



Women doctors in medical professional organisations in South Africa — a report by the Women in Medicine Workgroup

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Objectives. To determine the level of representation of women doctors in medical professional organisations in South Africa historically and currently, and if not adequate, to ascertain the reasons for women's limited participation in medico-political activities.

Design. A descriptive study of the membership of South African medical professional organisations and their executive structures.

Outcome measures. The number and percentages of women doctors as members and at executive level in medical

professional organisations compared with the number of registered women practitioners.

Results and conclusions. Women are inadequately represented at all levels in the great majority of organisations for which information was provided. In view of the rapidly increasing number of women doctors the profession and its professional bodies need to take active steps to promote the participation of women in these organisations.

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Women currently comprise at least half of all medical students at health sciences faculties in South Africa. Data supplied by the South African Medical Association (SAMA) indicate that in 2000, 47.1% of interns and 44.3% of community service doctors were women. According to data obtained from the Medical and Dental Professional Board of the Health Professions Council of South Africa (HPCSA), women constituted 26.0% of registered doctors in this country in 2001 (7 841 out of a total of 30 149). This compares with 17% in 1983¹ and 20% in 1994. Only 28.3% of registrars and 21% of specialists were women (23% of specialists in hospital practice and 12.4% of those in private practice). By 2020, 50% of the medical workforce will probably be female.

Although the percentage of female medical students and doctors in practice is steadily increasing, women are inadequately represented in the upper hierarchies of medical professional organisations in South Africa. Internationally, the literature indicates that male hegemony in the medical profession continues to determine the patriarchal culture of medicine, impacting on the way in which medicine is taught and practised. Some commentators consider that this situation is detrimental to medical students, doctors and patients and is unlikely to change unless women doctors achieve greater representation in medical academic hierarchies and in professional decision-making bodies.^{2,4}

We considered it necessary to analyse the past and present status of women at the executive level of the policy and decision-making organisations in medicine in South Africa to

quantify and then document a baseline so that change can be measured and evaluated. This study forms part of a multistaged project that is identifying the major structural, attitudinal and behavioural obstacles to optimal utilisation of women doctors in South Africa. It aims to raise awareness of the existence and causes of such problems among policy makers and other stakeholders and to recommend remedial action.

A survey of South African medical professional organisations was undertaken to determine the gender composition of the organisations and their governing bodies and to determine if women are proportionately represented. Where they are not, the survey aimed to ascertain the reasons for women's inadequate representation.

Results

Historical situation

The response to the request for historical information was generally disappointing. Many of the South African Medical Association (SAMA) branches and affiliates did not respond or indicated that they did not have the resources to access their archival material. The responses from doctors who had been members of the National Medical and Dental Association and other progressive groups were not adequate for reporting or analysis. The Academy of General Practice did not respond to repeated requests. The HPCSA, the Colleges of Medicine of South Africa (CMSA) and the head office of SAMA provided comprehensive information.

The Health Professions Council of South Africa (HPCSA)

The HPCSA, successor to the South African Medical and Dental Council (SAMDC) and the Interim Medical and Dental

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Council (IMDC), reported that several women, representing various health disciplines, had been members of the SAMDC since its inception in 1929. However, only 4 women doctors have served on the SAMDC and its successors since 1929.

The current Council consists of 52 members, 27 of whom are medically qualified. Only 2 of these doctors are women, although there are 10 other female members of Council representing other disciplines. The representation of women doctors as a percentage of medically qualified individuals on Council is therefore 7.4%, whereas 23.8% of registered medical practitioners were women in 1999 when the Council took office.

The new structures of the HPCSA include a Medical and Dental Professional Board consisting of 39 members, 30 of whom are medically qualified. There are 2 women doctors on the Board, forming a 6.7% minority on the body that plays a major role in determining professional policy affecting all medical students and practitioners.

Medical Association of South Africa (MASA)/South African Medical Association (SAMA)

The first South African Medical Association was established in Cape Town in 1883. In 1888 MASA was established in Griqualand West as a Branch of the British Medical Association (BMA) and became completely independent in 1945.⁵ It was renamed the South African Medical Association (SAMA) in 1998 after a lengthy process of unification with the progressive groups which had dissociated themselves from MASA during the apartheid years, particularly following the death in detention of Mr Steve Biko in 1977.

For many years the governing body of MASA was the Federal Council, consisting of 100 members. According to the records provided, no woman served on the Council until 1978, 90 years after the first South African branch of the BMA was founded. One woman was elected in 1978 and served a 2-year term. The next female member of Federal Council was a branch councillor from the Griqualand West branch who served from 1992 to 1998, followed by the female chairperson of the Junior Doctors Association of South Africa (JUDASA) who became a member of Council by virtue of her office in 1994. Between 1992 and 2001, 11 women served on Council as representatives of the Senior Hospital Doctors Association of South Africa (SEHDASA), the Registrars Association of the Medical Faculties of South Africa (RAMFSA), as branch councillors or as President of the Association.

During the 1990s, the governing structures of MASA were changed to make provision for a Board of Trustees or Directors (20 members) with powers to act as the executive body of Federal Council. Seven of the women councillors served on the Board between 1994 and 2001 because of the various offices they held.

The new management structures of SAMA, since unification

in 1998, differ from those of its predecessor MASA.

Representation of women at governance level has not improved, however, and it appears that 'transformation' has not addressed gender equity. In 2001/2002 the National Council consisted of 150 members, including 7 women (4.7%). The Board (26 members) included 2 women (7.7%). Since 1999, for the first time, a woman has served as Chair of one of the senior standing SAMA committees, the Committee for Full Time Practice.

Many of the women served on the Board and Council in their capacity as chairpersons or representatives of SEHDASA, RAMFSA and JUDASA. Only 1 woman has been elected as President of MASA/SAMA (in 1996/97), and no woman has served as Chairperson of the Council and the Board, the most powerful position in the Association. The largest number of women served as members of the Board and the Council in 1996/97, viz. 4 (20%) and 7 (7%) respectively, but even that low level of representivity has not been maintained.

In recent years women have been elected Presidents of SAMA Branches with increasing frequency, but otherwise do not appear to have become significantly more active in the SAMA hierarchy than before. Exceptions are the groups representing full-time public service doctors, i.e. JUDASA, RAMFSA (now the South African Registrars Association (SARA)) and SEHDASA. Details of women who served on committees, affiliated groups and branch councils for which historical information was provided, are available from the authors.

Colleges of Medicine of South Africa

The College was established in 1958. From 1958 to 1998 only 3 women were members of the Council of the College. One woman served from 1979 to 1989 and was President from 1983 to 1986. Two others were members of Council from 1995 to 1998, during which period the total membership of the Council was 40 (5%). The College was restructured in 1998 and the most senior body is now the Senate, consisting of 37 members of whom 2 are women (5.4%). Only 2 women were elected as chairpersons of Faculty Committees between 1958 and 1998. Five other women were Secretaries of Faculty Committees during those years.

When the structure of the CMSA changed in 1998 the Faculties became Colleges, and a Council, headed by a President, now governs each College. The current terms of office commenced in 1998 and run until 2002. Three of the 24 Colleges currently have female Presidents and four Colleges have female Secretaries of their Councils.

The number of women members of Faculty Committees increased slowly from 2/104 (1.9%) in 1958 to 13/206 (6.3%) from 1992 to 1995. At present (1998 - 2002), 22/228 (9.6%) of the Colleges' Councillors are women, which falls far short of the percentage of registered female specialists (21%).



Current situation

The current status of women, in the organisations whose data are presented in the previous section, has been included with the historical information.

Responses to a request for information were received from 25/35 SAMA-affiliated organisations (71.4%) during 2001. Several of the respondents did not provide all the information requested.

Analysis of the incomplete data indicates that women are generally inadequately represented in the professional organisations, both as ordinary members and as members of the governing bodies. This applies particularly to the surgical specialties. Only $\pm 11\%$ of governing body members are women, compared with $\pm 26\%$ of female registered practitioners. Only 3 of the 25 responding organisations have female chairpersons and on average women comprise slightly less than $\pm 15\%$ of membership.

Reasons for inadequate representation of women

Each organisation was also asked to suggest reasons for the insignificant role women generally play in medical professional organisations. There were relatively few responses to this request. Comments received stressed that women are seldom nominated or volunteer for office and have little time to spare for executive involvement with the professional bodies. In this regard, it is worth noting Pringle's comment, 'while loss of medical time (by women), through balancing family commitments, is counteracted by the time that men take out for "medical politics"'.² Some male respondents felt that women were not as aggressive as men, did not seek power and were alienated by the political in-fighting that occupied a significant percentage of time at meetings. Another suggested that influential individuals, male or female, would always be prominent but that such individuals were more likely to be men.

Discussion

Only a limited number of organisations provided the total number of members of their executive committees, their total membership and the number of women members. Consequently it is not possible to calculate accurately the percentage representation of women in each organisation or on the executive bodies. Despite these inadequacies it is apparent that women are not proportionately represented and some important issues are highlighted by the information provided.

The hiatus years

The first woman to hold office in any of the organisations that provided historical information was Dr Jane Waterston who was elected president of the Western Cape branch of the BMA

in 1905. It was not until 1971 that another woman achieved similar status and a further 12 years elapsed before a woman was elected to MASA's Federal Council in 1978. During the period from 1952 to the 1980s, many women doctors apparently directed their medico-political energy to the South African Society of Medical Women (SASMW), through which they lobbied with some success for the elimination of blatant discrimination. Women doctors, with rare exceptions, do not appear to have played a role in other professional organisations before or during that period. The SASMW is now virtually defunct and it has not been possible to determine why interest and enthusiasm have diminished to such an extent.⁶ In contrast, medical women's organisations elsewhere in the world are active and thriving. Indeed, in the USA, it has been reported that women are increasingly and disproportionately prominent as activists and leaders in physicians' labour unions.⁷

Tokenism

Since the early 1990s, senior women in the profession have mainly received recognition via election to the figurehead position of President of MASA/SAMA branches. These positions enjoy much prestige but the powerful individuals in the branches are the chairpersons, positions occupied exclusively by men. In the other two most important professional bodies (the CMSA and the SAMDC/HPCSA) only 2 women have reached positions of real power in the entire history of both organisations and they both rightly belong in the 'superwoman' category.

Superwomen and networking

It is noteworthy that a few women have made a real impact in medical politics and their names recur frequently in the records of various organisations. Their pre-eminence may be a factor of personality, superhuman energy, ambition, a consuming desire to serve the profession, powerful and encouraging mentors, relative freedom from domestic commitments and supportive families.⁸ The replies from respondents to this survey do not clarify this. However, the comments regarding the importance of selecting influential people for leadership positions are significant. It is recognised that women generally do not network effectively — a prerequisite for achieving influence. Research indicates that meetings of professional associations are an important means of meeting colleagues and maintaining relationships. Women doctors' inadequate participation in professional associations is therefore a double-edged sword — opportunities for establishing networks are missed, and women exclude themselves from the networks established by their male colleagues. Endowing women with networking skills at an early stage in their careers may be one of the mechanisms for increasing their participation in professional bodies — and vice versa.⁹ Superwomen are generally influential and have well-developed networking skills.



More power to younger women

The other exceptions to the general rule occur in the more recently established groups, JUDASA, RAMFSA/SARA and SEHDASA, which have elected several women chairpersons during their relatively short history. This is encouraging and may portend well for the future. It is possible, however, that younger women doctors have time and energy to spare for medical politics before their domestic and career commitments become too demanding. Later in their lives they may find it more difficult to participate in such activities. Anecdotally, many women doctors find it difficult to attend meetings of professional organisations after hours and cannot find time to get involved in medical politics in addition to work and family commitments. It has also been reported that women are generally not as attracted by the exercise of power as are men.¹⁰ This may apply more specifically to older women.

Male hegemony versus the feminisation of medicine

The increasing number of women in medicine necessitates a radical revision of the traditional conventions and assumptions about medical training and practice, patriarchal culture, gender inequality and male hegemony. Pringle refers to the 'realities of male medical power' and provides examples of the detrimental effects of male-dominated decision making on women doctors' careers.²

There is increasing reference in the literature to the 'feminisation of medicine'.^{2,3} This refers not only to the increasing number of women in the profession but to gender-determined division of labour, differentiation in modes of practice and the impact this will have on all aspects of medical training, practice and research. Research indicates that women doctors usually have a different approach to their patients. They tend to be more caring, empathetic, spend more time assessing lifestyle, are less directive and communicate better than men. Women doctors are more likely to use collaborative models of patient-doctor relationships and to facilitate partnerships and patient participation in decision-making than their male colleagues. It is suggested that these factors are critical to the establishment of satisfactory doctor-patient relationships and have a beneficial effect on the outcome of the interaction between patients and the health care system.^{2,4,11} This has been particularly significant in the field of women's health.^{2,4,12}

These are important characteristics that complement patients' increasing resistance to medical paternalism and their insistence on greater participation in decision-making about their health care. The culture of the medical profession as a whole will not, however, adapt rapidly to these societal needs while male patriarchy persists within the academic sphere and in the medical political arena.^{13,14} Pringle believes, however, that

'Women doctors are now claiming the right, like their male colleagues, to shape the field. In so far as they have a collective vision it necessarily involves the dismantling of current hierarchies and the movement towards a more tolerant, egalitarian and flexible profession.'²

Possible strategies to improve representation of women

Kazimirski reports that the Canadian Medical Association (CMA) has established a database of medical women, which will provide an invaluable tool for recruiting women for various medico-political and other positions. The CMA has also initiated leadership workshops for medical women that serve multiple purposes of networking, mentoring, training in medical politics, assertiveness, balancing career and family and participation in professional organisations.¹⁵ The American Medical Association and the Association of American Medical Colleges have initiated a variety of programmes, newsletters and publications that aim to improve women's leadership potential in American medicine as a whole.^{12,16} Many organisations, in several countries, have established women's structures within the main parent body (not as separate medical women's groups) that are responsible for implementing these programmes. These and other helpful guidelines are available and should be studied and implemented, as appropriate, by SAMA and other medical professional organisations. Commitment to increasing the number of women in the power structures is essential. This will ensure that the profession and the society it serves benefit from the advantageous changes that could be effected by greater participation of women doctors in the upper hierarchies of medical politics.^{2,4,16,17}

Conclusion

The composition of the medical professional organisations in this country is predominantly and disproportionately male, as are their governing bodies. Establishing a factual baseline so that future changes and progress towards achieving greater gender equity can be measured is a necessary step forward. This research attempts to meet that need. Further research should attempt to ascertain scientifically the reasons for women's inadequate representation in the power hierarchies of the profession and how this can be corrected. It is essential that serious efforts be made to enable and encourage women to play a more significant role in determining the policies, culture and practice of the profession. It is clear from initiatives in other countries that remedial steps are necessary, and can be identified and implemented successfully. The South African medical profession and its professional organisations should commit themselves to a dynamic programme of action in this regard.



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Congenital eunuchism and Favorinus

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Ancient Hebrew literature as well as the New Testament differentiate between castrated eunuchs and congenital eunuchs. Congenital eunuchism is very rare today, and assuming that this was also the case in classical times, we investigated possible reasons why congenital eunuchs feature prominently. We discuss the probability that the concept 'congenital eunuchism' might in ancient times have included effeminate men who, according to cultural views on 'maleness' and androgyny, were almost equated with eunuchs. The causes of congenital hypogonadism are

reviewed in order to attempt clarification of the condition of Favorinus, a congenital eunuch in the second century AD. We suggest that although he might have been a true hermaphrodite, as suggested by some authors, it is more likely that he had one of the following conditions: functional prepubertal castrate syndrome, testicular gonadotrophin insensitivity, selective gonadotrophin deficiency or Reifenstein's syndrome.

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In ancient Hebrew the word for eunuch was *saris*, and a distinction was made between *saris adam* (eunuch castrated by man) and *saris hamma* (congenital eunuch).¹ In the Bible the evangelist Matthew also distinguishes between kinds of eunuchs: 'For some are eunuchs because they were born that way; others were made that way by men; and others have

renounced marriage because of the Kingdom of Heaven' (Matthew 19:12).² The third category obviously refers to celibacy rather than eunuchism, but this passage again distinguishes between acquired and congenital eunuchism. While eunuchism resulting from castration is a well-researched field, the subject of congenital eunuchism remains vague. In an excellent overview, Levinson³ shows that apart from medical considerations, ancient rabbinical views on androgyny (hermaphroditism) and the essence of 'maleness' might well have influenced views on the nature of eunuchism. However, in the figure of Favorinus of Arles we have a person from the second century AD described by his contemporaries as a

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