20%	3	27%	3	50%	8	30%
Disagree	1	10%	1	9%	0	0%	2	7%
Total	10	100%	11	100%	6	100%	27	100%

5.2.4 Elaborating on the impact of race on the experience women doctors

Illustrating the enormous impact that race continues to have on women in the South African medical profession, the information in the table below indicates quite a wide variety of ways in which these women feel that it manifests itself in their experience. It is important to note that roughly a quarter of the respondents did not want to comment on this aspect (26%), similar to previous questions, where the respondents were found to agree with the existence of an influencing factor, but were hesitant to identify or elaborate on that factor. The biggest proportion of these women felt that the two most persistent factors contributing to the continued impact of race on the culture of medicine were because of their race group being in the minority in the profession (33%), as well as a noteworthy percentage actually being linked to the perception of patients based on their race (17%).

Table 5.19: All respondents' views on the nature of the impact of race

How does it do so?		Frequency	Percent	Valid Percent
Valid	Because you're in the minority	6	22%	33%
	Perception of patients	3	11%	17%
	Impacts the culture you belong to, thus associated gender roles	2	7%	11%
	In private practice impacts on type of patient pool and ease of transition	2	7%	11%
	Interaction with nursing staff	2	7%	11%
	Because of affirmative action	2	7%	11%
	Depends on the institution	1	4%	6%
	Total	18	67%	100%
Missing	Not applicable	2	7%	
	No answer	7	26%	
	Total	9	33%	
Total		27	100%	

5.2.5 The impact of the societal power structure on the advancement and attrition of women doctors

Question 19 assesses whether, and the degree to which, the respondents agree with the statement that *A female doctor's advancement and attrition is affected by her location in the societal power structure*. The table below indicates that a majority of the respondents agreed with this statement (59%), and that this was also true across samples (60% for sample 1, 55% for sample 2, 67% for sample 3). The minority of respondents were undecided on this issue (7%). It is quite interesting to note that the groups of women who were still active in the profession (samples 1 and 3) had bigger majorities agreeing with this statement. One would have to consider whether their continued proximity to the profession gives them better insight into this question, which could partly explain why the biggest proportion in the category of 'disagree' were sample 2 respondents.

Table 5.20: Respondents' views on the societal impact on women's advancement and attrition, across samples

Responses	Sample 1		Sample 2		Sample 3		Total	
Agree	6	60%	6	55%	4	67%	16	59%
Undecided	1	10%	1	9%	0	0%	2	7%
Disagree	3	30%	4	36%	2	33%	9	33%
Total	10	100%	11	100%	6	100%	27	100%

5.2.6 The impact of organisational culture on plans for family life

Question 20 asks whether the respondents felt that their *plans regarding family life had been altered by the organisational culture of the medical profession*. What was very significant, as shown in Table 5.21, was that the majority of these women acceded that the culture in the profession had made them change a lot of decisions with regards to their family, and whether or not they would have children (67%). It is also notable, and indicative of very clear perceptions around this issue, that none of the respondents was undecided on this question.

Table 5.21: Respondents' views on the impact of organisational culture on plans for family life, across samples

	Sample 1		Sample 2		Sample 3		Total	
Agree	7	70%	7	64%	4	67%	18	67%
Disagree	3	30%	4	36%	2	33%	9	33%
Total	10	100%	11	100%	6	100%	27	100%

5.2.7 The nature of the impact of organisational culture on plans for family life

When asked to indicate how the organisational culture had affected their decisions around family life, the respondents provided a range of answers, as indicated in the table below. Most notably, 35% of the respondents indicated that it had impacted on their choices with regard to the timing as well as number of children, while a further 35% indicated that it had negatively impacted on the quality of their family life.

Table 5.22: All respondents' views on the nature of the impact of organisational culture on plans for family life

Responses		Frequency	Percent	Valid Percent
Valid	Impacts amount of children as well as timing	6	22%	35%
	Has negatively impacted on quality of family life	6	22%	35%
	Have not been able to focus on anything else except my career	3	11%	18%
	Negatively impacts on career prospects	1	4%	6%
	Resistance to exposure to disease	1	4%	6%
	Total	17	63%	100%
Missing	Not applicable	9	33%	
	No answer	1	4%	
	Total	10	37%	
Total		27	100%	

5.2.8   Desire to drop out during education

The table below indicates that, to a varying degree, most respondents rarely felt like dropping out at some stage during their education, as the majority of respondents (63%) disagreed with this statement. It is also quite significant that this holds true across all samples. It is quite surprising that the respondents in sample 2 represented the smallest proportion of those who agreed with this statement. One would have to consider whether this might indicate that their experiences in medical school were not a very good indication of whether women doctors remained in or eventually left the profession. Also, when reviewing the reasons why the respondents in the sample said they had left (see Table 5.24), these rarely centre on their educational experience. This confirms the findings alluded to before, that women do not seem to struggle during their medical education and training (Hay & Jama, 2004). This could suggest that most of the respondents left for reasons related rather to their exposure to the profession than the medical education environment. This possibility is supported by the data discussed in the previous chapter that showed that although women are performing well in medical school, their progression into the profession is a much more problematic and complex issue.

Table 5.23: Respondents' views on desire to drop out during education, across samples

Responses	Sample 1		Sample 2		Sample 3		Total	
Agree	4	40%	2	18%	2	33%	8	30%
Undecided	0	0%	2	18%	0	0%	2	7%
Disagree	6	60%	7	64%	4	67%	17	63%
Total	10	100%	11	100%	6	100%	27	100%

5.2.9   Factors contributing to a desire to drop out

In an effort to gain a better sense of the reasons why people left, I turned to the responses to question 22.1, which asked the respondents to indicate which factors made them want to leave the profession. Because the responses are varied, and a large number of responses are missing for this item, an analysis of the proportional importance of the different reasons would be inappropriate. However, Table 5.24 provides a useful indication of the range of issues that the respondents perceived as having an impact on attrition.

Table 5.24: All respondents' views on factors contributing to a desire to drop out

	Responses	Frequency	Percent	Valid percent
Valid	Long hours on call	1	3.7	10.0
	Theoretical aspect of undergrad years	2	7.4	20.0
	Difficulty of studies	2	7.4	20.0
	Stress	1	3.7	10.0
	Felt discouraged	1	3.7	10.0
	Lack of quality of life, conditions in public service	1	3.7	10.0
	When my child was born	1	3.7	10.0
	Exposure to disease	1	3.7	10.0
	Total	10	37.0	100.0
Missing	Not applicable	17	63.0	
	Total	27	100.0	

5.2.10 Implications for those wanting to move between sectors of practice

Question 23 asked the respondents what the major implications would be for them personally if they decided to move from the private to the public sector and vice versa.

This question was not appropriate to ask the women in sample 2, as they were no longer practising. This question was important to obtain an indication of the forces driving movement between and sometimes attrition from either of the two sectors. The majority of the respondents said they would move either to the public or private sector based on financial and flexibility-related incentives (44%). The view is that the public service is undesirable because it is under-resourced and accompanied by bureaucracy, low remuneration, lack of flexibility of working hours and a lack of security, while the private service is regarded as being desirable because it is seen to offer exactly the opposite[80]. Most respondents acknowledge that they would be able to earn more money in the private sector, although many are divided with regards to the perspective of increased flexibility, because of the long hours still associated with establishing a private practice, as well as the specialization a doctor chooses.

Table 5.25: All respondents' views on implications of wanting to move between sectors of practice

Responses		Frequency	Percent	Valid percent
Valid	Mainly financial and flexibility in terms of time	7	26%	44%
	Politics in the public sector	1	4%	6%
	Impossible for me to move	3	11%	19%
	Isolation & constraints from funder industry in private sector	5	19%	31%
	Total	16	59%	100%
Missing	Not applicable	11	41%	
Total		27	100%	

Since the following chapter will summarise and discuss the main findings of the research, as well as other secondary information and literature, in order to provide recommendations for the retention of female medical doctors in the South African medical profession, I thought it appropriate to report on the views of the respondents with regard to retention in the next chapter.

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[80] The problems in the public sector have been discussed before (Coovadia et al, 2009).

5.3   THE IMPACT OF INDIVIDUAL FACTORS ON ATTRITION

This section will briefly evaluate the responses to questions 4 and 6 in the first section of the interview schedule. These two questions are important to consider here in order to get a sense of the possible profile of women who have a bigger propensity to leave or stay in the profession (we have already profiled the samples according to demographics in Chapter 2). I thus compare the samples on whether they viewed medicine as their first vocational option (to ascertain whether they were committed to the profession in the first place), and on whether or not they felt that they had appropriate role models in the profession (to ascertain whether a lack of appropriate role models could have impacted on their decisions to leave the profession)[81].

As indicated in Table 5.27 below, whether or not medicine was the respondent's first vocational option did not seem to have a significant impact on whether they would stay in or eventually leave the profession, as the majority of the respondents overall agreed that medicine was their first option (74%), as well as the majority in each sample (70% of sample 1, 73% of sample 2, 83% of sample 3). However, it is noteworthy, and consistent with our expectations, that the largest percentage of respondents that disagreed with this statement was found in sample 2 (27%).

Table 5.26: Respondents' views on medicine as a first vocational option, across samples

Responses	Sample 1		Sample 2		Sample 3		Total	
Agree	7	70%	8	73%	5	83%	20	74%
Undecided	1	10%	0	0%	0	0%	1	4%
Disagree	2	20%	3	27%	1	17%	6	22%
Total	10	100%	11	100%	6	100%	27	100%

However, whether people felt that they had appropriate role models in the profession differed substantially between the respondents who had left and those who had stayed. If we collapse the five-point scale into a three-point scale (Agree, Undecided and Disagree), we find that 60% of the respondents in sample 1 felt that they had appropriate role

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[81] Others (Kvaerner et al, 1999; Breier & Wildschut, 2006; Deech, 2009) have underscored the importance of providing access to mentors and role models in an effort to retain women doctors.

models in the profession, whereas 73% of the respondents in sample 2 felt that they did not. This could suggest that positive identification with appropriate role models in the profession might affect women doctors' decisions to stay in the profession.

Table 5.27: Respondents' views on appropriate role models, across samples

Responses	Sample 1		Sample 2		Sample 3		Total	
Agree	6	60%	3	27%	5	83%	14	52%
Undecided	1	10%	0	0%	1	17%	2	7%
Disagree	3	30%	8	73%	0	0%	11	41%
Total	10	100%	11	100%	6	100%	27	100%

5.4 RESULTS OF THE ICMP SCALE WHEN APPLIED TO THE RESPONDENTS

To ascertain whether the culture of medicine has an influence on the attrition of women medical doctors from the SA medical profession, and the degree of that influence, I constructed the ICMP scale, as mentioned before. The table below illustrates the descriptive statistics for each item on the ICMP scale. If we direct our attention to the mean scores on each item, with 1 indicating strongly disagree and 5 indicating strongly agree, we find that there was general agreement that the specific construct (culture of the medical profession) did affect a women doctor's propensity to stay in the profession. The majority of means (all except one item) were above 3.5, which is closest to a score of 5, thus indicating strong agreement (refer to Chapter 3, where we established the basis upon which the categories are divided into low, medium and high).

Table 5.28: Descriptive statistics for the results on the ICMP Scale

	N	Min	Max	Mean
Variable 30[82]	27	1.00	5.00	3.7778
Variable 28[83]	27	1.00	5.00	2.7407
Variable 27[84]	27	1.00	5.00	3.6667
Variable 26[85]	27	1.00	5.00	3.6296
Valid N (listwise)	27			

Across the four items included in the scale, the highest percentage of respondents scored in the high category, meaning that the proportional majority of the respondents (44.4%) felt that the culture of medicine did have a negative effect on female medical doctors' decisions to stay in the profession.

Table 5.29: Respondents' levels of agreement on the ICMP Scale

Category	Frequency	Percent
Low	4	15%
Medium	11	41%
High	12	44%
Total	27	100%

I have now presented the general characteristics of the sample and their responses to the items selected for the scale, as well as their general responses on the scale itself. The main findings of this chapter will not be considered in preparation for a wider discussion in the next chapter.

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[82] Variable 30 measures whether the respondent feels that the typically hierarchical structure of organisational culture reinforces the unequal power relations between men and women (strongly agree = 5 and strongly disagree = 1).

[83] Variable 28 follows from the previous question (variable 27) and asks the respondent to clarify whether she feels that this has been her own personal experience in her workplace (always = 5 and never = 1).

[84] Variable 27 measures whether the respondent feels that workplace structures present uncomfortable working environments for women (strongly agree = 5 and strongly disagree = 1).

[85] Variable 26 measures whether the respondent feels that a woman doctor's advancement is affected by her location in the organisational power structure.

5.5   SUMMATIVE REMARKS

In terms of the first goal (*Investigate the impact of institutional and societal factors on attrition*), I found the following main trends in this sample of women doctors:

- The majority of the respondents felt that doctors in general leave because of 'poor working conditions and lack of support in the public sector'. This is not surprising, and has been asserted as problematic by many doctors in various countries, but also specifically in South Africa (Harvey, Davison & Bichovsky, 1998; Chankova et al, 2009; SAMJ, 2009; Coovadia et al, 2009).

- The biggest proportion of respondents strongly agreed that a female doctor's advancement is affected by her location in the institutional power structure, and that the typically hierarchical structure of organisational cultures reinforces unequal societal power relations at institutional level.

- The proportional majority of respondents agreed that institutional structures present uncomfortable working environments for women, although many feel that this has never been their own experience.

- The proportional majority of respondents felt primarily negative about the extra year of community service, recognised both the positive and negative aspects of community service in rural areas, and felt primarily negative about the long hours on call, especially for trainee doctors. The proportional majority of respondents agreed strongly that these three aspects most definitely had an impact on a doctor's propensity to stay in the profession.

- The proportional majority of respondents agreed that the feminisation of the profession has mainly impacted positively on patient care, the healthcare system, and the profession itself.

- The majority of respondents strongly agreed that societal factors influence the attrition of women doctors, and the majority attributed the most influence to those factors associated with perpetuating patriarchy.

- Highlighting the continued influence of race, the proportional majority of respondents strongly agreed that the race of a female doctor impacted on her

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experience of the culture of the medical profession. This confirms findings by others (Walker, 2003, 2005; Breier & Wildschut, 2006).

- The proportional majority of respondents strongly agreed that a female doctor's advancement and attrition were affected by her location in the societal power structure, and acceded that the culture in the profession had made them change decisions with regard to their family (refer to Tables 5.21 and 5.22).

- Most respondents had felt like dropping out at some stage during their education, although the biggest majority of those who actually ended up leaving the profession (sample 2 respondents) strongly disagreed with this statement. Most women wanted to drop out/did drop out because they had a child, or because of the lack of quality of life they felt they were experiencing in the profession.

In terms of the second goal (*compare different samples' responses to whether medicine was the respondents' first vocational option and whether they felt that they had appropriate role models in the medical profession*), the following main trends were found in this sample of women:

- Whether the respondents felt that medicine was their first vocational option did not differ substantially between sample 1 (70% agreed) and sample 2 (73% agreed).

- Whether the respondents felt that they had appropriate role models in the profession seemed to be a more important factor in their identification with, and propensity to stay in, the profession. This is based on the finding that the responses differed substantially between those respondents who had left (sample 2) and those who had stayed in (sample 1) the profession. Sixty percent of respondents in sample 1 felt that they had appropriate role models in the profession, whereas 73% of sample 2 respondents felt that they did not. This could suggest that positive identification with appropriate role models in the profession might affect women doctors' decisions to stay in the profession. This is an important finding, as having role models has been identified by others as essential for women's advancement and retention in the profession (Richardson & Redfern, 2000; Riska, 2001; Park et al, 2005; Deech, 2009). What also surfaced is

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the changing idea of what aspects are valued as appropriate in a role model (this will be elaborated on in the next chapter).

In terms of the third and last goal (*report on the results of the ICMP scale*), we found the following main trend in this sample of women:

- The biggest proportion of all the respondents ranked high on the ICMP scale and thus agree that the culture in medicine most definitely impacts negatively on women doctors' propensity to stay in the profession.

In this chapter I have presented the outcomes of my attempt to meet Objective 2 numerically, and have found that there were no major differences between either the profiles of the respondents in samples 1 and 2, or their responses to most questions. On the contrary, in terms of both institutional and societal factors I found that these samples of women definitely felt that these factors influenced women doctors' propensity to stay in the profession. What was also quite apparent was the difficulty they had in divorcing the influence of these two factors (institutional and societal) on their experiences, as well as the importance they assigned to each in making decisions on their participation in the profession. This is in stark contrast to arguments of gender essentialism (Hakim, 2000), which would assert that men and women are fundamentally different and this is what explains differences in employment patterns, but in line with the arguments of others (Crompton & Lyonette, 2005; Riska, 1993).

Furthermore, I found that the responses, specifically to qualifying questions, illustrated that although these women agreed on the negative impact of the organisational structures within medicine, their responses either were not based on their own experiences, or they were unwilling to admit to this. This links to Acker's (1999: 178) assertion that maybe "women's organizational experiences are best explained by women's structural locations, not by their personalities". Thus, although I do not question the importance of women's perceptions of the reasons for attrition, I realise that an extensive review of their structural locations is also an important consideration.

In terms of the two themes (views on the impact of societal factors on attrition; views on the impact of institutional factors on attrition), there were not major differences across samples[86]. This is disappointing, because if we could identify clear differences between the responses of these two groups of women doctors it would bring us closer to an understanding of which factors impact on women doctors' decisions to leave the profession. Since the responses of these women to most of the questions did not differ greatly, we cannot assert that their perceptions are distinctly different. It appears that the culture and structure of the profession, as these elements have an impact on these women, might play the deciding role (Harvey et al, 1998; Kvaerner, Aasland & Botten, 1999, Deech, 2009).

In the next chapter we use a qualitative analysis of the interview transcripts[87] to bring us closer to understanding the underlying aspects that might impact on women doctors' propensity to leave the profession. Chapter 6 therefore illustrates the outcomes of my attempt to meet Objective 2 qualitatively.

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[86] This could also be an artefact of the small sample size.
[87] Here the reader is reminded that the interview schedule was semi-structured, but that the actual interviews more closely approximated in-depth interviews, and were tape-recorded and transcribed.

CHAPTER 6

IN AN EFFORT TO MEET OBJECTIVE 2 (QUALITATIVE ANALYSIS)

6.1   INTRODUCTION

Chapter 5 succeeded in meeting one of the objectives set out in terms of analysing the interview data. As established in Chapter 3, it is imperative to present and analyse the interview data numerically, as well as qualitatively. The former exercise (in Chapter 5) resulted in a descriptive analysis, and in some cases attempted an explanatory analysis, of how the sample was divided in terms of responses to the open- and closed-ended questions, and quite disappointingly found no major/significant differences between the respondents in sample 1 and sample 2 in terms of their responses. Although I realised the importance of attempting a quantitative profile of those who had stayed in the profession (sample 1) and those who had left (sample 2), as well as of the lecturers (sample 3), in terms of their perceptions of the reasons for the attrition of women doctors from the South African medical profession, I concede that generalisation was not the main aim of the study[88].

Recognising the statistical limits in terms of a quantitative analysis of this sample because of its size, we thus turn in this chapter to a more qualitative analysis to ascertain the underlying reasons for attrition, which in any event was the main objective of the study. Through talking with these women I attempted to contribute empirically (as has not been done extensively before in SA) to the literature on the feminisation of the medical profession in South Africa by providing a sense of why women leave the profession. Although we might have wished for a clearer answer, we find through the analysis that follows that the answer is much more nuanced and complex, but a valuable answer nonetheless.

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[88] In terms of this being considered a limitation, I refer back to the discussion in Chapter 3 of the trade-off when using qualitative interviews as the data gathering tool, where I assert that the method links very well to the theoretical underpinnings of the investigation.

In Chapter 3 I identified the main drive of the study as being an attempt to explore and uncover the **gendered organisation of medicine** as a possible driver of attrition, and explained that this framework would be used to qualitatively analyse the transcripts of the interviews with the respondents. Firstly, we would have to ask ourselves whether the aspects are present/evident, in other words, whether, according to these women's subjective experiences of the South African medical profession, a gendered organisation of medicine exists. Secondly, I will evaluate, through the narrative of these women, whether this organisation is perceived to be linked to attrition.

Furthermore, an evaluation of the responses of these women indicates not only that they are appropriate for an investigation of the presence of a gendered substructure in the South African medical profession, but also aptly illustrate the very interesting process of gender construction and reconstruction of the medical profession. This is also where the literature on masculinity and femininity becomes relevant, as these women illustrate the extent of the masculine gendering of the medical profession, where this is achieved through various mechanisms. This illustrates organisations and professions as important arenas for the definitions of masculinity[89] and for characterisations of 'masculine' and 'feminine' work (Simpson, 2004).

In Chapter 2, we saw that Rao et al (1999) recognise that constraining gender roles and ideologies influences organisational structures, values, behaviour and outcomes. They identify the gendered substructure[90] of organizations as consisting of four elements: *valuing heroic individualism*, a *split between work and family*, *exclusionary power*, and a *monoculture of instrumentality* (for more detail please refer back to Chapter 2).

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[89] Authors such as Connell (2000) and Kerfoot and Knights (1993, 1998) have placed masculinity at the centre of analysis of organisations and institutions by focusing on the dynamics of masculinity.
[90] This can be defined as the basic structure or features of a system or organisation.

6.2 VALUING HEROIC INDIVIDUALISM

A culture that tends to "value the hero who works day and night against tremendous odds to solve a crisis" (Rao et al, 1999).

The concept of valuing heroic individualism is illustrated in the medical culture experienced by this sample of women, that supports excessively long working hours, does not support people who want to work shorter hours, either through 5/8 posts, flexitime arrangements or part-time specialisation, and does not view other options as the norm. Thus, there is an overwhelming sense that those people who do not conform to this concept of the ideal are deemed less valuable than those who do (these are usually women doctors). Examining the presence of this aspect involved evaluating the responses of the respondents that were coded under the themes long hours on call, views on 5/8 posts, many colleagues opting for part-time work and views on part-time specialisation. The quotes from interviews with respondents, firstly illustrate that they clearly recognise and are aware of this concept (valuing heroic individualism) as being the ideal. Secondly, the responses illustrate not only that many of the respondents have internalised this concept as an ideal, but also their resistance against it.

In terms of *excessively long working hours* being seen as essential and ideal in general, but specifically for trainee doctors on call, the respondents recognise this as something of a *rite of passage and entrenched in the culture of the profession*. To some extent, this also illustrates the aspect of *hidden power* (where certain ideas are supported and put forth as normal, and thus people do not question them).

6.2.1 Views illustrating recognition of valuing heroic individualism

Firstly, illustrating the recognition of valuing heroic individualism, as well as this being constructed as the ideal attribute for a doctor, some respondents report that:

> "a lot of them in an academic hospital are… they work excessively hard, and that is what they will boast about how hard they work, how many hours they work…"
> (R9, sample 3)

Without clearly indicating their agreement or disagreement with the aspect of long hours when on call, many of the respondents noted that it is entrenched in the culture of the profession:

> "it's almost like the historical tradition in medicine - long hours on call" (R1, sample 1).

> "there is a sort of, certain element of it sort of being almost like an initiation rite" (R25, sample 1).

> "it's something that's so entrenched that people feel that. You must just. It's a kind of rite of passage, so, there's, there's probably no reason for it…" (R19, sample 1)

> "we complained a lot, but the attitude from the older doctors was always, we did it, so why can't you?" (R4, sample 3).

> "I've almost got a feeling it's become a culture that like these older surgeons and older doctors say, well I had to do it why not the young people, what is so soft about them?" (R23, sample 3)

In the above quote (from R23), and also as mentioned later by R18, the respondents identify 'softness' and 'cushiness' as undesirable aspects (usually constructed as feminine attributes, equated with women) of being or becoming a doctor. In this instance it illustrates the 'distancing' of the nature of the profession from a feminine identity of 'softness'. As Mclean and Rozier (2009: 288) note, "masculinity is defined in opposition to femininity". This is similar to the distancing efforts employed by men in female-dominated professions in an attempt to protect and emphasise the masculine traits by distancing themselves from feminine traits (Evans, 2003; Simpson, 2004).

6.2.2 Views in support of valuing heroic individualism

Many of these women doctors seem to internalise this concept as central to being a good doctor and substantiate this claim in various ways, firstly by saying that it is correct as they themselves had to go through it:

> "O please don't give me that… they think they have long hours, but they don't know what long hours are because you know, they work like, 12 hours and then they go off, in our day we worked no, 36 hours and then we maybe got off, whereas here they've reset hours and the amount of hours, the call and time that junior doctors do now compared to what we did" (R10, sample 3).

> "there is a kind of rite of passage, you know, and I think if it's all too cushy you know, I worry that we turn out doctors who are in the same way that I think if, education is too cushy you end up with learners, or students who don't understand what it is to compete, they don't understand what it means to be, be the best or to, to try to be the best, you know and I think that there's something in resilience, in building resilience that is important there" (R18, sample 2).

This is an interesting comment from R18, as competitiveness is a trait traditionally associated with masculinity and equated with men. One would also have to consider whether this can be seen as illustrative of the extent of the internalisation of the values of the dominant group (in this case masculine). This again clearly indicates the gender identity that is daily reinforced in gendering a profession, as well as illustrates women's own compliance (Connell et al, 2005) in perpetuating the gendered construction of a profession.

Secondly, many of the respondents claimed that the aspect of long hours (associated with the concept of valuing heroic individualism) is necessary to maintain continuity of care[91]:

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[91] Continuity of care is an important and valid consideration from the curriculum point of view and should thus be acknowledged (De Villiers & De Villiers, 1999). However, the potential barrier that this aspect might pose to the retention of women doctors cannot be ignored (Deech, 2009).

"the call and time that junior doctors do now compared to what we did, is, is very much less and I think there's a, a major problem with continuity of care" (R10, sample 3)

"part of one's training is to actually be on call, see patients through, so I think that the business of shift work, you're in you're out, lack of continuity, lack of thing, is, is a problem" (R24, sample 2).

Support for this notion is further sustained through the associated problem of shortages within the national health system, thus working long hours is deemed imperative for service delivery:

"equally the system would collapse if everybody just felt that they were gonna work their 8 hours a day, I mean it just doesn't work like that uh, you gonna have to work some additional hours" (R15, sample 3).

Fourthly, it is also claimed that long hours are very necessary because of the importance of experience and training gained after hours, which cannot be obtained in part-time positions:

"a lot of your training does happen after hours when you're on your own, that's when you kind-of learn by mistakes and things, so I think that a certain amount of after hour work is necessary" (R22, sample 1).

"I also think that there are night-time situations and on-call situations where it is essential for trainees to be – they need to be there at those times, they need to see after hours emergencies" (R8, sample 1).

"night duty gives you certain emergency kind of demands, which would be different in your experience than the daytime" (R23, sample 3).

"I think that, and I don't know if I've been too indoctrinated by the boys, but the high degree of, the lack of full term service, umm, within the profession, does negatively impact on performance, on running a unit" (R2, sample 2).

"I realised that I was missing out on what was happening at work, everything that was important and interesting seemed to me psychologically, it happened in the afternoons when I was gone" (R23, sample 3).

"I do feel that there're lots of things like, that I could have done that I haven't been able to do because medicine is all-consuming you know…if you're going to do that, really, kind-of, in a committed way, there's lots of things you miss out on" (R10, sample 3).

R2's reference to "indoctrinated by the boys" indicates an acknowledgement and awareness of the possible influence of the gendered culture of the profession. R10, in her interesting reference to being involved in the profession in a committed way that requires an all-consuming approach to the practice of the profession, also illustrates the gender construction of medicine. Thus, if one is not involved in the profession in an all-consuming way, you would be classified as not being committed (this would by definition include those people working part-time, usually women). This is also noted by Mclean and Rozier (2009: 296) in their study of male physical therapists, where "women were perceived as lacking the full-time commitment needed to advance the profession, particularly because of beliefs about the limitations of family roles".

6.2.3 Views critical of valuing heroic individualism

Rao et al (1999: 4) further elaborate on this aspect in asserting that "the person who manages her work smoothly, thereby avoiding such crises, is invisible and undervalued", as R14 (sample 1) indicates:

"but then you also have women who, uh just become invisible, um, really much the kind of drones, um, come to work, do your thing, go home, don't knock the system, don't get into trouble, don't get marked down, don't get overlooked for promotion and things like that, um, if you do that then you won't be overlooked, but I mean… it's so numerous I can't even know".

There are respondents that clearly do not support this notion (valuing heroic individualism), as illustrated firstly by their questioning of the continued relevance of long hours to the training of future doctors, especially in the light of continuous technological advances in the field:

"technology has advanced so much, it's much more stressful, those hours, up till, you know, when our professors were doing it, they, there was only so much that they could do, and the rest was up to whoever, ja, but uh, now there is much more, so it requires, you know that you're there more often, thinking, working out, you know, I mean it's much more technical and, so, I think people haven't actually factored in the, you know, how exhausting that is" (R17, sample 2).

Secondly, many challenge this notion by contending that the number of hours people work are not the only indicator of the quality of a doctor.

"it didn't cost the unit that much more [employing two part-time doctors to accommodate one female doctor that wanted to work flexi-time], um, but I think they probably have gained, because I think part-time doctors still achieve, achieve a great deal" (R20, sample 2).

"those people who work part-time work incredibly hard and deliver in the hours that they're there" (R18, sample 2).

"there should be options for part-time specialisation, ja, um, I think with continuity of, of care it's uh, the more people you have working shorter hours the

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more difficult it is, it can be done, it's just kind of, changing the mind-set and changing the policies" (R21, sample 2).

In her reference to "changing the mind-set", R21 identifies the existence of a specific culture and way of thinking that underlies practices in the medical profession.

Thirdly, some criticise the informal discrimination against women who want to work part-time or are in part-time positions, or want the opportunity to specialise part time (usually these people are women). It thus is evident that this work arrangement is not seen as the ideal:

> "there are many training doctors that are women that are prepared to take half the money if they could genuinely leave at 12:30, you know, and that you weren't considered to be, you know, slacking off because of it" (R26, sample 2).

> "technically, you're not working, you're not doing all of your hours, they're like why did you get it right and I didn't, and the men think you're just lazy" (R3, sample 2).

> "technically, to be quite honest, the colleagues never like that because those people are always like skiving off early and, the baby's sick, and they can't be on call, because of this that and the next thing, you know, when you are also tired and that actually cuts no cheese" (R1, sample 1).

The above three quotes illustrates the negative perceptions associated with working part-time, which amounts to informal discrimination. They make reference to being considered "lazy", "slacking off" and "skiving off early" if you are not working full time. R3 also importantly touches on the professional jealousies of other women doctors in terms of "why did you get it right and I didn't??. This indicates that many women in the profession actually would like to have a part-time arrangement, although it appears that this is not very easy to arrange. This desire is also illustrated in the next quote in relation

to the fact that, although there are many people who want these kinds of arrangements, it is not supported in the profession:

> "there's so many people that want to specialise so why should they stay for 8 years rather than 4…I think you're still seen as not fully committed" (R4, sample 4).

Furthermore, R9 (sample 3) indicates another element of the lower status associated with part-time positions, and recognises the essential nature of gender roles in stating that one "expects married women to come and do the sessional jobs".

> "it's the kind of job you won't expect someone who's like the main breadwinner to [be] doing, the pay is so low in the state, so we sort-of expect married women to come and do the sessional jobs, um, which is really not good" (R9, sample 3).

Lastly, refuting the continued relevance of this notion, many of the respondents lamented and illustrated the devastating effects that the concept of working long hours has on doctors in general:

> "it affects who you are, and your personality, your judgements, and it's dangerous for your patients" (R20, sample 2)

> "excessively long hours are inappropriate, they're destructive for the person concerned, they're destructive for the health care system because doctors that are too tired can't actually function, so I think that's a very destructive process" (R24, sample 2).

> "I think it's unhealthy, it's actually been shown, there is evidence that sleep deprivation promotes, um, certain diseases, um, it's emotionally unhealthy, it's unsafe for patients, it damages people's social life and family lives" (R9, sample 3).

"doing one in four calls at the labour ward at Groote Schuur, and having to work the entire day, after you've been on. I remember actually falling asleep driving home several times, you know, and it's not good" (R1, sample 1).

"I think it impacts on your own safety, because that increases the amount of needle-stick injuries, and I think it impacts on patients' safety because that's when people make mistakes, so I think that that is something that the medical profession needs to look at quite strongly" (R22, sample 1).

"that for me is a big issue, because, you know, you cannot function if you've been working non-stop for 20, for 36 hours, which we sometimes had to" (R17, sample 2).

"there were times when I hadn't had a night's sleep and I was assisting with a surgery and I was falling asleep at the operating table, I mean it's irresponsible if, you know you can't perform, um, I mean patients' lives are at risk" (R25, sample 2).

"it's not acceptable, you can't expect a person to function when they've been on call for over 24 hours, I mean they stop functioning, they don't allow pilots to fly for that length of time, why do they allow patients' lives to be in the hands of doctors that have worked that length of time – that's not acceptable" (R8, sample 1).

"I mean I remember being post call, the morning after doing ward rounds, the number of, not mistakes, but, forgetting things, I'd have to go back two or three times to remember, what was it, why am I on the ward, why am I seeing this patient?" (R19, sample 2)

R19 (sample 2) also touches on the entrenched culture when she asserts that it will "take a lot to convince people to change the culture":

> "it's essentially dangerous for patients, you know so, it's, it's unhealthy for, for doctors and for patients, it's unnecessary, if you work your schedule correctly, there's no reason why people can't work 8, 12 hour shifts at a time, instead of 24 hours, um, ja, but I think it's, it would take a lot to convince people of, to change the culture, ja".

Lastly, within the context of the difficulties experienced specifically by women doctors, two respondents highlighted that:

> "the need to utilise your workforce is different to unacceptable hours, ok, no, there's no doubt about that, that it's not acceptable, um, you know, and uh, from a gender point of view, when we trained we were told we were all wus (slang for wimp), because women couldn't work the same hours" (R14, sample 1).

> "it's a huge problem, it's a massive problem, it's a completely service-driven issue, it's got nothing to do with training, okay, and it's something which makes it difficult for women" (R26, sample 2)

Also, challenging the principle of continuity of care as being essential and central to providing good health/patient care, while also referring to a specific culture in her reference to "ethos", this respondent notes:

> "I think the structure is always a problem…patient care is a continuum of care and it cannot be done in any way differently to how it's been done, okay, and how it's always been done is that you have ward rounds, it starts at 7:30 in the morning and then you do all your work, and then you have more ward rounds at night, and then you do, you're on calls and you work on week-ends and the patient always comes first, that is the ethos, okay, and if you don't do it like that you're

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perceived as being lazy, okay, or slack, or being distracted by other issues, okay, and the bottom line is that those things are incompatible with actually running a decent home in which you don't actually outsource every aspect of home care, and the model of adapting the medical work environment to really suit women, just does not come into their heads" (R26, sample 2)

It is also interesting that this respondent uses the same type of language to indicate the discrimination against people not working full-time hours in the medical profession. She refers to being "lazy", "slack" and, interestingly, "distracted by other issues" (which probably refers to family life), which again create an image of someone who is not committed. These descriptions are linked closely to Frehill's (2004)[92] assertion that one of the themes important to understanding masculinity is the absence or exclusion of women, which is definitely displayed in the terms used in these quotes.

6.2.4 Do the responses indicate a link between attrition and valuing heroic individualism?

A further aspect that is important to our discussion is found when R2 (sample 1) indicates that the ideal of valuing heroic individualism has been linked to attrition from the profession, and touches on the fact that all doctors are complicit in the perpetuation of this concept.

"you are cutting off your nose to spite your face because you are preventing people from going into a profession by doing this. You are ultimately affecting their performance, because everybody knows about the people who are on anti-depressants and things like that – that is rife, and everybody still ignores it"

R7 (sample 1) alludes to the organisational culture, which she links to attrition. When asked why women leave, she states:

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[92] Frehill (2004: 392) identifies three themes as being important in understanding masculinity: "the absence/exclusion of women, the inclusion of sports and the outdoors, and the notion of proving manhood".

"long hours, stressful job, um, hostile environment…"

6.3   SPLIT BETWEEN WORK AND FAMILY

"the ideal worker excludes and marginalizes women who cannot, almost by definition, achieve the qualities of a real worker because to do so is to become like a man" (Rao et al, 1999).

A split between work and family is evident in a culture where, although not stated explicitly, the reality is that women either decide not to have children, postpone having children and a family, or remain single. This concept aims to separate productive and reproductive work, and thus links to earlier discussions on the public/private divide and the devaluation of women's work (in Chapter 2). Examining the existence of this aspect required the analysis of the quotes coded under the themes: workplace structures present uncomfortable working environments for women, appropriate role models, and women doctors affected by traditional perceptions of women's roles, plans regarding family life changed, and children.

6.3.1   Views illustrating recognition of the split between work and family

Indicating an awareness of this concept as being the ideal in the medical profession, many respondents indicated that, in various ways, men are still viewed as ideal workers:

> "it was kind-of, seen if you work, if you wanted to succeed, you had to be like a man, and in that kind of environment…" (R22, sample 1)

> "people are concerned that a woman's going to get married and have kids, and not devote herself as, as fully as other people might do" (R10, sample 3).

> "women are not seen as being as career oriented, as driven as their male counterparts and colleagues, [and questions whether] they are easily distracted by social life, pregnancy and marriage" (R2, sample 1).

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"when you decide to have a baby, and you're pregnant and they've gotta cover maternity leave, your standing will suddenly drop, and not only in the eyes of your male counterparts, but also your female counterparts who are not having babies and who have to cover for you…" (R20, sample 2)

The references to "not devote herself as fully as other people might do" and to being "easily distracted" are quite telling. Again, women who want to have a family are portrayed as being "not devoted" or "distracted" (as opposed to a masculine trait of being focused). This links to the theme of not being committed to the profession if you want to have children. Men actually note that "one of the greatest advantages they have in the field [here referring to physical therapy] hinges on the widespread belief that as soon as a woman gets a baby, she will want to work part-time" (Mclean & Rozier, 2009: 297).

This portrayal of and emphasis on the "feminine traits" associated with women, or distancing men from feminine traits (as also shown in the quote below), contributes to essentialising gender in the profession and is central to maintaining the masculine gender construct of medicine. Here this respondent equates men with being "cut-and-dried"[93], "strong", "not allowed to cry", "wrong to show the emotional side".

"I think men see things very differently, men tend to be much more cut-and-dried, and how they see things…and it was almost an attitude that, you had to be strong to be a doctor, and you know, you weren't allowed to cry, it was wrong to cry, it was wrong to, to show the kind of emotional side of things" (R22, sample 1).

The idea that men are the ideal workers is supported by discrimination against women who plan to have children. Although it is not ethical or legal, some respondents indicated that it had been their own experience, or they reported on other women doctors'

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[93] Mclean and Rozier (2009:300) in their study of male physical therapists note the "typical 'masculine identified' descriptors relating to the mind and work included: knowledgeable, intelligent, problem solver, analytical, assertive, hands-on, independent, skilled diagnostician, efficient, and technically competent".

experiences of this aspect often surfacing during job interviews. This also links to the aspect of *exclusionary power* (elaborated on later). For instance, R15 (sample 3) reports on themselves, and other women doctors they know of, being asked whether they plan to have children in a job interview,

"I've heard somebody do that [asking a potential employee whether they plan to have children] and uh, somebody say, sorry you're not allowed to answer, and in fact it's wrong because it implies that you won't get the job if you do".

"the first question often is how you gonna balance a family and, and a, and your profession, and my response would usually be, how would you, how do you balance your family and, and your profession" (R14, sample 1).

"when I was appointed as a paediatric registrar, we had quite a, um, there, the Prof that was in charge of the appointments was probably quite a masochist [*she probably meant misogynist[94]*], he, he was very anti appointing women because women got pregnant and then it impacted his service" (R22, sample 1).

"when I interviewed for the job, uh, to be accepted for training as a specialist, uh, I was told I was gonna fall pregnant and um, there, that uh, um, uh, I would be a waste of tax-payers money" (R14, sample 1).

"I was interviewed by a group of old time men, and the one said to me, you're a woman we can't rely on you, that was said to me" (R23).

The reality of this concept as an ideal is illustrated by some of the respondents' assertions when referring to the women doctors who were their role models (suggesting that to be successful, these women had to discard their biological and social life):

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[94] A misogynist is a person who dislikes women in particular.

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"the majority of them were single women who had careers, and there wasn't that much role-modelling of women with families" (R24, sample 2).

"the only women role models I had were people that didn't have children" (R26, sample 2).

6.3.2   Views in support of the split between work and family

Illustrative of women actually internalising the aspects of being able to separate yourself from home and not letting your personal life interfere with your work as important and appropriate in the practice of medicine (in other words taking on 'masculine traits'), some of the respondents noted that:

"women tend to emulate the male role models if they move into a profession". (R17, sample 1)

"…then you go there and you find this group of males, or even women who have turned, also they're all kind of in their outlook and wear, it's masculine and the way that they, yes, so it's kind of like a masculine environment" (R13, sample 1)

Some respondents supported the notion that family issues should be completely distinct from work and family life, as illustrated by the following respondents:

"you can't be negotiating with someone to do work after hours, if you say can you please next week work with, and they say no I can't, my children, they have to make means of sorting out that attitude, so that the services can go on, so I mean, you know it, the fact that it, it's a job that requires you to be working 24 hours" (R14, sample 1).

R23 (sample 3), reflecting on having a baby, stated that:

"um, I think it is a handicap for instance, I couldn't say I'm going to work in Johannesburg".

"some of the frustration as employer, you know comes in, is that yes they do wanna go off and have babies and yes they do then wanna work part-time and its irritating, you know and so that, that part of it..., and I see the attitudes here as well you know, it's like, oh well, they can't be serious academics, or serious researchers because they wanna work 5/8s because they're bringing up 2 small children, um, so they can't be serious about, you know, it, it's a part-time job" (R18, sample 2).

Not only is this concept supported openly, but it is also internalised to the extent that it is not recognised as discriminatory against women. R15 refers to a conversation with a male mentor who advised her to not do surgery, and notes that this advice was "highly appropriate" and that "he knew how hard he worked" (identifying hard work as incongruent with what a woman should do). Her response is also quite interesting as it provides evidence of women's acceptance of and role in maintaining these concepts, as she stated that he had not wanted to "discourage me".

"he said you'd be very good at it, but what about your sex life? He says, you can't, you know you can't be a surgeon and have you know, presumably he meant marriage, but marriage and children and everything else, so yes I mean that was, highly appropriate because he knew how hard he worked and he knew what, and he was married and he had children and he was trying to be as helpful as he could not wanting to discourage me, but just wanting me to look at the realities of it" (R15, sample 3).

It is interesting to evaluate how this quote indicates a degree of internalisation of the correctness of the value being passed on, which is that women's main role is sexual reproduction[95], and that they would not be able to fulfil this role if they become surgeons. Secondly, the degree of internalisation is also evident in the fact that she does not

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[95] This also links to the earlier discussion on the productive/reproductive work dialectic, as well as the public/private divide.

question this mentor's advice, as she concedes that "you can't be a surgeon and have marriage and children and everything else", despite the fact that this man has all these things. He was married and had children and was a surgeon, so how was it possible for him to do that? (he had someone supporting him in the so-called private sphere, probably a wife!). This is also an interesting example of the fact that men never seem to be confronted with this choice.

6.3.3 Views critical of the split between work and family

It is evident from the respondents' differing views on this concept that many are critical of its appropriateness:

> "I think it's kind of unrealistic, um, I am sympathetic to um, women who want to have children, and who are the sort-of primary parents, so I think um, needs, um, you know, it's good to try and accommodate um, people like that but, it really depends on the, the speciality, whether it's um, really feasible" (R25, sample 2).

> "you can't do everything, and the problem is that, that is the currency, if you want to advance, then you need to do research and you need to teach and you need to do clinical things, and most women can't do all of those things if they're actually managing their home, and as a result of that, I would say the advancement, even though technically there's no, there's no barrier to women getting advanced placement if they um, meet, if they stand equally to their male counterparts" (R26, sample 2).

As alluded to by R26, the other respondents also recognise as important and link this aspect to the extent to which a doctor can actually advance and achieve, again illustrating that women have to be more like men to succeed and advance in "this environment":

> "I do believe that men get further in this environment than women do" (R22, sample 1).

"if you're not having kids I think you can probably achieve, ja, quite well, ja, you know, similarly" (R20, sample 2).

Referring to women having children and working part time:

"it does I think then begin to, make it more difficult for them to advance" (R18, sample 2).

Further, there are also practical illustrations of a masculine culture that does not provide for the inclusion of women, or results in women feeling uncomfortable, for instance:

"in the surgical blocks, I think it's very, they're not, they don't really cater, or try to cater for females in, in, in a sense that, umm, you know like the theatre gear" (R16, sample 2).

"I mean like if you go to, let's say to meetings or something of high quality, I mean the, the testosterone is palpable...it's about upmanship" (R13, sample 1).

In contradiction to what this thesis is trying to establish, some of the respondents refuted or challenged that this ideal was still operating in the profession, and claimed that women doctors who did not have children or who remained single did so not because of the culture, but purely based on their own decisions:

"if she was willing to meet the requirements of the position, I think no, it's just, if she would be willing to meet those requirements and say it involves a certain amount of overtime work or, certain number of hours, and she wasn't prepared to, then no, but if she was prepared to, I haven't experienced that, no" (R21, sample 2).

"ja, I mean if you, if you, if you bright and you perform and you're enthusiastic you'll, you'll climb up the ranks ja, um, I don't think it's particularly more

difficult for a female doctor than a male doctor, um, but I, I think there are very, very entrenched hierarchies… I think it is generally difficult for any, any doctor, I don't think it has anything to do with gender" (R19, sample 2).

"if I'd really wanted to have kids, then I would have made a plan, but it would have made, it would have been difficult to have them, but I would have, you know, if, if I really wanted to, I would have done it" (R10, sample 3).

Although R10 is asserting that she had not been influenced by the culture in the profession, by alluding to having to *make a plan* she intimates that that is something that would be necessary before one could have a family and continue to be a medical doctor. It is not something that can happen naturally, but would have to be planned actively to fit into her life as a doctor and mother. However, one would have to be cautious about extrapolating from this statement that this woman has been constrained by the medical profession, because many women in many professions would also have to plan for a family, regardless of a supportive organisational culture.

Some respondents refuted this conception by stating that:

"young women often are more hardworking, um, they're prepared to go that extra mile, it's not a given rule but I think my experience over the years" (R18, sample 2).

"people that I've seen do that, take off 3 or 4 months and they're back working flat out and doing the job, so I have to revise my own thoughts about that" (R15, sample 3).

This indicates that the respondent herself is starting to reflect on her own assumptions about women going off to have babies and thus being less committed to the profession. Both R18 and R15's statements are good examples of women starting to reflect on their assumptions and their conceptualisations of what is right in the profession, which is a

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good illustration of the points I made earlier in terms of a sense that women are reconstructing their own conceptualisations and experiences of the profession.

Many women are starting to realise the inappropriateness of such a concept and are seeking new role models and not identifying with the old role models, which would have ascribed to many of the aspects of this concept (split between work and family). R22 (sample 1) recognises that being able to balance rather than split your personal and work life as admirable:

> "she was a woman who was an academic, very strong researcher, strong teacher, outstanding clinician, but she balanced that with a family-life and I think, I mean, she was just the most amazing person".

6.3.4 Do responses indicate a link between attrition and the split between work and family?

Fundamentally linking this concept to attrition are the responses below:

> "I think attrition happens because, I mean I'm trying to talk about the academic environment, because that's where I am, to achieve academic success, you have to work 11 hours a day, effectively, you have to be writing papers at home at night, and you have to be reading and researching, and you cannot maintain that when you've got kids, and so you automatically lose, just because you're not putting in the effort, that your male colleagues are putting in, well that they can put in" (R20, sample 2).

> "the family demands became such, that I could no longer dance to the expected boys' tune" (R26, sample 2).

Reflecting on why we lose women doctors, R1 (sample 1) states:

> "because they are not being supported in their place of work".

6.4 EXCLUSIONARY POWER

Exploring the existence of exclusionary power involved the examination of illustrations of the presence of various sites of power: positional power, agenda-setting power, hidden power, power of dialogue and the power of conflict. This aspect involved the review and analysis of themes coded under: hierarchical structures reinforcing unequal power relations, views on community service in rural areas, views on extra year of community service, and location in societal power structure impacting on power relations. This aspect of the culture is not very overt, and illustrated in instances where informal male exclusionary networks and the position of men as being more powerful in the profession are preserved by hierarchical institutions that have a majority of men managing or controlling key aspects of the profession due to the history of the profession (this is central to the maintenance of hegemonic masculinity[96], discussed in Chapter 2).

6.4.1 Views in support and critical of positional power

Within this sample of women (all the respondents), the aspect most commonly referred to seemed to be that of *positional power (derived from the authority of an office or title).* This is very clearly linked to the maintenance of hegemonic masculinity, as indicated below:

> "I do not think that nowadays, it, it, there are policies that are systematically excluding women as before, it's not like that, it, it, it's not like that, it's more people who are already in positions who are doing that yes…" (R13, sample 1),

Emphasising and illustrating the concept of intersectionality (in this instance showing how women of colour are more disadvantaged than white women) quite well are the respondents' indications that this is affected by one's race:

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[96] Connell 2000, cited in Simpson (2004: 350) defines this as the "culturally exalted form of masculinity which guarantees the dominant position of men".

"people are still in positions and you know they rather take a white female, this is what I'm saying, you know, like to fill that, the quotas, yes" (R13, sample 1).

R2 (sample 2) reports on this exclusion being present, and its racial aspect, when she reflects on her experience of moving from the public sector to the private sector, and tells of a male doctor having influence with the hospital manager:

"to the hospital manager, what you need is two white blonde females, and he made him make rooms for two white blonde females, and when the coloured chick wanted to come out [into private practice], they were told there was no rooms".

R3 (sample 2) also notes an overt display of this racism, as well as the issue of *tokenism*, in stating:

"we can't run away from the fact that there is racial connotations to everything, so people feel um, upset with you that you have an advancement, because a) your female, and b) you are not white, so then it was, like if you, it's almost like this idea that you were placed there".

As a less blatant example of men's positional power in medicine, R14 (sample 1) remarked:

"women are now the primary health care level doctors, in terms of GPs, uh, uh, um, Community Health Centres etcetera, who's there, the superintendent that lands up being a bloody man, but the women are the workers and the minute that happens, there's a shift in the worth of the work you give".

This is similar to the internal segregation alluded to by Reskin and Roos (1990), who point out that women end up at the lower status levels within an occupation.

R2 (sample 1) also elaborated on and illustrated the ways in which men in power made use of it in the profession, and in her specialty (obstetrics and gynaecology) specifically. This illustrates exclusion through informal male networks, also referred to as occupational closure.

> "GPs will send you the nutcase, they will send you the one who has discharges that's bothering her, that has libido issues, but they won't send you the one that has the huge uterus, because the boys need to get that. So the boys get the operational things, they get the hands on things".

R2 (sample 1) further indicates, elaborating on this concept, that:

> "there's golf course politics here, where it would be that you're playing golf with the GPs, you're drinking with the GPs, your, you know they're in that social structure, and or in that sports structure, most of my female colleagues go home and feed the kids, you know, and sort the husband whatever, but the husbands end up sorting, you know going off to the golf course, it's just, it's an entirely different social structure that I noticed with my male counterparts who came out into private and myself".

6.4.2 Views in support and critical of agenda-setting power

As an illustration of *agenda-setting power* (what is not important to men does not surface on the agenda), R2 (sample 1) elaborates:

> "it's about men's, it's simple things, it's how they organise congresses according to the golf courses that are around, they um, you know, the total disrespect that I find in this speciality to women, and for recognising the role women play in the role of women's health".

R8 (sample 1) very eloquently summarises this when she states that:

"there are still vestiges of that system that sit in positions of power and those tend to be men, and they tend to be, but you get women as well hey, that do exactly the same thing…people in positions of power whether they're maybe male or female and I must admit I think they're more often are male, that will force you to make decisions in the interest of the organisations that they're running even though it might be difficult for you with your other responsibilities, so I don't think there's many allowances made for women with, with families".

The above response also links to the aspect of the *split between work and family* (where the respondent alludes to there not being many "allowances for women with families"), as well as the next theme of *monoculture of instrumentality* (where the respondent refers to "decisions in the interest of the organisation". What is also very interesting in this response is the acknowledgement of women's role in perpetuating and maintaining hegemonic masculinity.

R26 (sample 2) further illustrates how women's issues are ignored when she comments on the aspect of the extra year of community service:

"the problem is that for women, your biological time to have children corresponds with this time, and I mean, I had my first child when I was 26, okay, now I would not even be finished with my community service, I wouldn't even be starting my community service".

R20 (sample 2) is clearly ambivalent in her response. While denying the existence of these barriers, she alludes to an attitude change that needs to occur, which in itself can present a barrier. She also maintains that it is "women who choose not to enter into that", but it the extent to which choice is determined by structural possibilities remains questionable.

"I don't know that men inflict it, if you see what I mean, I think it's that women choose not to enter in to that… maybe it does need to be more accessible, maybe

there does need, there needs to be attitude change that women can actually move into that".

6.5   MONOCULTURE OF INSTRUMENTALITY

"an organizational cultural focus which excludes people, perspectives, and processes not directly related to the accomplishment of the narrow goal" (Rao et al, 1999).

Investigating the presence of a monoculture of instrumentality as part of the gendered substructure involved the analysis of quotes coded under the themes of feminisation affected the healthcare system, high proportion of women students, feminisation affected profession itself, feminisation affected patient care, and internal segregation. This concept, when applied to the medical profession, would contain aspects such as technicality and skill being highly valued, an image of a doctor being almost Godly and distant, a premium put on the status associated with being a doctor, the maintenance of strict hierarchies, and a premium on tenure and efficiency of service as opposed to quality of service, etc.

Individuals in support of a monoculture of instrumentality, would see any aspect other than those needed to successfully complete a task as superfluous. It thus would denigrate practices such as empathy and care (refer to section on feminist ethics of care in Chapter 2). Although this concept still seems to be present in the medical profession today, it appears to be fading and is not mentioned to the same degree by the respondents as some of the previous aspects.

What struck me is that many of the respondents have alluded to this concept, but often that reference is in terms of it being an outdated notion of medicine. The respondents attributed this shift mainly to two facts: firstly, due to the increasing feminisation bringing a new culture to the practice of medicine, and secondly, largely due to the change in curriculum, which prioritises patient-centred care as an approach to medicine and recognises the importance of treating a patient holistically. The extent to which the shift in identification with this aspect can be ascribed to the change in teaching and

curriculum, or rather to the increasing feminisation, thus is up for debate. I do find it significant that this sample of women most explicitly links or attributes the shift in culture to the increasing feminisation of the profession.

6.5.1 Views illustrating recognition of a monoculture of instrumentality

As examples of a clear acknowledgement of the existence of a monoculture of instrumentality, some respondents noted the associated traits, status and image in support of sustaining this concept:

> "they you know they, they really aren't interested in their patients, they're really just interested in the mechanics and the carpentry and the plumbing of the whole thing… it takes the women doctors a lot longer to clear the clinic than it does the men, because we spend more time chatting to our patients" (R20, sample 2).

> "there is an element there, that we bring in that men just didn't have before and that was my own personal experience of medicine and my, when I was younger all my GPs were men, you know and they were these superglory Gods, that you couldn't even talk to, they were these men that you go and visit and they look very nice and spiffy and their suits and you were scared to death of them" (R3, sample 2).

> "men are very, I think they're sort of more kind-of status oriented and hierarchical, whereas women are more, more, not that way, not as status oriented" (R21, sample 2).

The latter quote indicates the way in which women themselves contribute to the maintenance of gender divisions by essentialising 'feminine' traits to be associated with women, and 'masculine' traits to be associated with men. The response also touches on an element of hegemonic masculinity and power in the reference to a hierarchy.

This monoculture of instrumentality is often reflected in, and associated with, the description of a surgeon (who is more often than not a man).

"but surgeons in general they, they're good with their hands and that's what they want to do, they're not interested in the whole patient, so they want to see a patient, operate on them and not really be involved, so they don't really see the whole patient and the other problems" (R10, sample 3).

"there are obviously exceptions, but it, it attracts the sort of [people that are] very like power-hungry, dictatorial, poor interpersonal skills" (R25, sample 2).

"there's quite a difference between surgical and clinical physicians you know, quite often men tend to like the practicality of being a surgeon – you get into a job you finish it off and you don't look back – it's done – and uh, quite often women like to engage in a longer standing relationship where you actually see people monthly or every three months and build up a long, long-term relationship" (R5, sample 1).

6.5.2 Views in support of a monoculture of instrumentality

Although not many of the respondents were in support of this mentality, R1 (sample 1) still very clearly identifies with this 'masculine' trait of "fixing things":

"But in terms of things like, the surgery that I can do, I know that I can actually fix something, and that appeals to me, I have that sort of mentally. I like, if it's broken, I want to be able to fix it"

6.5.3 Views critical of a monoculture of instrumentality

Some of the respondents were of the opinion that women bring a different aspect to medicine that does not actually conform to a monoculture of instrumentality, and criticise this as an outdated notion. Many are noticing a shift away from this concept in reflecting on the role models they had while training (who portrayed the more traditional ,and in many instances, masculine notions associated with being a good doctor), and they are

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challenging those older notions and striving to become different kinds of doctors. They thus find elements contradictory to the aspects associated with a monoculture of instrumentality as being inspirational.

"even though she's brilliant, even though she's achieved a lot, she, she, she and other are starting to bring in a, a culture that is less about hierarchies, less stiff, more let talk, lets discuss, what are your views about this" (R19, sample 2).

"so um, ja, and I mean men that are a lot older are not necessarily an appropriate role model for a young doctor" (R9, sample 3).

"I believe women can be much more holistic where medicine is concerned. Much more towards the model, which us as the newer generation in doctors have been told, been taught about, the kind of bio-psycho-social model… it is much more than just your physical symptom that is the issue, and I feel that women are much more comfortable to attack that, and just explore that entire thing, and even although it's going to crash your entire day, you'd explore the patient's feelings and what's going on" (R2, sample 1).

In support of this broader, changing medical culture, two respondents noted the following:

"you know medicine is not only about, you know correcting damages in the body, it's about healing of the mind, the spirit, and the body, and we [referring to women doctors] bring that" (R13, sample 1).

"I think the profession itself has come to incorporate much more a holistic approach… also to incorporate alternative therapies" (R5, sample 1).

Although this redefinition can be seen as positive, many of these claims of women adding value to the profession unfortunately are made on gender essentialist grounds, which can only perpetuate hierarchies. This is illustrated in the remarks below:

"the female doctors, their approach to patients are different I think, yeh, I think there's more the, men are more sort-off the mechanical, get the job done – do it well, but get the, get, solve the problem type of people and women are more, you know, um, women are more worried about the social problems and the emotional impact and that type of thing, which is very important, it's more of a broad way of approaching patients" (R16, sample 2).

These responses are not only valuable in what they reflect the existence of the concepts we are interested in, but they also are very useful to illustrate the construction of gender within the profession, and how these women interact with it.

"I think there'd be aspects of a more, um, a less paternalistic approach to medicine, I think there, is has had an impact in terms of, perhaps more patient-centred approach… because women view things perhaps from a slightly broader perspective technically than men do" (R24, sample 2).

"the positive spin-off is the caring ethos that women bring to the profession" (R22, sample 1).

"women just take more time and they make sure that it is done properly" (R1, sample 1).

"growing knowledge that medicine is not all those things, but I think that has shifted, but I think that as more women are going into medicine now, as the status of medicine has in fact decreased, like you see in Russia and all these other countries, as the status of the profession decreases because the money-earning

potential in that profession decreases, so the number of women in it, go up" (R26, sample 2).

"it becomes more patient-centred when women are involved as a group, obviously there are individual absolute shits in there, um, but as a group it brings that aspect" (R14, sample 1).

Although the response by R14 might be seen as a gender-essentialist statement, the phrase that there are "individual absolute shits" shows a recognition of variations amongst women, and does not treat women as a homogenous group.

Also presenting the other side of the issue is the realisation by R24 (sample 2) that women are constrained in the profession, despite their increasing access.

"I don't think it's positive benefit as being fully realised because of, I think we're too entrenched in the old ways of, of, um, of lack of flexibility".

6.5.4 Do responses indicate a link between attrition and a monoculture of instrumentality?

The responses coded under the themes evaluated for indications of the presence of a monoculture of instrumentality did not link attrition to this concept.

6.7 CONCLUDING REMARKS

In the review of the data emanating from the interviews, it appears that it would not be an overstatement to claim the following:

- Firstly, although they might disagree in terms of the extent of its impact on the profession at present, **the respondents definitely recognise the presence of a gendered substructure in medicine in the South African**

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context, as illustrated through their confirmation of the presence of all four aspects of this culture.

- Secondly, the aspect of a monoculture of instrumentality seems to be the least relevant in terms of its presence and relevance to the profession today, as well as its perceived impact on attrition.

- Thirdly, the aspects of valuing heroic individualism, the split between work and family, and exclusionary power seem to be those most commonly linked to attrition by these respondents.

In terms of the gendered construction of the medical profession, the quotes also illustrate the tension of continued gender reconstruction in terms of hegemonic masculinity in medicine and the construction of new femininities[97] in medicine within the South African context.

Most importantly, I feel what we can learn from this analysis of the interview transcripts that not only is this gendered substructure still perceived to be present, but some aspects are perceived to be linked to attrition from the profession to varying degrees. This is significant because it is not only the view of women who have actually left the profession, but is shared across all samples. Importantly, it is a shared perception among those respondents still active in the profession, which might impact on their decision to remain.

As explained in Chapter 3, I set out to provide a profile of women who have left the profession in an attempt to show the factors that specifically impacted on their decisions to leave, assuming that they would be significantly different to those women who chose to remain in the profession. However, my quantitative as well as qualitative analysis found them not to be significantly different at all. The respondents in sample 2 seem to differ only in their willingness to verbalise the aspects that made them want to leave,

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[97] To grapple with this issue further, one can consider Simpson's (2004: 351) suggestion of the possibility of a 'compromised femininity' being possible within the context of women moving into a male-dominated profession, which is in contrast to the possibility of 'compromised masculinity' for men entering female-dominated professions. This is because the former can be associated with increased status and the latter with a fundamental assault on manhood.

although these are not very different from the factors still continuing to affect the women doctors remaining in the profession. Thus, what this analysis does show is that the reasons for attrition in the South African medical profession can be linked to a gendered subculture, which although it is changing, is still present, and thus still has the propensity to impact on the attrition of women doctors from the profession. This is a very important finding. It implies that those still in the profession either deny the realities or are not comfortable to speak about them. If the latter could be facilitated, we maybe could deal with these issues before it became necessary for women to leave the profession.

What I also want to highlight here is how the elements of a gendered substructure are a reflection of the concepts and metaphors conventionally used to subordinate women, and this explains its pervasiveness to some extent. These concepts are central to maintaining the gendered construction of medicine as a masculine profession. For example, it is clear that the element of a *split between work and family* is based on the discourse surrounding the *public/private divide,* and *productive vs. reproductive work*. It is also possible to assert that the roots of the discourse surrounding *'care work'* can be identified in the element of a *monoculture of instrumentality*, as the latter aims to devalue aspects such as *care, empathy*, etc., as these are not judged as essential to successfully completing a task. This also links to the devaluation of *women's work*, because care primarily has been associated with women.

In the next and final chapter we review the results and findings of all the chapters, and consider how these are contradictory to, in support of, or present a different perspective on the existing knowledge in this field of research. I also consider what these results and findings mean for retaining women doctors in the South African medical profession.

CHAPTER 7

CONCLUSIONS

As explained before, Objective 3 aimed to provide recommendations on the retention of women doctors in the SA medical profession. It thus is fitting, before we close by providing these recommendations, to consider the findings across the chapters in terms of the literature.

7.1 DRAWING TOGETHER FINDINGS WITH THE REVIEWED LITERATURE

Chapter 1 set out to establish the background to and motivation for this study. It noted the international trend of increasing feminisation, in itself a contested term (see Riska, 2008), of medical education and the profession (Williams, 1999; Gjerberg, 2001; Crompton & Le Feuvre, 2003; Levinson & Lurie, 2004; Burton & Wong, 2004), and illustrates that this is also a reality in our national context (Unterhalter, 1985; Brink et al, 1991; Hay & Jama, 2004; Breier & Wildschut, 2006). This chapter frames the feminisation of the SA medical professional and educational context as being plagued by difficulties very similar to those encountered in other traditionally male-dominated fields (Brink et al, 1991; Walker, 2003; Wildschut, 2008; Wynchank, nd). The particular relevance for further research and debate is illustrated through the noticed discrepancy between women's proportional representation in enrolment and graduation at medical schools in South Africa, and their proportional representation in the profession itself. Although acknowledging the impact of a time lag before women's representation in the profession would be commensurate with their representation in medical education, there is evidence to suggest that "the impact should have been greater by now" (Deech, 2009: 11).

The chapter then progresses to explaining UCT as the institution best placed to be the case study for further investigation, and closes by stating three main research objectives. Objective 1 aims to establish the sex composition of the cohort of medical graduates that have not entered, or have decided to exit, the medical profession. Objective 2 investigates

the reasons behind sex trends in the medical school and the profession, and Objective 3 aims to provide recommendations on the retention of medical doctors in general, and women doctors specifically, in the South African context on the basis of the outcomes of the previous objectives. The importance of such an investigation is underscored by Deech (2009: 3), who states that "women fought long and hard for entry into medicine; it will require continuous commitment and effort to ensure that they fulfill their potential".

Chapter two recounts the history of the medical profession and how it came to be defined as a male profession, as well as being male dominated. This required the consideration of various metaphors and concepts that, throughout history, have operated to subordinate women in support of the wider system of patriarchy. As the investigation in this study identifies itself as feminist, it is essential that concepts and theories be used that will not only illuminate the locations of gender inequality in the medical profession, but also present a theoretical framework within which to discuss a change in the status quo. Before even considering the more meso- and micro-level literature and theories, which firstly debate the issues surrounding gender in professions, and secondly gender within the medical profession, I draw on feminist, power and gender theories (macro-level) to illustrate the underlying assumptions (around science and medicine[98], the concepts of 'women's work'[99] and 'care work'[100], the productive versus reproductive work dialectic[101], the public/private divide[102], and the gendered construction of professions[103]) that contribute to the continued gender inequality experienced in the medical profession today.

I then considered the more meso- and micro-level theories and literature relevant to a discussion of the feminisation of the medical profession in South Africa. While clearly having to admit to the increasing feminisation of medical education and the profession as

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[98] Stellman (1977); Clarke (1983); Hubbard (1990, 2003); Eichler et al (1992); Fausto-Sterling (1992, 2003).

[99] Culkin (1999), Carter (2009).

[100] See the importance of a 'feminist ethics of care' in Gouws (2009), Sevenhuijsen et al (2003).

[101] O'Brien (1981); De Beauvoir (1989); Firestone (1971), Carter (2009).

[102] See Kerber (1988) and Prokhovnik (1998)

[103] This is also where a consideration of gender identities (masculinities and femininities) becomes particularly relevant and important. Of specific relevance are the issues surrounding the maintenance of hegemonic masculinities across various professional fields (Parpart & Zalewski, 2008; Connell et al, 2005).

a reality in the quantitative sense, the literature examining this phenomenon debates whether it will have an impact on the nature and/or the status of the profession (Gjerberg, 2001; Levinson & Lurie, 2004; Jovic et al, 2006, Breier & Wildschut, 2006). When looking at the literature, each line of argument espouses a certain set of outcomes (that the increasing feminisation will impact on the status and/or the nature of the profession). The phenomenon of increasing feminisation in the medical profession provides a good framework from which to consider whether this phenomenon has impacted on the profession in other ways; for instance, the gendered construction of the medical profession, the perceptions around the impact of the institutional structures of medicine on women, the perceptions around the impact of societal factors on women in medicine, etc.

In sum, the chapter most importantly establishes the theoretical framework within which I propose to analyse and debate the outcomes of this study. It shows that I will be using concepts situated within macro-level theories (feminist, gender and power theories), meso-level theories (gender in the profession and organisation) and micro-level literature (feminisation of, and attrition in, medical schools and the profession). Taking all of these themes into consideration, I then frame my approach as a feminist-organisational approach and highlight the concept of "feminization as a discourse on gender and medicine… [which] constructs the gendered organization of medicine" (Riska, 2008: 3). Thus, I am using a study of the phenomenon in the South African medical profession not only to establish sex trends in the data, but to uncover the gendered assumptions that surround this phenomenon as a silent contributor to attrition as deduced from the preliminary data analysis. Following from this, and most relevant to the qualitative analysis of the interview data, I explain Rao's (1999) conceptualisation of the gendered substructure, and how I will be using this conceptualisation to discuss and uncover whether a gendered organisation of medicine as a possible driver of attrition is evident in the South African case.

Chapter 3 established and explained the research methodology. It starts by describing the sample and found that, in terms of race, the sample was dominated by white women

(77.8%), followed by Indian (11.1%), African (7.4%) and coloured (3.7%) women. Contrary to expectations that were based on the findings of other studies that elaborate on the difficulties for women doctors of being married and having children (either during training, full-time practice or specialisation) (Dobson, 1997; Kane-Berman, 1998; Acker, 1999, Hilton, 2004; Deech, 2009), the majority of sample 1 women (women who were still in the profession) were married and had children.

The chapter also set out the data collection, coding and analysis to be done in an effort to meet both Objectives 1 and 2. In closing, it explains the construction and use of the Institutional Culture of the Medical Profession (ICMP) scale and its specific importance for this study, as well as reliability and validity considerations. Finally, the chapter closes with a consideration of ethics.

Chapter 4 attempted to meet Objective 1, which seeks to *establish the difference between the graduation rate of men and women medical students compared to their entry rates into the SA medical practice between 1996 and 2005*. I also simultaneously compared the results emanating from attempting to meet this objective to the findings in the UCT case study as a way in which to contextualise the national findings. Thus, there are three parts to the analysis (national quantitative, cohort quantitative, and qualitative data analysis), which, as a method of triangulation, lend credibility to our study findings and indicate its reliability. The advantages and suitability of this kind of method have been confirmed elsewhere in similar studies (Breier & Wildschut, 2006; Breier, 2009; Erasmus & Breier, 2009).

Meeting Objective 1 required me, firstly, to establish the difference between the graduation rate of men and women medical students between 1996 and 2005, and then to compare the graduation rates with entry rates into the SA medical practice during the same period. In terms of the former I found an overall national increase in female enrolment and graduation, accompanied by an overall decrease in male enrolment and graduation during the relevant period. A consideration of women's proportional representation in 2005 showed that they comprised 56% of the national total for medical

students for both enrolment and graduation. The UCT general enrolment and graduation data, on the other hand, indicates a disparity between the proportion that women make out of enrolments and the proportion they comprise of graduations for the entire period between 1996 and 2005, indicating possible attrition from medical school.

In examining the UCT cohort data, which is a much more accurate representation of graduation rates, I find that women medical student attrition generally was lower than that of men during the period 1996 to 2005, which confirms observations by others (Hay & Jama, 2004; Breier & Wildschut, 2006, Levinson & Lurie, 2004; Burton & Wong, 2004) that women do not struggle in medical school and actually outperform men. However, illustrating the continued influence of race, and possibly culture, the UCT cohort data shows that African women still have the highest attrition rate within the category of women. It is clear that race continues to have an impact in South Africa, as is probably true for numerous countries:

> "white women are historically socially, educationally, economically and politically privileged in relation to black women… the historical educational privileging of white women is likely to remain a partial determinant for some time with respect to the location of black women and white within the academic hierarchy" (Pillay, 2007: 15-16).

Chapter 4 establishes a few things in terms of a consideration of general and women's attrition in medical school:

- Firstly, the body of literature focusing on attrition in the medical school (undergraduate) finds that some aspects of training might have negative effects on students' mental and emotional health, in turn suggesting that this might contribute to attrition (Dyrbye et al, 2005). Furthermore, attrition is seen to be linked mostly to academic[104], financial and, occasionally, personal reasons (Simpson & Budd, 1996; Huda & Agha, 2004). In the South African case, the higher attrition rate of minorities is emphasised specifically (Moomal & Pick,

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[104] In the case of South Africa, the continued high attrition rates of black students in particular have resulted in critiques of the necessity of science-oriented pre-clinical years (Lehmann & Sanders, 1999).

1998; Lehmann & Sanders, 1999), and this is borne out in the cohort data findings of this study.

- Most studies, however, agree that women do not struggle particularly in undergraduate medical education, although there is some evidence that this might not be the case in postgraduate training[105]. The importance of mentoring for female residents is thus highlighted.

- Furthermore, this chapter emphasises the importance of cohort studies in the investigation and establishment of attrition rates, as is evident in the slightly skewed picture one obtains from a simplified consideration of proportional representation in enrolment and graduation, as well as graduation rates (which essentially are a formula dividing the numbers of graduates by the numbers of enrolments in the same year). Although I am not refuting the importance of this data in terms of establishing proxies, and to get a general sense of trends in education, a concurrent consideration of cohort studies would add considerable value.

In terms of considering the attrition between graduation and entering the profession, I find, firstly, that the racial transformation of the profession has occurred much faster than the gender transformation. Most importantly, when considering the year-on-year growth rates, I find an increase in the progression of men into the profession from 2004 to 2007 (from 39.3% to 81.4%), accompanied by a much smaller increase in progression of women during the period[106] (from 63.9%, which was higher than that of men, to 77.3%, which is now lower than that of men). Furthermore, if we consider the percentage change in progression between 2004 and 2005, we find a smaller increase in progression for women (26.6%) compared to men (32.7%). In the period between 2005 and 2006, we find that males show an increase (6.2%), while females show an 11% decline, despite having a higher progression compared to males in this period. Lastly, considering the progression between 2006 and 2007, we find that men show a 3.2% increase in

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[105] Walker et al (1993: 182), for instance, found in their study on attrition from orthopaedic surgery residency that "female residents had a statistically higher attrition rate than male residents".

[106] This attrition cannot be attributed to postgraduate training, because an MBChB graduate cannot move into a registrar position (specialist training position) before having completed an internship, community service and registration as a medical practitioner in the category independent practice.

progression, while women still continue to show a decline, albeit smaller, of 1.7%. This is quite surprising, given that the great increases in the enrolment and graduation of women in this period lead to an expectation of gains in women's subsequent progression into the profession, rather than attrition.

Relating these findings to the debates on the attrition of women from the medical profession and science in general:

- I do find considerable literature on attrition in the medical profession in general (Berhan, 2008; Chankova et al, 2009), as well as literature considering the attrition of women in science professions (Andrews, 2002, Holmes et al, 2008). The latter literature finds that, similar to those of medicine, women leave mainly because of factors linked to the structure of the profession, the role of time lag, and the more biological determinist assumptions of women's inherent preferences (held and perpetuated by men and women alike). In terms of establishing the attrition rates of women doctors, data from Singapore suggest that, although the attrition rate of women doctors from the profession generally is higher than that of male doctors, this situation is increasingly changing. Comparing data from 1979, when women doctors' attrition rates were about 11% higher than that of males, more recent data (1994) suggests only a 5% difference (Sadasivan, 2003[107]).

- Most literature alludes to the subject of attrition, but does not comprehensively interrogate the reasons behind this attrition. What I do find encouraging when reviewing the more recent literature is that there is an increased realisation of the importance of further studies to ascertain the reasons underlying attrition in the medical profession (Rittenhouse et al, 2004[108]; Moschos & Beyer, 2005; Cropsey et al, 2008[109]), suggesting the importance of innovative retention strategies

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[107] Of course I cannot compare the attrition rates established in this study with these rates, and the Sadasivan study is based on professional attrition rates and does not look at attrition between graduation and registration.

[108] Rittenhouse et al (2004), in their consideration of the reasons for medical practitioner attrition, question the factors used to predict attrition.

[109] Cropsey et al (2008: 1111), in their study of women in academic medicine, assert that "the majority of reasons for faculty attrition are amenable to change. Retaining high-quality faculty in medical settings may justify the costs of faculty development and retention efforts".

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(Berhan, 2008[110]). However, as explained in the introductory chapter, there are very limited evaluations of the attrition of women from medicine, and the attrition of women from South African medicine more specifically.

Chapter 5 set out to meet Objective 2, which aims to *establish and explain the reasons underlying the attrition trends of female medical doctors in the SA medical profession between 1996 and 2005*. Through SPSS analysis and coding, a quantitative illustration of the qualitative interview data was established.

In terms of both institutional and societal factors, I found in this sample of women that they definitely felt that these factors influenced the probability of women doctors staying in the profession. What was also quite apparent was the difficulty they had in divorcing the influence of these two aspects, as well as the importance they assigned to each in making decisions on their participation in the profession. This finding is in stark contrast to arguments of gender essentialism (Hakim, 2000), which would suggest that men and women are fundamentally different and that this is what explains differences in employment patterns, but in line with those of others (Riska, 1993; Crompton & Lyonette, 2005).

A consideration of the impact of individual factors established that, when comparing whether these respondents felt that they had appropriate role models, and whether medicine was their first vocational option, the former seemed to be the more important factor[111] in their identification with, and propensity to stay in, the profession (Riska, 2001; Park et al, 2005; Richardson & Redfern, 2000). Deech (2009) also emphasises the importance of role models and mentoring for women doctors. What also surfaced was the changing idea of what is appropriate in a role model. Whereas these women previously might have been inspired by doctors (usually male) who worked long hours, they now admired those doctors (male or female) managing to balance work and family.

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[110] In a study of attrition of medical doctors in Ethiopia, Berhan (2008) remarks that concrete retention mechanisms should be put in place, for example, providing physicians with land , low-cost housing, low-cost or interest free loans on housing and automobile procurement, an improved staff taxation system for academic staff, dual employment options, etc.

[111] Please refer to Chapter 5, where this is established.

I find that specifically qualifying responses illustrates that, although these women conceptually agree with the negative impact of the organisational structures in medicine, their responses either were not based on their own experiences, or they were unwilling to admit to this. This finding links to Acker's (1999: 178) assertion that maybe "women's organizational experiences are best explained by women's structural locations, not by their personalities". Thus, although I do not question the importance of women's perceptions of the reasons for attrition, I realise that an extensive review of their structural locations[112] is also important. Again, this should not be viewed as a weakness, as I used the qualitative interview as a data gathering tool particularly because I am interested not only in the facts, but in the ways in which these women constructed and reconstructed their experiences. Through this method I try to show "how individuals respond to social constraints and actively assemble social worlds" (Mason, 2002: 56).

This is quite an important finding (referring to women's unwillingness to admit to discrimination), which can help us understand the dimensions of and reasons for continuing discriminatory practices (Acker, 1999) or structures in a profession such as medicine. The finding might also suggest that, because these women are highly educated, they can identify discriminatory practices or institutions within the profession, but because of their recognition of their own power would not like to admit that they either have allowed these to take place, or are victims of these practices. This is part of the reason why organisational structures of gender inequality continue to exist in the 1) procedures, activities and divisions, 2) images, symbols, forms of consciousness, 3) interactions between individuals and groups, and 4) internal mental work (Acker, 1999).

The results of the ICMP scale were considered and it was found that the majority of respondents ranked highly on this scale, which means that the respondents felt strongly that the culture of the medical profession impacted negatively on women doctors' propensity to stay in the profession, but similar to the findings of other studies, this does not bring us closer to an understanding of what that culture constitutes. However, the

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[112] This refers to how women are positioned in terms of organisational structures, for instance their levels of seniority and responsibilities within a profession.

responses to the items used for the scale can be considered as a reflection of women's perceptions of the influence of organisational culture on their experience of the profession.

Conceding that the previous chapter did not establish any significant differences between the responses of the respondents in sample 2 in relation to the rest of the women doctors, Chapter 6 aimed to present a qualitative representation of the interview data.

It is clear that we needed to evaluate the responses in a different way and not to concentrate on the numerical aspects, as generalisation was not the aim of the study. I thus turned to evaluating the responses in terms of what they revealed of the presence of a **gendered substructure** in the profession as a possible driver of attrition (referred to by Rao et al (1999) as uncovering the *deep structure*).

This evaluation entailed a consideration of the interview data in terms of what it revealed about the presence of the following aspects of a gendered substructure: 1) valuing heroic individualism, 2) the split between work and family, 3) exclusionary power, and 4) a monoculture of instrumentality. Based on the analysis in the chapter, I conclude most importantly that:

- The respondents clearly recognized the presence of a gendered substructure in medicine in the South African context
- The monoculture of instrumentality appeared to be the least relevant aspect[113] in this sample of women
- The aspects of valuing heroic individualism, the split between work and family and exclusionary power appear to be most commonly linked to attrition by these women.

These findings link to observations by others that women's non-advancement in professions might be influenced by the way in which they have been included, rather than

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[113] This might be due to the fact that, post-1994, the medical profession in South Africa has undergone a shift to a more holistic, patient-centred care approach, which would emphasise the consideration of more than just addressing the physical symptoms of a patient.

because of their outright exclusion (Witz, 1990; Acker, 1999). This certainly seemed to be the case in the UCT medical school, where it was stated that "…the male hierarchy of the medical profession… appears to go hand in hand with the authoritarian practice of medicine, which characterized the South African medical profession" (FHS, 2002: 73). This statement illustrates how different sites of power can reinforce certain outcomes for certain individuals or groups, although access has been ensured.

The fact that the responses of the women in my study were very ambivalent in many respects is an illustration of the slowly changing conceptualisations around the institutional structure and culture of medicine (refer to discussions in Chapter 6). The women's verbatim accounts show their recognition of these oppressive institutions, not only as passive observers, but also as active agents involved in resistance and, through their reconceptualisations of their experiences, actually changing these institutions. These women are in many instances trying to reconstruct gender. However, their role in the construction of gender in the medical profession, based on older values associated with hegemonic masculinity, must be acknowledged.

7.2   RECOMMENDATIONS ON THE RETENTION OF WOMEN MEDICAL DOCTORS IN SA

Before presenting final recommendations and suggestions for further research, I turn here to an examination of the responses to questions 26 and 27, which asked the respondents for recommendations for retention in general, and in relation to women doctors specifically. Looking at the table below it is evident that the proportional majority of the respondents felt that there should be increasing flexibility of working hours (37%) in order to retain physicians.

Table 7.1: Recommendations on the retention of doctors in general

		Frequency	Percent	Valid percent
Valid	Flexibility of working hours	10	37%	38.5%
	More part-time opportunities	3	11%	11.5%
	Better salaries and Resources in public service	2	7%	8%
	Standardising of practices and education	2	7%	8%
	Providing more personnel	2	7%	8%
	Adequate political leadership and evidence-based approach	1	3%	4%
	All of the above	6	22%	23%
	Total	26	96%	100%
Missing	No answer	1	4%	
Total		27	100%	

Specifically with regard to the retention of women doctors, most of the respondents (44.4%) agreed that there was a need for more flexibility in the public service specifically.

Table 7.2: Recommendations on the retention of women doctors specifically

		Frequency	Percent
Valid	More flexibility in public service (maternity leave, job sharing, part-time, child-care)	12	44%
	More 5/8s posts	4	15%
	Opportunities for part-time specialisation	6	22%
	Better opportunities for career advancement	1	4%
	Change in attitude toward female doctors	1	4%
	Providing better working conditions (security, working environ)	3	11%
	Total	27	100%

In sum, the proportional majority of respondents felt that there should be increasing flexibility of working hours to retain physicians and, specifically with regard to the retention of women doctors, the largest proportion of respondents agreed that there was a need for more flexibility in the public service.

Given the above, it is clear that flexibility in the medical profession is paramount to the retention of doctors, and women doctors specifically. This is a difficult challenge to

overcome, as the central values in the profession, such as the importance of continuity of care, would suggest that providing increasing flexibility to medical doctors would impact negatively on patient care. Thus, discourse and debate on the resolution of this tension traditionally has been from the perspective of trying to keep continuity of care intact, given that it is essential to the effective practice of medicine, rather than from a perspective that realises that women form the majority of the pool of medical graduates and that acknowledges and values their contribution (given that traditional practice patterns are no longer the reality) in order to retain their expertise and skills. The central debate therefore remains how one "address[es] the demands in creating a workforce that meets clinician needs without compromising patient care and, indeed, expectations" (Deech, 2009: 3). What is encouraging, however, is that the more recent literature seems to be coming from the latter vantage point of retention.

As shown in a more recent study of women in medicine in England, where a National Working Group on Medicine was established in 2008 in recognition of the importance of this issue, and in the main recommendations of the first report to the SA Department of Health, three areas are outlined:

- Improvement of the existing structures so that there is better advancement to certain crucial career turning points as well as different ways of working.
- Ensuring that new processes such as revalidation have the flexibility and capacity to accommodate doctors who may not be conforming to the usual working patterns.
- Providing additional support for the practical realities of caring for a child or a dependent relative (Deech, 2009: 5).

Based on the outcomes of my investigation, it is clear that the national sex attrition trends are a cause for concern in terms of resourcing the National Health System against the backdrop of a widely acknowledged shortage of doctors in South Africa (Breier, 2009) and elsewhere. If women doctors do not progress effectively into the system, yet form the majority of graduations, this is a tragic loss. This state of affairs also has possible policy implications, because it appears that, in trying to retain doctors, the government has

increasingly turned to measures that are restrictive (compulsory community service, restrictions on foreign doctors), rather than focusing on ways in which to make doctors want to stay.

7.2.1   Suggestions for further research

In terms of suggesting options for further research, I need to acknowledge that gender might not be the only influencing factor in attrition and that it would be important for further research in this field to consider the impact of race, class, ethnicity, etc. As shown in this investigation, my attempt to meet Objective 1 fully was thwarted, as it required a determination of racial attrition. The fact that people were unwilling to indicate their race, and that the HPCSA therefore could not gather racial information, makes it impossible to profile the extent of attrition across sex and race. The differences in terms of race are quite apparent in the medical student data, and because there is no such comparable professional data (disaggregated by sex and race), it is impossible to ascertain the true picture of attrition between graduation and registration.

This finding clearly has implications for further research in the area, and highlights the need for a more effective engagement with doctors when asking them to indicate race. Many, understandably, are unwilling to indicate race based on the arbitrary racial classifications during the apartheid regime, which formed the basis of racial discrimination, and its continued use is associated with the perpetuation of those discriminatory categories. Furthermore, on a practical level, many people are from mixed decent and it has become increasingly difficult for people to categorise themselves based on previous racial categories. Although these are valid concerns, within the context of an attempt to measure transformation in the profession (in terms of both sex and race) more comprehensively the need for more people to consider indicating their race in the profession is highlighted.

In general, most studies on attrition in the medical profession refer to the culture of medicine, personal reasons, financial reasons, etc., and allude to the impact of gender in attrition, but do not extensively consider the reasons behind attrition. The obstacles in

fulfilling the objectives set out in this research project allow me to highlight and suggest the following options for further research, which have relevance to three main areas of medicine: 1) medical schools/training/education, 2) medical profession/culture, and 3) society in terms of their expectations of women.

Of relevance to both medical education and the professional context

- is the importance of considering the impact of other variables/influencing factors, such as race, class, ethnicity, language, socio-economic status, etc. on trends in attrition from the medical profession as well as in training.

- is the importance of constructing a database/compiling information on the class, origin, etc. of medical practitioners (this highlights the importance of tracer and cohort studies), which would require integration between information management between medical education and the profession.

- one should underscore the importance of investigating women's structural locations concurrently to qualitative interviewing (constructing organograms in conjunction with this kind of investigation to get a sense of women's real locations, rather than what they are willing to say).

- is the importance of facilitating the voicing of the perceptions held by women doctors in an effort to expose discriminatory structures, and through this the ability to address these issues.

- is a consideration of how the unhappiness/discomfort of many women doctors remaining in the profession affects their performance.

- is the continued evaluation of the quality of education, and the suitability of the medical curriculum aided by bridging programmes (as evidenced through the continued higher attrition rates of minorities in medical education).

- is the importance of evaluating and monitoring the conditions under which internship and community service is being provided. This factor highlights the importance of support and supervision to counteract the many negative experiences of interns and community service doctors, which may also play a big role in attrition between graduation and registration as a medical practitioner (Moomal & Pick, 1998).

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Arguably the most important, and probably the most difficult to effect, would be the recommendations of relevance to society as a whole, which would advocate, on the basis of the findings of this research, that a reconceptualisation of the values that constitute the norm in the workplace is not only timely, but necessary. As Venitha Pillay (2007) recognises, the liberation of women in society, on an intellectual, personal and emotional level, requires much more than only the revision of structural arrangements in the workplace: it demands a reconceptualisation of work, the self and family.

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WEBSITES

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www.aamc.org

British Medical Association (BMA)

www.bma.org.uk

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DATASETS

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APPENDIX 1

ETHICS

Human Sciences Research Council
Lekgotla la Dinyakisišo tša Semahlale tša Setho
Raad vir Geesteswetenskaplike Navorsing
Umkhandlu Wezokucwaninga Ngesayensi Yesintu
Ibhunga Lophando Ngenzulu-Lwazi Kantu

HSRC Research Ethics Committee

FWA Registration: **Organisation No. 0000 6347**
                          IRB No. 0000 3962
Secretariat: Room 1411, HSRC Building, Pretoria.
Tel: 27 12 302 2800
Fax: 27 12 302 2828

HSRC
Social science that makes a difference

22 August 2005

Dr Mignonne Breier
Human Resources Development Research Programme

Dear Dr Breier

Application for ethical clearance of Protocol REC 7/11/05/05: Professional Education in South Africa: Continuation of the Case Study on Medical Practitioners

Thank you for your application for ethics approval of the above study. This was considered by the HSRC's Research Ethics Committee at its meeting on 10 August 2005.

Ethics clearance of the study was granted, and the Committee wishes you success in your research.

Yours sincerely,

Professor Peter Cleaton-Jones
Chairperson
HSRC Research Ethics Committee

134 Pretorius Street, Pretoria   Private Bag X41, Pretoria, 0001, South Africa   Tel: 27 (12) 302 2000   Fax: 27 (12) 302 2828
750 Franscois Str, Cato Manor, Durban   Private Bag X07, Dalbridge, 4014, South Africa   Tel: 27 (31) 273 1400   Fax: 27 (31) 273 1403
69 - 83 Plein Street, Cape Town   Private Bag X9182, Cape Town, 8000, South Africa   Tel: 27 (21) 467 4420   Fax: 27 (21) 467 4424

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APPENDIX 2

EXAMPLE OF LETTER OF INVITATION

**Research Programme on
Education, Science & Skills
Development**

HSRC

Social sciences that makes a difference

Dear prospective participant

**Invitation to contribute to PHD research project on the attrition of female medical
practitioners from the South African medical profession**

I am conducting a research project on the attrition of female medical practitioners from
the South African medical profession. This research has a two-fold purpose; 1) to
establish the gender composition of the cohort of medical graduates that have not
entered, or decided to exit the medical profession, and more importantly, 2) to establish
the reasons underlying women doctor's decisions not to enter, or to exit the profession,
after their graduation. Thus, my two central questions are:
- What is it about the profession, that makes it very difficult, or in some cases
  totally untenable for women to stay in practice, and also,
- For those that stay, what are their coping mechanisms?

This study will also address certain cross-cutting themes, such as labour market supply
and demand, feminization of the profession, institutional and organizational culture, and
power. As part of a study of professions, I was involved in the completed HSRC study of
medical practitioners, and during this study identified the gender trends inherent in
medical training, graduation and then the transition into the profession. I realized this
needed further investigation.

I would be very grateful if you would agree to contribute to my research by means of an
interview. I attach a copy of the consent form, which I will ask you to sign at the time of
the interview. You will see that it gives you the option of remaining anonymous and
outlines the steps we take to ensure confidentiality.

The reason I embark on these interviews, is an attempt to illustrate more nuanced
experiences of female medical practitioners still practicing, non-practising, as well as
lecturers in the profession, which I am sure would not have been addressed by a purely
quantitative analysis of data.

Attached to this message is a link to the research monograph of our study on medical
doctors. This should give you an idea of what we have managed to outline in terms of
the issues within the broader South African medical profession. My contact details are
set out below, if you have any points of concern or of clarity. This is a theme that I am
very passionate about, and I am sure might be an issue you have been grappling with
yourself, as a women in the profession. I hope this can present an ideal way to
contribute to greater understanding and awareness of the issues experienced by female
practitioners within the medical profession. I look forward to hearing from you.

Yours Sincerely

Ms Angelique Wildschut
Researcher/ PhD Intern
Human Sciences Research Council
(Cape Town office)
Tel: 021 466 7980/8093
Cell : 0842332116
E-mail: awildschut@hsrc.ac.za

APPENDIX 3

EXAMPLE OF INFORMATION AND CONSENT FORM

Human Sciences Research Council
Lekgotla la Dinyakisišo tša Semahlale tša Setho
Raad vir Geesteswetenskaplike Navorsing
Umkhandlu Wezokucwaninga Ngesayensi
Yesintu

**Research Programme on
Education, Science & Skills
Development**

HSRC

Social sciences that makes a difference

**Research project: A feminist investigation into the reasons for attrition of women doctors from
the South African medical profession and practice**

Information and consent form for <u>Interview </u>Participant

As a DPhil candidate at the University of Stellenbosch, currently working as a researcher in the
Education, Science & Skills Development (ESSD) Programme of the Human Sciences Research
Council, I am conducting research on "the South African medical profession and practice". This
study originated as an extension on a previous HSRC study on the profession and education of
medical practitioners, which was part of a broader project on 'Professions and Professional
Education'. The central, and more specific objective for my study is: to identify and explain the
reasons for attrition of women doctors from the South African medical profession and practice.
This could enable suggestions around strategies for retention of medical practitioners from the
South African medical practice.

The research on doctors involves an extensive review of literature, analysis of statistics and qualitative

interviews with three samples of women doctors;

- *S1 consisting of female doctors currently in medical practice,*
- *S2 consisting of non-practicing female doctors, and*
- *S3 consisting of female lecturers in medicine*

The research is due to continue until June 2009. You are invited to participate in an interview.

Participation in this research is voluntary. There will be no remuneration or any other direct
benefit for participation. Refusal to participate will involve no penalty or loss of benefits to which
you are otherwise entitled. You may discontinue participation at any time without penalty or loss
of benefits. There should be no foreseeable risks, discomforts, side effects or benefits from this
research.

With your consent, the interview may be audio-recorded to ensure accuracy. The audio
recordings and notes taken during the interview will not be made available to any persons other
than the researcher concerned and the transcriptionist, who is required to sign an oath of

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confidentiality. The files will be stored with the project during the duration of the research. They will be destroyed after two years.

Your personal identity will be kept anonymous, unless you indicate that you are prepared to be mentioned by name and/or specific designation and this identification would contribute significantly to the validity of the report.

Please contact me, Ms Angelique Wildschut, if you have any queries in this regard. My contact details are:

Tel: 021 466 8089 or 021 466 7980
Cell: 0842332116
Email: awildschut@hsrc.ac.za

Consent

1. I hereby consent to being interviewed with the following conditions (please choose one of the below and cross out what is not applicable):

    (a) I consent to being identified by name and designation

    (b) I consent to being identified by designation only

    (c) I do not wish to be identified.

2. I consent to an audio-recording of the interview | **Yes** | | **No** |

Signature: _____

Date: _____

134 Pretorius Street, Pretoria	Private Bag X41, Pretoria, 0001, South Africa	Tel: 27 (12) 302 2561	Fax: 27(12) 302 2532
359 King George V Ave, Durban	Private Bag X07, Dalbridge, 4014, South Africa	Tel: 27 (31) 273 1400	Fax: 27 (31) 273 1403
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APPENDIX 4

EXAMPLES OF INTERVIEW SCHEDULES FOR EACH SAMPLE

ATTRITION OF FEMALE DOCTORS FROM THE SOUTH AFRICAN MEDICAL PROFESSION AND PRACTICE: DRAFT INTERVIEW SCHEDULE: SAMPLE 1

My research investigates the reasons for attrition of SA female doctors. I specifically want to try and make explicit the gender specific institutional- and societal factors influencing the levels of attrition of female medical practitioners from the SA medical profession. As a secondary objective, I will also examine the changes in the profession and education of medical practitioners in South Africa, focusing on how this has possibly shaped attrition in the profession. Thus I will be asking some general questions aimed at eliciting responses around the education and training of medical practitioners, while the more specific questions will relate to your experiences and views around attrition of female medical practitioners from the SA medical profession and practice.

I have three goals:

1. Describe the attrition trends of women doctors in the SA medical profession, between 1996 and 2005.

2. Establish and explain reasons underlying attrition trends of female doctors in the SA medical profession between 1996 and 2005

3. Provide recommendations on retention of women doctors registered in the category independent practice (GP) in the SA medical profession.

The aim of the interview schedule is to achieve the last two goals by obtaining information to answer the qualitative research question:

- Which institutional factors (organisational culture, glass ceiling, sexual harassment) and/or societal factors (childcare, division of labour, gender identity) have influenced the attrition of women doctors from SA medical practice between 1996 and 2005.

S1 will provide us with information on, and experiences of, practicing female doctors.

Personal

1. Are you married?			
Yes		No	
1.1 If yes, how has this influenced your experience of the medical profession? ……… ……			
2. Do you have children?			
Yes		No	
2.1 If yes, how has this influenced your experience of the medical profession? ……… ……			
3. Are you in a part- or full time position? (Explain that this does not refer to a permanent or contract position)			
Part time		Full time	

4. Medicine is my first vocational option.				
Strongly agree	Agree	Undecided	Disagree	Strongly disagree

5. There are many negative factors about a career as a medical doctor. Why do you think so many young people still want to be medical doctors? Prompt: Altruistic motivation, or financial motivation for wealth. (Clarify the term altruistic). ……… ………

6. I had appropriate role models in the medical profession, who inspired me.				
Strongly agree	Agree	Undecided	Disagree	Strongly disagree

6.1 Explain who and why? ……… ………

7. There were areas in my training and education that I found more difficult in comparison to other modules.				
Strongly agree	Agree	Undecided	Disagree	Strongly disagree

7.1 Which ones, and why? ……… ………

8. There is a high proportion of women medical students at UCT. This is a national and international trend. I agree that this is good for the profession.				
Strongly agree	Agree	Undecided	Disagree	Strongly disagree
8.1 Explain …… ……				
9. In terms of medical student performance, our figures show that whites still form the majority of graduations. This confirms my own experience.				
Strongly agree	Agree	Undecided	Disagree	Strongly disagree
9.1 Your ideas on why? …… ……				
10. In lieu of the impact of HIV/AIDS, I think doctors should be trained differently.				
Strongly agree	Agree	Undecided	Disagree	Strongly disagree
10.1 How? …… ……				

Institutional

11. According to your view, what contributes to attrition in the medical profession in general, and in SA specifically? …….. ………..				
12. A female doctor's advancement is affected by her location in the organisational power structure.				
Strongly agree	Agree	Undecided	Disagree	Strongly disagree
13. According to some theorists, workplace structures present 'uncomfortable' working environments for women.				
Strongly agree	Agree	Undecided	Disagree	Strongly disagree
13.1 This has been my experience at my organisation.				
Always	Very often	Sometimes	Rarely	Never
13.2 Explain ………..				

....

14. The typically hierarchical structure of organisational cultures reinforces unequal power relations between men and women.				
Strongly agree	Agree	Undecided	Disagree	Strongly disagree
14.1 Why?				
15. What are your views on the following issues: Extra year of community service, Community service in rural areas, and long-hours on call especially for trainee doctors?				
15.1 These issues play a role in doctor's decisions to stay in the profession.				
Strongly agree	Agree	Undecided	Disagree	Strongly disagree
16. The feminisation of the profession has affected patient care, health care systems, and the profession itself.				
Strongly agree	Agree	Undecided	Disagree	Strongly disagree
16.1 How?				

Societal

17. Societal factors influence the attrition of women doctors generally, and from SA medical practice specifically.				
Strongly agree	Agree	Undecided	Disagree	Strongly disagree
17.1 How and why?				
18. The race of a female doctor impacts on her experience of the institutional culture.				
Strongly agree	Agree	Undecided	Disagree	Strongly disagree
18.1 How?				

……
19. Female doctor's advancement and attrition is affected by traditional perceptions of women's roles in society.

Strongly agree	Agree	Undecided	Disagree	Strongly disagree

20. My plans regarding family life been altered by the organisational culture I find myself in.

Strongly agree	Agree	Undecided	Disagree	Strongly disagree

20.1 How?
……
……
21. I felt like dropping out at a stage of my education (internship/ community service).

Strongly agree	Agree	Undecided	Disagree	Strongly disagree

22. What made you want to drop out, and why did you decide to continue?
……
……
……
23. What do you think the implications would be if you decided to move from public to private practice?
……
……

Retention of women doctors in the SA medical profession

24. Are there any of the individuals in your class that you know have emigrated?

Yes	No

24.1 What are the reasons?
……
……
25. The conditions in the public health sector affects whether doctors decide to stay and practise in the country.

Strongly agree	Agree	Undecided	Disagree	Strongly disagree

25.1 How? ……… ………
26. How should the institution of medicine be altered to become a more balance friendly environment - as male doctors are also increasingly demanding more quality of life, and a better balance between work and life? ……… ………
27. What would your recommendations be for the retention of women doctors in the SA medical profession? ………. ……….

ATTRITION OF FEMALE DOCTORS FROM THE SOUTH AFRICAN MEDICAL PROFESSION AND PRACTICE: DRAFT INTERVIEW SCHEDULE: SAMPLE 2

Introduction: My research investigates the reasons for attrition of SA female doctors. I specifically want to try and make explicit the gender specific institutional- and societal factors influencing the levels of attrition of female medical practitioners from the SA medical profession. As a secondary objective, I will also examine the changes in the profession and education of medical practitioners in South Africa, focusing on how this has possibly shaped attrition in the profession. So I will be asking some general questions aimed at eliciting responses around the education and training of medical practitioners, while the more specific questions will relate to your experiences and views around attrition of female medical practitioners from the SA medical profession and practice.

I have three goals:

4. Describe the attrition trends of women doctors in the SA medical profession, between 1996 and 2005.

5. Establish and explain reasons underlying attrition trends of female doctors in the SA medical profession between 1996 and 2005

6. Provide recommendations on retention of women doctors registered in the category independent practice (GP) in the SA medical profession.

The aim of the interview schedule is to achieve the last two goals by obtaining information to answer the qualitative research question:

- Which institutional factors (organisational culture, glass ceiling, sexual harassment) and/or societal factors (childcare, division of labour, gender identity) have influenced the attrition of women doctors from SA medical practice between 1996 and 2005.

S2 will provide us with information on, and experiences of, non-practicing female doctors to establish their reasons for not entering the profession.

Personal

1. Are you married?	
Yes	No
1.1 If yes, how has this influenced your experience of the medical profession? …… ……	
2. Do you have children?	
Yes	No
2.1 If yes, how has this influenced your experience of the medical profession? …… ……	

3. Were you ever in a part or full time position? (Explain that this does not refer to a permanent or contract position)		
Part time	Full time	Neither

4. Medicine is my first vocational option.				
Strongly agree	Agree	Undecided	Disagree	Strongly disagree

5. There are many negative factors about a career as a medical doctor. Why do you think so many young people still want to be medical doctors? Prompt: Altruistic motivation, or financial motivation for wealth. (Clarify the term altruistic).
……
……

6. I had appropriate role models in the medical profession.				
Strongly agree	Agree	Undecided	Disagree	Strongly disagree

6.1 Explain who and why?
……
……

7. There were areas in my training and education that I found more difficult in comparison to other modules.				
Strongly agree	Agree	Undecided	Disagree	Strongly disagree

7.1 Which ones, and why?
……
……

8. There is a high proportion of women medical students at UCT. This is a national and international trend. Do you agree that this is good for the profession?				
Strongly agree	Agree	Undecided	Disagree	Strongly disagree
8.1 Explain ……… ………				
9. In terms of medical student performance, our figures show that whites still form the majority of graduations. This was my personal experience as well.				
Strongly agree	Agree	Undecided	Disagree	Strongly disagree
9.1 Your ideas on why? ………. ………..				
10. In lieu of the impact of HIV/AIDS, doctors should be trained differently.				
Strongly agree	Agree	Undecided	Disagree	Strongly disagree
10.1 How? ………. ………				
11. How has the medical education landscape changed since the years when you studied? ………. ………				
12. What is your area of specialization, and what influenced your decision to go into this specific area? ……… ………				

Institutional

13. According to your view, what contributes to attrition in the medical profession in general, and in SA specifically? ………. ……….				
14. Female doctor's advancement is affected by her location in the institutional power structure.				
Strongly agree	Agree	Undecided	Disagree	Strongly disagree

15. According to some theorists, workplace structures present 'uncomfortable' working environments for women.				
Strongly agree	Agree	Undecided	Disagree	Strongly disagree
15.1 This been my experience at my organisation.				
Always	Very often	Sometimes	Rarely	Never
15.2 Explain ……….. ………..				
16. The typically hierarchical structure of organisational cultures reinforces unequal power relations between men and women.				
Strongly agree	Agree	Undecided	Disagree	Strongly disagree
16.1 Why? ……….. ………				
17. What are your views on the following issues: Extra year of community service, Community service in rural areas, and long-hours on call especially for trainee doctors? ……….. ………..				
17.1 These issues play a role in doctor's decisions to stay in the profession.				
Strongly agree	Agree	Undecided	Disagree	Strongly disagree
18. Feminisation of the profession has affected patient care, health care systems, and the profession itself.				
Strongly agree	Agree	Undecided	Disagree	Strongly disagree
18.1 How? ……….. ………..				

Societal

29. Societal factors influence the attrition of women doctors generally, and from SA medical practice specifically.				
Strongly agree	Agree	Undecided	Disagree	Strongly disagree
19.1 How and why?				

....				
20. The race of a female doctor impacts on her experience of the institutional culture.				
Strongly agree	Agree	Undecided	Disagree	Strongly disagree
20.1 How?				
21. Female doctor's advancement and attrition is affected by traditional perceptions of women's roles in society.				
Strongly agree	Agree	Undecided	Disagree	Strongly disagree
22. My plans regarding family life have been altered by the organisational culture I find myself in.				
Strongly agree	Agree	Undecided	Disagree	Strongly disagree
22.1 How?				
23. Have many of your colleagues opted for part-time work, rather than full-time employment? And specialisations?				
Yes			No	
23. 1 Why do you think this is the case?				
24. At which stage of your education did you decide to discontinue your training?				
Internship			Community service	
24.1. Which factors influenced your decision to not practise medicine?				

Retention of women doctors in the SA medical profession

25. Are there any of the individuals in your class that you know have emigrated?	
Yes	No

25.1 What are the reasons?

……..

……

26. The conditions in the public health sector affects whether doctors decide to stay and practise in the country.

Strongly agree	Agree	Undecided	Disagree	Strongly disagree

26.1 How?

……

……

27. How should the institution of medicine be altered to become a more female-friendly environment, or more balance friendly environment - as male doctors are also increasingly demanding more quality of life, and a better balance between work and life?

……

……

28. What would your recommendations be on the retention of women doctors in the SA medical profession?

……

……

ATTRITION OF FEMALE DOCTORS FROM THE SOUTH AFRICAN MEDICAL PROFESSION AND PRACTICE: DRAFT INTERVIEW SCHEDULE: SAMPLE 3

Introduction: My research investigates the reasons for attrition of SA female doctors. I specifically want to try and make explicit the gender specific institutional- and societal factors influencing the levels of attrition of female medical practitioners from the SA medical profession. As a secondary objective, I will also examine the changes in the profession and education of medical practitioners in South Africa, focusing on how this has possibly shaped attrition in the profession. So I will be asking some general questions aimed at eliciting responses around the education and training of medical practitioners, while the more specific questions will relate to your experiences and views around attrition of female medical practitioners from the SA medical profession and practice.

I have three goals:

1. Describe the attrition trends of women doctors in the SA medical profession, between 1996 and 2005.

2. Establish and explain reasons underlying attrition trends of female doctors in the SA medical profession between 1996 and 2005

3. Provide recommendations on retention of women doctors registered in the category independent practice (GP) in the SA medical profession.

The aim of the interview schedule is to achieve the last two goals by obtaining information to answer the qualitative research question:

- Which institutional factors (organisational culture, glass ceiling, sexual harassment) and/or societal factors (childcare, division of labour, gender identity) have influenced the attrition of women doctors from SA medical practice between 1996 and 2005?

S3 will provide us with information on, and experiences of, lecturers in medicine, to obtain their insights into the institutional factors influencing attrition.

Personal

1. Are you married?	
Yes	No

1.1 If yes, how has this influenced your experience of the medical profession?
………
………

2. Do you have children?	
Yes	No

2.1 If yes, how has this influenced your experience of the medical profession?
………
………

3. Have many of your colleagues opted for part-time work, rather than full-time employment? And specialisations? (Explain that this does not refer to a permanent or contract position)	
Yes	No

3.1 Why do you think they have gone this route?
………
………

4. Medicine was my first vocational option?				
Strongly agree	Agree	Undecided	Disagree	Strongly disagree

5. What is your area of specialization?
………
………

5.1 What influenced your decision to go into this area?
………
………

6. There are many negative factors about a career as a medical doctor. Why do you think so many young people still want to be medical doctors? Prompt: Altruistic motivation, or financial motivation for wealth. (Clarify the term altruistic).
………
………

7. I had appropriate role models in the medical profession.

Strongly agree	Agree	Undecided	Disagree	Strongly disagree

7.1 Explain who and why?

………

………

8. There were areas in my training and education that I found more difficult in comparison to other modules.

Strongly agree	Agree	Undecided	Disagree	Strongly disagree

8.1 Which ones, and why?

………

………

9. There is a high proportion of women medical students at UCT. This is a national and international trend. This is good for the profession.

Strongly agree	Agree	Undecided	Disagree	Strongly disagree

9.1 Explain

………

………

10. In terms of medical student performance, our figures show that whites still form the majority of graduations. This was my own personal experience as well.

Strongly agree	Agree	Undecided	Disagree	Strongly disagree

10.1 Your ideas on why?

………

………

11. What steps do you take to help students who are not achieving?

………

………

12. Your perspective on the shift to PHC model and Problem-based teaching? The expertise and quality of the type of graduate coming from this type of teaching is…..

Excellent	Above average	Average	Below average	Extremely poor

12.1 Why?

………..

………..

13. The medical education landscape changed significantly since the years when I studied.				
Strongly agree	Agree	Undecided	Disagree	Strongly disagree
14. In lieu of the impact of HIV/AIDS, doctors should be trained differently.				
Strongly agree	Agree	Undecided	Disagree	Strongly disagree
14.1 How?				

Institutional

15. According to your view, what contributes to attrition in the medical profession in general, and in SA specifically?				
16. Female doctor's advancement is affected by her location in the institutional power structure.				
Strongly agree	Agree	Undecided	Disagree	Strongly disagree
17. According to some theorists, workplace structures present 'uncomfortable' working environments for women.				
Strongly agree	Agree	Undecided	Disagree	Strongly disagree
17.1 This has been my experience at my organisation.				
Always	Very often	Sometimes	Rarely	Never
17.2 Explain				
18. The typically hierarchical structure of organisational cultures reinforces unequal power relations between men and women.				
Strongly agree	Agree	Undecided	Disagree	Strongly disagree
18.1 Why?				
19. What are your views on the following issues: Extra year of community service, Community service in rural areas, and long-hours on call especially for trainee doctors?				

……
……

19.1 These issues play a role in a doctor's decisions to stay in the profession.				
Strongly agree	Agree	Undecided	Disagree	Strongly disagree
20. The feminisation of the profession has affected patient care, health care systems, and the profession itself.				
Strongly agree	Agree	Undecided	Disagree	Strongly disagree
20.1 How? …… ……				

Societal

21. Societal factors influence the attrition of women doctors generally, and from SA medical practice specifically.				
Strongly agree	Agree	Undecided	Disagree	Strongly disagree
21.1 How and why? …… ……				
22. The race of a female doctor impacts on her experience of the institutional culture.				
Strongly agree	Agree	Undecided	Disagree	Strongly disagree
22.1 How? …… ……				
23. Female doctor's advancement and attrition is affected by traditional perceptions of women's roles in society.				
Strongly agree	Agree	Undecided	Disagree	Strongly disagree
23. My plans regarding family life been altered by the organisational culture I find myself in.				
Strongly agree	Agree	Undecided	Disagree	Strongly disagree
23.1 How? ……				

....
24. I felt life dropping out at a stage of my education (internship/ community service)?

Strongly agree	Agree	Undecided	Disagree	Strongly disagree

24. 1 What made you want to drop out, and why did you decide to continue?
....
....
....
25. What do you think the implications would be if you decided to move from public to private practice?
....
....

Retention of women doctors in the SA medical profession

26. Are there any of the individuals in your class that you know have emigrated?

Yes	No

26.1 What are the reasons?
....
....
27. The conditions in the public health sector affects whether doctors decide to stay and practise in the country.

Strongly agree	Agree	Undecided	Disagree	Strongly disagree

27.1 How?
....
....
28. How should the institution of medicine be altered to become a more female-friendly environment, or more balance friendly environment - as male doctors are also increasingly demanding more quality of life, and a better balance between work and life?
....
....

29. What would your recommendations be on the retention of women doctors in the SA medical profession?

……….

………..

APPENDIX 5

CODEBOOK

Mar_influence_how				
	Label	Value	Count	Percent
		How has your marital status influenced your experience of the medical profession?		
Valid	1	Positively	5	19%
Values	2	Negatively	4	15%
	3	Has not influenced	11	41%
Missing	-1	Not applicable	6	22%
Values	0	No answer	1	4%

Note: Not applicable refers to unmarried respondents (thus this question did not apply to them).

Chil_influence				
	Label	Value	Count	Percent
		How has this influenced your experience of the medical profession?		
Valid	1	Positively	4	15%
Values	2	Negatively	11	41%
	3	Neutral	3	11%
Missing Values	-1	Not applicable	9	33%

Note: Not applicable refers to respondents that did not have children at the time (thus this question did not apply to them)

Why_doctor				
	Label	Value	Count	Percent
		Why do you think so many young people still want to be medical doctors?		
Valid	1	Altruistic motivation	4	15%
Values	2	Financial motivation	1	4%
	3	Scholastic achievement/status	5	19%
	4	All of the above*	12	44%
	9	I don't know	5	19%

Note: *All of the above indicates when asked why they think so many young people still want to become medical doctors, these respondents indicated all three motivations (altruistic, financial and scholastic/status associated) as equally important reasons.

Rolemodel_who				
		Value	Count	Percent
	Label	Explain who		
Valid	1	Female general practitioner	2	7%
Values	2	Female specialist	3	11%
	3	Male general practitioner	6	22%
	4	Male specialist	1	4%
	5	Male and female general practitioners	1	4%
	6	Male and female specialists	2	7%
Missing Values	-1	Not applicable	12	44%

Note: Not applicable refers to respondents that stated that they had no role models in the profession.

Rolemodel_why				
		Value	Count	Percent
	Label	Explain why		
Valid	1	Skilful & inspiring women	4	15%
Values	2	Skilful and inspiring men	6	22%
	3	Skilful and inspiring person	4	15%
	4	Managed to combine a family and career	1	4%
Missing Values	-1	Not applicable	12	44%

Note: Not applicable refers to respondents that stated that they had no role models in the profession.

Diffmodules_what				
		Value	Count	Percent
	Label	Which ones?		
Valid	1	Anatomy	2	7%
Values	2	Psychiatry	1	4%
	3	Clinical and practical aspects	5	19%
	4	Theoretical aspects	6	22%
	5	Gynaecology	2	7%
	6	Pathology	1	4%
	7	Paediatrics	1	4%
	8	Surgery	4	15%
Missing Values	-1	Not applicable	5	19%

Note: Not applicable refers to respondents that stated that they did not find any areas in their training and education difficult.

Diffmodules_why

		Value	Count	Percent
	Label	Why?		
Valid	1	This specialty does not suit my personality	2	7%
Values	2	In this specialty you do not feel like you can cure people	1	4%
	3	This specialty too invasive	1	4%
	4	Not logical	2	7%
	5	Difficult & stressful	6	22%
	6	Not enjoyable	3	11%
	7	Too emotive	1	4%
	8	Did not enjoy the surgical side	6	22%
Missing Values	-1	Not applicable	5	19%

Note: Not applicable refers to respondents that stated that they did not find any areas in their training and education difficult.

Feminisation_explain

		Value	Count	Percent
	Label	Explain why you feel this way		
Values	1	Mainly positive implications for the profession	12	44%
	2	Mainly negative implications for the profession	4	15%
	3	Both positive and negative implications for the profession	11	41%

Whitemajority_why

		Value	Count	Percent
	Label	Why do you think this is the case?		
Valid	1	Majority of class was white	18	67%
Values	2	More acclimatised to academia and more support	6	22%
	3	Due to transformation, white students have to be excellent candidates	1	4%
Missing Values	0	No answer	2	7%

Note: The missing 2 values indicate respondents that could not elaborate on why they think that whites still form the majority of medical school graduations.

HIVAIDS_why

		Value	Count	Percent
	Label	Why?		
Valid	1	General principles still apply regardless of status	5	19%
Values	2	Already sufficiently incorporated in curriculum	7	26%
	3	Not sufficiently incorporated into the curriculum	6	22%
	4	Not adequately taught to deal with emotional side	4	15%
Missing Values	0	No answer	5	19%

Note: Missing values indicate 5 respondents that could not elaborate on why they thought doctors should be trained differently to deal with the impact of HIV/AIDS.

Attrition				
		Value	Count	Percent
	Label	What contributes to attrition in the medical profession in general, and in SA?		
Valid Values	1	Political uncertainty and crime	4	15%
	2	More opportunities abroad	2	7%
	3	Poor working conditions and lack of support in public sector	14	52%
	4	No career path in public sector	1	4%
	5	Having children & needing more time	3	11%
	6	Difficult profession	1	4%
	9	I don't know	2	7%

Organ_powerstruc_explain				
		Value	Count	Percent
	Label	Explain		
Valid Values	1	No separate change rooms/theatre gear for female doctors	3	11%
	2	Treatment by other health care or associated professions or patients	6	22%
	3	Men still dominate high ranks in medicine	1	4%
	5	Working conditions and lack of resources in public sector	4	15%
	6	Difficulty to juggle both life and work	3	11%
	7	Inflexibility for women with children	1	4%
	9	All of the above	1	4%
Missing Values	-1	Not applicable	8	30%

Note: *All of the above indicates when a respondent indicated all of the reasons as equally important.

Reinforce_why				
		Value	Count	Percent
	Label	Why do you think this is the case?		
Valid Values	1	Difficult to specialise/advance if you want to have babies, male still ideal worker	3	11%
	2	Tokenism to create illusion of equality	1	4%
	3	Men still dominate the high ranks of medicine	7	26%
	4	Definitely in certain male dominated specialisms	1	4%
	5	Still a very masculine environment & incompatible structure for women	4	15%
	6	Male still seen as preferable and better employee	1	4%
Missing Values	0	No answer	10	37%

Views_commservice				
		Value	Count	Percent
	Label	What are your views on the extra year of community service?		
Valid	1	Primarily negative	12	44%
Values	2	Primarily positive	6	22%
	3	Both positive and negative	9	33%

Views_commservicerural				
		Value	Count	Percent
	Label	What are your views on community service in rural areas?		
Valid Values	1	Primarily negative	8	30%
	2	Primarily positive	6	22%
	3	Both positive and negative	13	48%

Views_longcallhours				
		Value	Count	Percent
	Label	What are your views on long hours on call especially for trainee doctors		
Valid Values	1	Primarily negative	21	78%
	2	Primarily positive	1	4%
	3	Both positive and negative	5	19%

Feminisation_how				
		Value	Count	Percent
	Label	How has it done so?		
Valid Values	1	Mainly positively	11	41%
	2	Both positively and negatively	7	26%
	3	No effect	5	19%
	9	Don't know	4	15%

Soc_attrition_how				
		Value	Count	Percent
	Label	How?		
Valid Values	1	Role of women as prescribed by culture, religion and other systems of patriarchy	14	52%
	2	Primarily child care responsibilities	6	22%
	3	All the above*	1	4%
Missing Values	0	No answer	6	22%

Note: *All of the above indicates when a respondent indicated both reasons as equally important.

Race_impact_how				
		Value	Count	Percent
	Label	How does it do so?		
Valid Values	1	In private practice impacts on type of patient pool and ease of transition	2	7%
	2	Interaction with nursing staff	2	7%
	3	Because you're in the minority	6	22%
	4	Depends on the institution	1	4%
	5	Because of affirmative action	2	7%
	6	Perception of patients	3	11%
	7	Impacts the culture you belong to, thus associated gender roles	2	7%
Missing	-1	Not applicable	2	7%
Values	0	No answer	7	26%

Note: Not applicable refers to unmarried respondents that indicated that they do not feel race has an impact on their experience of the profession.

Family_how				
		Value	Count	Percent
	Label	How?		
Valid Values	1	Impacts amount of children as well as timing	6	22%
	2	I never wanted children	1	4%
	3	Have not been able to focus on anything else except my career	3	11%
	4	Negatively impacts on career prospects	2	7%
	5	It has not impacted	6	22%
	6	Has negatively impacted on quality of family life	6	22%
	7	As soon as I had a family did not want to expose myself to diseases as readily	1	4%
Missing Values	0	No answer	2	7%

Dropping_out_what				
		Value	Count	Percent
	Label	What made you want to drop out?		
Valid Values	1	Long hours on call	2	7%
	2	Theoretical aspect of undergrad years	2	7%
	3	Difficulty of studies	2	7%
	4	Stress	1	4%
	5	Felt discouraged	1	4%
	6	Strict selection procedures before specialising	1	4%
	7	Lack of quality of life, conditions in public service	4	15%
	8	When my child was born	4	15%
	9	Exposure to disease	1	4%
Missing Values	-1	Not applicable	9	33%

Note: Not applicable refers to respondents that never wanted to drop out of the profession.

Continue_why					
			Value	Count	Percent
Valid Values	Label		Why did you decide to continue?		
	1		Adversities were trivial	2	7%
	2		Enjoyed the clinical aspects of postgrad	2	7%
	3		I don't know	2	7%
	4		got easier after undergrad	1	4%
	5		I dropped out for a while, or entered another career	11	41%
Missing Values	-1		Not applicable	9	33%

Note: Not applicable refers to respondents that never wanted to drop out of the profession.

Private_Public					
			Value	Count	Percent
Valid Values	Label		What do you think the implications would be if you decided to move from public to private and vice versa?		
	1		Mainly financial & flexibility in terms of time	7	26%
	2		Politics in the public sector	1	4%
	3		Impossible for me to move	3	11%
	4		Isolation & constraints from funder industry in private sector	5	19%
Missing Values	-1		Not applicable	11	41%

Note: Not applicable refers to respondents that are not practicing at the moment.

Immigration_reasons					
			Value	Count	Percent
Valid Values	Label		What are the reasons?		
	1		Mostly pull factors	4	15%
	2		Mostly push factors	9	33%
	3		Both push and pull factors	12	44%
Missing Values	0		No answer	2	7%

Public_how					
			Value	Count	Percent
Valid Values	Label		How		
	1		Hierarchy, working conditions, staff shortages in public service	11	41%
	2		Lack of flexibility for women with children	3	11%
	3		All of the above*	2	7%
Missing Values	-1		Not applicable	1	4%
	0		No answer	10	37%

Note: Not applicable refers to 1 respondent that did not feel that conditions in the public sector affects whether a doctor wants to stay in the profession. *All of the above indicates when a respondent indicated both factors as equally important.

Institution_medicine				
		Value	Count	Percent
	Label	How should the institution of medicine be altered to become a more balance friendly environment?		
Valid Values	1	Better salaries and resources in public service	2	7%
	2	Standardising of practices and education	2	7%
	3	Flexibility of working hours	10	37%
	4	Providing more personnel	2	7%
	5	More part-time opportunities	3	11%
	6	I don't know	1	4%
	7	Adequate political leadership and evidence-based approach	1	4%
	8	All of the above	6	22%

Note: *All of the above indicates when a respondent indicated all mentioned factors as equally important.

Retention				
		Value	Count	Percent
	Label	What would your recommendations be for the retention of women doctors in the SA medical profession		
Valid Values	1	More flexibility in public service (maternity leave, job sharing, part-time, child-care)	12	44%
	2	More 5/8s posts	4	15%
	3	Opportunities for part-time specialisation	6	22%
	4	Better opportunities for career advancement	1	4%
	5	Change in attitude toward female doctors	1	4%
	6	Providing better working conditions (security, working environ)	3	11%