The experience of Black medical specialists in training at two medical schools in the Western Cape

By

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DECLARATION

By submitting this thesis electronically, 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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ABSTRACT

Medical education has seen the increase of previously marginalised groups (Black, female, disabled) in undergraduate training. However, this shift is not as noticeable at postgraduate level. This has led to a number of calls for the transformation of medical education. Recent student protests in South Africa have illuminated issues of access and citizenship in higher education and have led to urgent calls for decolonised curricula and the transformation of higher education institutions. There are contestations regarding what transformation really is, with arguments suggesting that while policies exist, there is a huge gap between policy and practice. In order to realise the efforts of transformation, it is important to understand the lived experiences of students in South Africa. This study looks at the experiences of medical specialists in training (registrars) at Stellenbosch University (SU) and the University of Cape Town (UCT). The concept of race trouble was used to conceptualise the racialised experience of registrars in relation to their training and the extent to which they felt a sense of belonging. The dissertation also theoretically explores Black subjectivity in post-apartheid South Africa by looking at how the persistence of coloniality in historically advantaged institutions presents itself, and shapes the experience of higher education. The intersection of race, class and gender is also briefly discussed in this body of work; however the main focus is on race and the experience thereof within medical training. Due to recent conversations about the pace at which historically advantaged institutions are transforming and what this really means, I set out to explore the day-to-day experiences of medical specialists in training at SU and UCT. A qualitative research design was employed. A total of 19 semi-structured, individual interviews were conducted with 11 registrars from both SU and UCT. Initial themes from the interview data were presented to a group of registrars in a form of a focus group for the purpose of respondent validation. Thematic analysis was used to code and analyse the data. This was done in efforts to find patterns and themes for interpretation.

Registrars mostly spoke about their undergraduate experiences, but also reflected on their current training. Results highlighted the complexity on the road to medical specialisation. The core finding related to the level at which registrars felt they had access to supportive structures. As such, one of the most salient themes in the data is the sense of registrars not feeling at home at these institutions, and they highlighted a need for more support and mentorship structures. The data show that there is still a need to discuss what deep transformation in higher education can look like in the future.

Keywords: Black Medical Registrars, Race Trouble, Transformation, Higher Education, Institutional Racism, Medical Education, South Africa

OPSOMMING

Voorheen benadeelde grope (swart, vroulik, gestremd) betree toenemend mediese opleiding op voorgraadse vlak. Hierdie skuif is egter minder sigbaar op nagraadse vlak, wat op sy beurt, die transformasie van mediese opleiding vertraag. Die onlangse Suid-Afrikaanse studenteproteste het kwessies rakende toeganklikheid en burgerskap in hoër onderwys aan die lig gebring en, op sy beurt, aanleiding gegee tot ‘n drigende beroep vir die dekolonisering van kurrikulum en die transformasie van hoër onderwys instellings. Die ware betekenis van transformasie is debateerbaar en argumente hou voor dat, alhoewel beleide in die verband wel bestaan, daar steeds ‘n groot gaping tussen beleid en praktyk is. Dit is dus belangrik om die belewenisse van Suid-Afrikaanse studente te begryp binne konteks van transformasie In hierdie studie word die belewenisse van mediese opleidingsspesialiste (registrateurs) aan die Universiteit van Stellenbosch (SU) en die Universiteit van Kaapstad (UK) ondersoek. Die rasverwante opleidingsbelewenisse van die registrateurs asook hulle gevoel van behoort is deur middel van die rasse-probleme “race trouble” konsep gekonseptualiseer. Die verhandeling ondersoek ook, op ‘n teoretiese wyse, swart subjektiwiteit in post-Apartheid Suid-Afrika. Dit sluit ‘n ondersoek na die voorkoms van volgehoue kolonialiteit binne histories bevoordeelde instellings in, asook die wyses waarop laasgenoemde die belewenisse van hoër onderwys beïnvloed. Hoewel die kruising van ras, klas en gender ook kortliks in hierdie werk bespreek word, bly ras en die belewenis hiervan binne mediese opleiding die oorhoofse fokus van hierdie werk. As gevolg van die onlangse gesprekke rakende die pas waarteen histories bevoordeelde instellings transformeer en die dieper betekenis hieraan verbonde, is die daaglikse belewenisse van mediese opleidingsspesialiste aan US en UK begin ondersoek. ‘n Kwalitatiewe navorsingsontwerp is gevolg. Negentien individuele, semi-gestruktureerde onderhoude is gevoer met elf registrateurs van beide US en UK. Die aanvanklike temas is in fokusgroep formaat vir ‘n groep registrateurs aangebied. Dit het dus

ook gedien as respondente validering. Data is volgens die tematiese data-analise metode gekodeer en ge-analiseer. Hierdie metode het patrone en temas vir interpretasie aan die lig gebring. Registrateurs het grotendeels hul voorgaadse ondervinge bespreek, maar hulle het ook op hul huidige opleiding gereflekteer. Bevindinge het die komplekse opgang na mediese spesialisering na vore gebring. Die kern bevinding behels die mate waarin registrateurs toegang tot ondersteuningsnetwerke ervaar het. Een van die mees opvallendste temas wat voortgespruit het uit die data is dat die registrateurs nie tuis voel binne hierdie instellings nie. Hulle het ook die behoefte aan verhoogde ondersteuning en mentorskapsstruktuur uitgewys. Die data dui op die behoefte aan voortgesette gesprekke rakende die wyse waarop ware transformasie in hoër onderwys in die toekoms daarna kan uitsien.

Sleutelwoorde*:* swart mediese registrateurs, rasse-probleme “race trouble”, transformasie, hoër onderwys, institusionele rassisme, mediese opleiding, Suid-Afrika

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LIST OF ABBREVIATIONS

BEE – Black Economic Empowerment

BC – Black Consciousness

CSI – Community, Self and Identity

DBE – Department of Basic Education

DHET – Department of Higher Education and Training

DOE – Department of Education

EP – Extended Programme

FHS – Faculty of Health Sciences

HAIs – Historically Advantaged Institutions

HDIs – Historically Disadvantaged Institutions

HE – Higher Education

HEIs – Higher Education Institutions

HPCSA – Health Professions Council South Africa

IRC – Internal Reconciliation Commission

IRTC – Institutional Reconciliation and Transformation Commission

MBChB – Bachelor of Medicine

MMed – Master of Medicine

NP – National Party

SA – South Africa

SASO – South African Students' Organisation

SARs – South African Registrars

SNRs – Supernumerary Registrars

SNA – Social Network Analysis

SU – Stellenbosch University

TA – Thematic Analysis

TRC – Truth and Reconciliation Commission

UFS – University of Free-State

UK – United Kingdom

UKZN – University of KwaZulu-Natal

UOFS – University of Orange Free-State

UP – University of Pretoria

USA – United States of America

UWC – University of Western Cape

WITS – University of Witwatersrand

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CHAPTER ONE: INTRODUCTION AND OVERVIEW

By way of introduction

How it all started

In August 2015 I decided to move back to Cape Town after having completed my community service year[1] as a clinical psychologist. I had expressed an interest in doing my PhD to my Masters supervisor whom I consider a mentor now. I decided to join a research project that a group of Black[2] medical specialists who formed an organisation called Harambee, were doing. Compared with White South African medical doctors, fewer Black doctors in South Africa undergo specialist training, and it appears that relatively few of those pass their examinations, resulting in too few Black consultants (Thackwell, Swartz, Chiliza, Dlamini, & Phahladira, 2017).

Drawing from their own experiences of training, Harambee members started wondering if race was a factor leading to this imbalance. The Harambee team developed a study to explore issues of race in a specialist training of medical doctors, and I was to do some of the qualitative work for the study for my doctoral degree. I energetically focused my attention on formulating a proposal. First the proposal had to be submitted to the departmental panel for an internal review before it went to the faculty's Higher Degrees and Research Committee. I walked into the room where the esteemed panel of academics (both from my home department, psychology, and from the education and health sciences faculties) sat ready to give feedback on whether the study was doable and if it qualified as a doctoral project. I was met with a lot of scepticism. Many people questioned the relevance of the study, arguing that because the universities were changing, the topic was likely to be of little

[1] A department of health initiative that mandates that certain health professionals, including clinical psychologists, complete a year of community service in underserviced areas after completing their internships.

[2] The term "Black" in this study is used to describe Black, African, South African individuals instead of speaking broadly about people of colour (Indian, Coloured otherwise known as mixed race) in South Africa. This is discussed in more detail in chapters to follow – please see the terminology section in this chapter and the theoretical discussion in Chapter Three.

interest and obsolete within a very short period. I had also chosen at the time to use Steve Biko's Black Consciousness (BC) writings[3] to ground my research theoretically, which was not very popular. The conversation quickly became tense, and my co-supervisor directed a question to one of the panellists, "Are you suggesting that there is no such thing as structural racism at Stellenbosch University?" In retrospect, I do not think that it was the intention of the person to whom my co-supervisor was talking to suggest that there is no structural racism at my university. But something was being enacted in the interaction. Upon reflection, I cannot help but think that the very questioning of the research, its relevance, substance, and novelty (although I am appreciative of the teaching moments) was problematic in itself. Walking into a room where only a minority of the congregation of academics wanted to acknowledge that there was a problem at South African universities was intimidating. I wondered if I would be able to actually do my research or would have to err on the side of caution and choose something less political. After much debate, it was suggested that I effect changes such as explaining more clearly my theoretical orientation and that it would have to go for review again. The proposal was accepted and my journey started. I remember feeling anxious because I was worried about the study's importance due to the review discussions and because others, such as Serote (2011), had done similar studies already.

A change in political climate

In chapters that follow I will provide more information on the contemporary context concerning race in higher education in South Africa. It is important to mention here that during the course of my study, but after the proposal was accepted, higher education in South Africa was convulsed with calls for radical change. The Rhodes Must Fall (#RhodesMustFall) protest in March 2015 called for the removal of a statue of Cecil Rhodes

[3] Biko was a medical student and South African anti-apartheid activist and one of the forerunners of the Black Consciousness movement in South Africa. The Black Consciousness movement was one that focused on restoring Black people's sense of pride.

at the University of Cape Town (IRTC, 2018, p. 12). Students country-wide called for decolonisation and this raised important questions about coloniality within higher education, all issues I discuss in more detail in the next chapter. Students also started demanding more in terms of transformation in higher education (Chikane, 2018). The Fees Must Fall (#FeesMustFall) movement followed from the Rhodes Must Fall protest and it was more widespread and long-lasting (Chikane, 2018). Fees Must Fall, which came to be known as #FMF on social media, is described by Chikane (2018, p. 145) as: "the HE system engaging in open warfare between students, academics, workers, university management and the state through the police force". This warfare was regarding a free education for all, calling into question the extent to which higher education is accessible. All of a sudden, there was something forcing the academy to stop and consider the subjective experience of students and issues that impede on their success (van der Westhuizen, 2018, p. 339):

> Access and success remain highly determined by race, gender, class and location. The incongruities clustering around axes of difference mean that the HE system continues to haemorrhage particularly Black, poor students, who are lost due to prematurely dropping out, or not advancing through the system.

I felt vindicated in knowing that there was still, and there always has been, something to be said, an opportunity for the academy to rethink ideologically what transformation can mean (van der Westhuizen, 2018). Van der Westhuizen's (2018) argument touches on the very thinking that drove this research, issues that keep the Black student, and in this case medical student, at a disadvantage. Paul (2019) reflects that even a science such as medicine is not immune to being shaped by the socio-political context, which raises questions regarding the experience of training under such turbulent times in higher education.

1.1 What to expect

This work has been deeply personal for me, and for many reasons. These range from why I decided to do a PhD (I discuss this in Chapter Four), to my identifying with some of the registrars' experiences as a health professional myself, and as a young Black consumer of the higher education system. This made for a very emotional journey, and I could not imagine taking the personal out of it, so in keeping with contemporary developments in social theories which I shall explain in later chapters, I decided to use my own subjectivity as part of the research process. This is why I have chosen to use an active voice, and I have added a personal narrative as a chapter as well. The first purpose of this is to state that I have an emotional investment in the study and acknowledge that my own subjectivity can influence the data. The second is to call up the politics of voice in terms of what is considered scholarly and what counts as knowledge. The study looks at the state of higher education in South Africa with a focus on the experience of registrars in the Western Cape. It also attempts to look at some of the subjective experiences of Black people in post-apartheid South Africa and how these are mirrored within higher education.

1.2 Key terminology

1.2.1 Apartheid

In Afrikaans, a South African language politically (though not accurately) known as the language of the oppressive apartheid government, *apartheid* refers to "apartness" (Clark & Worger, 2013, p. 3). This was the name the National Party (NP) government used to describe its segregationist policy – one of hierarchically organising and separating races along racial lines. The period of apartheid in South Africa was between the years 1948 to 1994.

1.2.2. Black or black or African?

In efforts towards transformation, the Employment Equity Act section 55 of 1998 defines three designated groups for preferential treatment for employment, namely "blacks", women, and persons with disability (Department of Labour, 2018; Posel, 2001). This act is one of the examples of how racial categories (the very ones that were spawned from apartheid and colonial racialisation) are kept alive through transformation efforts (Alexander, 2013; Posel, 2001). During apartheid racial categories were used to determine privilege, and in post-apartheid South Africa these categories are still used to assess the key transformation question of redress (Posel, 2001, p. 56). The convention of using "black" as it is in the Employment Equity Act will not be followed exactly in this study. Posel (2001) also highlights that the Act does not clearly define "black", but it is assumed to be an all-encompassing term to include "Coloureds[4] and Indians[5]". However, in this study the term "Black" (with a capital "B") is used to only include those historically known as "Bantu" (see Chapter Three) and "black" (with a lower case "b") is used to refer to Black[6], Coloured and Indian together. This distinction is made because of the fact that during apartheid Coloureds and Indians were, as Serote bitingly put it, deemed more "agreeable" than Black South Africans, which means that their experience would be qualitatively different (Serote, 2011, p. 5). By this Serote is referring to an informal "racial hierarchy" in South Africa with Whites at the top of the hierarchy, followed by Indians, Coloureds, and finally Black South Africans at the bottom of the hierarchy. In choosing to focus in this study on Black Africans, I am aware that I am placing myself in something of a contradictory position. Black

[4] A racial category for a diverse group of people, some of whom identify as mixed-race; others are of various origins such as Indonesian (In South Africa, the term "Malay" is sometimes used, inaccurately for this group). Some people currently known as "Coloured" identify as San or Khoisan, arguing that they are the true First Nations people of South Africa, predating the migration of both Black and White people to this country (Posel, 2001).

[5] In South African usage, both formal and informal, the term "Indian" refers to South Africans who are in the main descended from low-paid workers brought to this country to work largely in what at the time was Natal province, currently known as KwaZulu-Natal.

[6] Some authors would use the term "Black African" for this group, also known as "Bantu" for many years during apartheid.

consciousness in South Africa (which I discuss below) emphasises solidarity amongst all previously disenfranschised South Africans, and views the distinctions on the basis of race as "illusory". I am sympathetic to this view. My study however was conducted in the Western Cape, a province in which "coloured" people are in the majority and in which Afrikaans, which is the most common language spoken by "coloured" people, is the most commonly spoken language. Historically, furthermore, the Western Cape had a "coloured labour preference policy" (Johnson, 2017) which positioned coloured South Africans differently from other disenfranchised groups, especially in the Western Cape.

1.2.3 Black consciousness

Black consciousness (BC) emerged in South Africa in the late 1960s (Macqueen, 2018, p. 149). Gail Gerhardt, an American professor, described the rise of BC in South Africa as *"Black power"*[7], which was highly contested by BC activists as it assumed that the American ideology was applied without thought to South African events (Macqueen, 2018, p. 750). The apartheid government's initial reaction to the movement was that of feeling justified in their segregationist ideologies, until they saw that BC was more than just essentialising the Black experience, but rather a stand against oppressive apartheid, and indeed, South Africa's colonial structures (Mangcu, 2013). Central to this emergence was political activist and medical student, Steve Biko. Biko argued that black people needed to challenge internalised notions of inferiority to realise their worth (Clark & Worger, 2013; Mangcu, 2017).

[7] Gerhart, G. M. (1979) *Black power in South Africa: the evolution of an ideology.* London: University of California Press

1.2.4 Citizenship

Farred (2012) challenges the idea of assuming that representation necessarily leads to citizenship. His work focused on questions of national identity, but his arguments are also useful for discussion on the contemporary discourses on citizenship in relation to teaching and learning, especially in South Africa. He goes further to question how representation works and what the conditions of citizenship are. He wonders, "Must blackness be overcome? Transcended? Incorporated?" (p. 1047) in order for black people to be counted as citizens. The term citizenship in this study is not used to describe "nationhood" but rather a sense of accountability from people that occupy a political space. It includes the awareness of and respect for all people within an environment and working towards ensuring that everyone feels a sense of contributing to and benefiting from being part of a community (Leibowitz, 2012). The sociopolitical history of an institution also has an impact on students developing a sense of belonging and identity within higher education. Issues of access, the legacies of historically advantaged institutions (HAIs), and power structures thereof influence the extent to which HEIs can foster the development of citizenship (Leibowitz et al., 2012, p. 6).

1.2.5 Transformation

The concept of transformation, as I use it in this dissertation, refers to moving to a more equitable post-apartheid South Africa. This means that discriminatory structures that served to privilege certain groups must be dismantled and rebuilt (Pattman & Carolissen, 2018, p. 1). In higher education, transformation involves the implementation of various policies in order to redress past inequalities. South Africa no longer has "racially designated universities" as in during the apartheid era (Pattman & Carolissen, 2018, p. 1). Despite institutions now being known as historically advantaged/disadvantaged institutions

(HAIs/HDIs), the informal use of the constructs “formerly White” or “formerly black” institutions points to how these spaces were shaped by the apartheid ideology and will therefore have an impact on how students experience those spaces (Pattman & Carolissen, 2018, p.1). Transformation is not complete but an ongoing process.

1.2.6 Registrar training

Registrars, known as residents in the United States, are qualified doctors receiving advanced training in a specialist field of medicine (Bagwandeen & Singaram, 2018). This training often takes four to six years and is usually completed at an academic hospital (Thackwell, 2014). The training involves formal lectures, practical clinical experience and research, and success in this training also depends on feedback from consultants (medical specialists working in the hospital system) (Bagwandeen & Singaram, 2018; Thackwell, 2014).

The first purpose of the study is to highlight that part of the barriers we see in healthcare provision are due to a lack of representation in terms of the workforce. This is due to the low number of doctors successfully completing medical and specialist training relative to the demographic need in the South African population. This then raises questions as to why we do not have such representation, which brings us to the second purpose. This is to look at the training environment and understand what the conditions that shape the experience of medical trainees are.

1.3 Chapter outline

1.3.1 Chapter two: The literature review

This chapter outlines the history of education in South Africa, and the legacy of education under colonialism and apartheid is discussed in this section. There is also a brief

mention of how White superiority and black inferiority were constructed. Higher education under apartheid is then discussed, highlighting how limited access for Black individuals was. Medical education during apartheid is discussed and the University of Natal Medical School's importance is mentioned. I also discuss higher education in post-apartheid South Africa with a specific mention to medical education and the experience of specialist training. Some related themes are also mentioned in this section where I discuss issues relating to participation parity, citizenship and access. I also discuss the culture of medicine here as it gives us a sense of the training environment that the registrars need to function in.

1.3.2 Chapter three: Theoretical orientation

In this chapter I discuss, on a theoretical level, issues relating to transformation in higher education. Some like Makhubela (2016) have argued that perhaps the problem with some narratives around transformation and decolonisation is an epistemological one, which may impede the efforts of deep transformation. Scholars like Teeger (2018) suggest that we need to approach transformation by thinking beyond desegregation. Therefore, in this section I discuss coloniality and decoloniality as a way of setting the scene for the ways in which inequality is reproduced in the higher education space (Teeger, 2018). Firstly, I try to deal with race as a construct. I use the word "try" deliberately here as attempting to define anything relating to race is quite contentious. I then move on to discussing racialisation and formal racial categorisation that occurred during apartheid. I then engage in a theoretical discussion looking at critical race theory (CRT), CRT in education and CRT in medical education. I also thought it appropriate to discuss intersectionality as it is one of the key tenets of CRT. Colour-blindness on the race front is also mentioned in this section, and how it is seen to promote social cohesion. However, I also highlight how this can actually lead to some injustices persisting (Collins, 2015; Pattman & Carolissen, 2018; Warikoo & Novais,

2014). I then explore racial microaggressions and how these create a troubling tension between individuals, which sets the tone for the following discussion on race trouble. The term race trouble that was formulated by Durrheim and colleagues (2011) is discussed. This is further unpacked by theoretically discussing Black trouble, self-stigmatisation, and racial stereotypes and women. The chapter ends off by discussing how colonialism impacted on Black people's psyches. Here I look at Steve Biko's black consciousness and discuss how we can attempt to understanding Black South African subjectivity.

1.3.3 Chapter four: Research design and methods

In this chapter I describe in some detail the research process. I outline the research design, the two methods used (individual interviews and focus groups) and why. I give some demographic information to show how many registrars participated, how many were women and the number of interviews conducted with each. I was limited in terms of how much detail I could provide in terms of demographic characteristics. This is due to the sample being from across specialties and some specialties having very few Black registrars, so there was a risk of them being identified. I also discuss the process of data analysis. Thematic analysis with a psychosocial lens was used to analyse the data and generate themes. The section concludes with ethical considerations.

1.3.4 Chapter five: Situated knowledge and practice

In 2016 I visited Oslo University and attended a doctoral summer school for two weeks. In the second week I attended a critical psychology course presented by Professor Ian Parker. It took on an unconventional course as he read a personal narrative on his journey through psychology. The course required that we do the same, and the article *Feeling some typ'a way: a young Black woman's journey through education* came to life. I had intended for

it to only be a reflexive piece for this dissertation; however it was subsequently published in the South African Journal of Higher Education. Therefore, there may be some repetition in that chapter as it is included its published form. In this section I offer a personal narrative, and again position myself within the research. The chapter outlines my journey through education and then through psychology. I discuss my experience of my clinical masters training and insecurities I felt at the time. I discuss and problematise issues of diversity and how I experienced and continue to experience my Blackness.

1.3.5 Chapter six: Results

In this section I present the interview data in the form of themes that emerged from the analysis. No interpretation is introduced at this point, but rather a presentation of the data as is. Only the themes that served to answer the research question were included.

1.3.6 Chapter seven: Discussion

In this section I present a discussion of the themes drawing on literature and theory in order to answer the research questions. The first focus is a discussion on the experience of registrars and highlighting what they decided to speak about. The second focus is one that engages with transformation in medical education as well as in higher education in general.

1.3.7 Chapter eight: Conclusions, Limitations and Recommendations

In this section I offer a concluding discussion, outline the potential limitations of the study and make recommendations for future studies.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

South Africa's colonial and more recently apartheid history has resulted in substantial healthcare gaps. In South Africa's constitution, access to healthcare on an equitable basis has been emphasised; however, racial division and discrimination form part of many of the structural inequalities affecting both healthcare access, and training of health professionals (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009; Wildschut & Gouws, 2013). South Africa has always been a diverse country. In societies that are rapidly becoming more multicultural, healthcare systems are increasingly dealing with patients from a variety of ethnic backgrounds (Seeleman, Suurmond, & Stronks, 2009). One of the strategies that has been identified to address difficulties experienced by minority groups in the United States of America, for example, has been to increase diversity in postgraduate medical trainees (Mensah & Sommers, 2016). Regarding the issue of diversity, the health workforce in South Africa has received substantial attention only relatively recently (Serote, 2011; Thackwell, 2014).

South Africa has nine medical schools which offer specialist training programmes. While it is evident that gender and racial diversity has improved in undergraduate admissions to medical schools since the end of apartheid, there is less evidence of an increased gender and racial diversity amongst medical specialists (Karim, 2004; London, Kalula, & Xaba, 2009; Wildschut, 2011). In order to attain greater diversity in higher education, it is important to acknowledge and cater for diverse values, cultural beliefs, racial, ethnic and gender backgrounds, sexual orientations and experiences (Thackwell, 2014). It is also important to be mindful of how racial issues are perpetuated daily in South Africa, and the impact that apartheid had, and continues to have, on the country. Presented in this section is a description of South Africa's colonial and segregationist history. Issues of racism (although not explicitly

discussed here) come to the fore as this is an important theme. However, this is dealt with in more detail in the next chapter. By way of background, I now provide a very brief history of education in South Africa insofar as it is relevant to this study.

2.2 A brief history of education in South Africa

2.2.1 Colonial education

Discussing colonial education in the British Empire, Hall (2008, p. 774) notes:

> Colonists and colonial policy had to think about the creation of new subjects – colonial subjects – who would consent to be ruled. Education was key to that process. [Blacks], Indians and other indigenous populations had to be encouraged to be different kinds of people – people who would labour.

This education included literacy, numeracy and industrial skills (R. Swartz, 2018, p. 369). The movement toward the "civilisation" (or what some would term the domestication) of black people was not only linked to the global imperial enterprise, but was also influenced by how government perceived black people (R. Swartz, 2018, p. 369). R. Swartz (2015) argues that education played a significant role in the construction and the perpetuation of racial difference in the mid-nineteenth century. Debates about the education of black people included questions of the relationship between the settlers and black people; if the education provided would create a much needed labour force in the colony; and whether black people would be equal to the White settlers once they were "civilised" (R. Swartz, 2015, p. 4).

R. Swartz (2018) argues that the relationship between education and civilisation was complicated; ideas about the civilisation of Black people quickly fused with notions of black people's innate inferiority (p. 371). Policies about the education of black people were

influenced by local colonial politics, and the convenient construction of black races being better suited for labour (p. 371).

At first, the move to educate was designed in large part to socialise the indigenous people in order for them to operate within the settler society. Then there were questions regarding "the meaning of race in relation to educability" (R. Swartz, 2018, p. 369). This gave birth to ideas of intellectual capacity being inherently linked to race (R. Swartz, 2015, p. 5), with White people being viewed as inherently more intelligent than black people. As a consequence, it was then suggested that education be tailored to cater for the capabilities of different races. By the 1850s, race as a construct had come to be viewed as biological, and therefore racial differences as innate. This resulted in restricted opportunities for black people. Education was thus central in the construction of racial division and in racist ideas about fitness to learn.

2.2.2 The education policies under apartheid

The inception and the implementation of many apartheid laws happened between the years 1948 and 1980. Racism and discrimination impacted all areas of people's lives, and aspects of previous informal segregation, which were common to many colonial societies, began to be legislated and systematised on an unprecedented scale. Racial oppression was legitimated by "experts" who colluded with racism during apartheid, with the idea of innate racial difference providing an important ideological underpinning for legitimating racist policies (Hook, 2004; Soudien, 2006). Education was one of the ways in which the new social order of apartheid was reinforced. Education in South Africa was developed under the principle of segregation and was organised along racial lines (Mekoa, 2011; Netswara & Mathabe, 2006; Nkoane, 2006).

Shortly after the National Party (NP) came into power in 1948, the Commission on Native Education, or the Eiselen Commission, as it was known, was put in place in 1949. The ruling party at the time was determined to limit the aspirations of Black[8] people and to obliterate any hope of equality and integration (Ilora, 2006; Soudien, 2006). The Eiselen Commission argued that Black people had distinct characteristics and that education for Black people should be separate. Education for Black people had to be modified in order to prepare them effectively for labour at low skill levels. The most significant recommendation by the commission was that of the establishment of Bantu Education (Ilora, 2006). The Bantu Education Act motivated for the separation of Black learners and students from other races. They argued that Black people had developed a false sense of their destiny through the adoption of western cultural practices, and that their future must be securely situated within their own environment (Ilora, 2006; Soudien, 2006). The Bantu Education Act established in law the principle to deny Black children the same educational opportunities as those afforded to White children and with time, during apartheid, the gap and differences in the provision of education grew wider (Heaton, Amoateng, &Durfur, 2014). The schooling system became one of the ways in which the philosophy of apartheid was constructed and passed through generations. Education for Black children served to prepare them for low-wage labour, and schools that catered for them were overcrowded and lacked resources. It also ensured that White children were protected from competing with children of other races, thus preserving White superiority (Heaton et al., 2014; Durrheim, Mtose, & Brown, 2011).

[8] The Eiselen Commission and others which followed focussed chiefly on the majority "race" group in South Africa – what they called "Bantu", and what, as I have discussed in the previous chapter, I call "Black". In all the legislation, however there was consideration of "Coloured" and "Indian" people as constituting separate "races" or what in apartheid terminology came to be known as "population groups". The general pattern for all educational provisioning was that Whites received the highest level of investment and Blacks the least, with Indians and Coloureds obtaining far less than Whites but far more than Blacks.

2.2.3 Higher education institutions under apartheid

In 1953 the Holloway Commission was put in place to assess the feasibility and the financial implications of the establishment of separate universities for blacks (Badat, 2002). The commission argued against the idea on financial grounds (Badat, 2009; Ilora, 2006). Holloway suggested that separation of the races could be possible by admitting Black and Indian undergraduate students at the University of Fort Hare and University of Natal where classes were separate anyway. The commission further suggested that Black, Coloured and Indian postgraduates were to be admitted at universities willing to take them (Badat, 2009). However, the apartheid government proceeded with the policy to segregate university students, and the development of higher education institutions (HEIs) in South Africa occurred along racial lines (Badat, 2009; Ilora, 2006; Nkoane, 2006). The Extension of University Education Act of 1959 served to segregate HEIs and gave complete power over black institutions to the apartheid government. Black students were denied admission into White universities; special permission from the government was needed in order for access to be granted and only where comparable courses were not available at black institutions (Davies, 1996). Black[9] students had to attend universities in the bantustans. Bantustans were developed as part of the National Party's strategy to preserve the purity of the White race. Black people were to be forcibly relocated to rural reserves that were then converted into "independent states" or bantustans (Davies, 1996). The 1959 Promotion of Bantu Self-government Act established these bantustans where Black people would nominally govern themselves, but actually remain under the control of the National Party (Christie & Collins, 1982). The timing of the establishment of the black universities and the establishment of the bantustans was not accidental, as Badat (2009, p. 53) argues:

[9] As with other legislation, this applied to Coloureds and Indians as well (please see previous footnote) but for ease of presentation I use the word "Black" in what follows in this section, except where the administrative distinctions are clearly made between Black, Coloured and Indian students.

> The intention was to restrict the economic advancement, social mobility and political rights of [Blacks] to the bantustans and it was there that the products of the [Black] universities were expected to exercise their talents.

Far fewer resources were granted for Black institutions than for White institutions. According to Nkoane (2006), the philosophy of the apartheid government constructed the cultural positions and realities of all HEI in South Africa, including White institutions. The Afrikaans-medium institutions created a space for racist thought to take place; Black institutions were containers of powerlessness and forced servitude; while English-medium institutions would often, and perhaps according to what benefited them politically, oscillate between servitude and rebellion (Nkoane, 2006).

Davies (1996) raises, and answers, the question of why the apartheid government would provide higher education for black people at all if they ultimately wanted to limit their aspirations, especially given the disagreements within the ruling National Party, where most members were opposed to university training for Black people. Prime Minister Verwoed argued that there was a need to develop a *"loyal university-trained Black bureaucracy"* for the credibility of the bantustans (Davies, 1996, p. 322). Ultimately, Black universities operated under the supervision of the state, and the state determined who would sit on their governing bodies, what the academic standard would be, and the state controlled the curriculum (Davies, 1996).

2.3 Early training of doctors in South Africa

Since the establishment of the colonies, healthcare and medical education provisions were influenced by the state's philosophy on segregation, and hence on oppressive policies. After the formation of the Union of South Africa in 1910, health services were racially

divided. Healthcare facilities and services available for Black people, especially, were often in a state of neglect (Ncayiyana & Seedat, 2014; Noble, 2009).

The University of Cape Town (UCT) has the oldest medical school in Southern Africa, with its faculty of medicine being established in 1912 (Müller & Crawford-Browne, 2013). Subsequently, medical schools at the University of Witwatersrand (Wits), University of Pretoria (UP), Stellenbosch (SU), and the University of the Orange Free State (UOFS at the time, now the University of the Free-State, UFS) were established, the latter three being exclusively White, Afrikaans-medium schools. Black students were banned from studying at the medical schools in the country – in part – out of fear that the inclusion of Black students would lead to fraternisation and racial mixing (Digby, 2005). Due to colonial ideas of Black people's innate inferiority, disciplines like medicine were not thought of as fitting for Black students; however this seemed to also be related to a fear of competition with White students (Ncayiyana & Seedat, 2014; Digby, 2005). Later, both Wits and UCT admitted "a token number of black students" (Ncayiyana & Seedat, 2014, p. 272).

Prior to this, black South African students had to go abroad to study medicine, and this was funded primarily through the church. Thirty-two black doctors qualified between the years 1900 and 1940 in the United Kingdom and in the United States of America. Wits agreed to allow the admission of a small number of Black students, although under stringent conditions, in 1939. The first cohort of Black medical students was enrolled at Wits in 1941. After being placed under enormous pressure by prominent members of the Coloured community in Cape Town, UCT trained approximately ten Indian and Coloured medical students, while Black students continued to be excluded from admission (Digby, 2005). The number of black medical students was higher at Wits than at UCT (Digby, 2005).

In 1951 the Natal Medical School opened, and aimed to train approximately forty Black and Indian doctors annually. Like Wits, Natal Medical School was male dominated

with only one woman in every seven graduates by 1965 (Digby, 2005). Digby (2005) highlights that Dr. Bremer, who was the Minister of Health at the time, stressed that the purpose of this medical school was to prepare Black medical doctors to cater for their own people. This served to construct and maintain a racialised ideology of separation within the medical training system (Digby, 2005).

After a black medical training institution was successfully established in Natal, access into other medical schools was further restricted. This problem persisted until additional training was provided with the opening of the Medical University of South Africa (MEDUNSA) in 1978 (Digby, 2005; Mabokela, 2000). At UCT, Coloured and Indian medical trainees were not allowed to work on White cadavers, could not enter into White wards and were excluded from learning opportunities that involved a White patient – social restrictions were reflected through clinical restrictions. As impractical as these restrictions were, Indian and Coloured students still had to sign an agreement with these conditions to ensure that they could register each year (Digby, 2005; Perez, Ahmed, & London, 2012). This agreement outlined that these students understood that the institution could not promise inclusion in all clinical training opportunities, and that they agreed to excuse themselves from certain classes. This also made them partial agents of their own exclusion (Perez et al., 2012). In summary, there were a number of substantial obstacles faced by Black, Coloured and Indian medical trainees during apartheid South Africa (Noble, 2015).

2.4 The role of the Natal Medical School in establishing the Black Consciousness Movement in South Africa

The attempt by the ruling party during apartheid to limit and ultimately rid White medical schools of Black students resulted, on some level, in the coming together of students in the struggle against racial oppression (Noble, 2015). Some identified with student

organisations that expressed the need for unity across racial lines (Noble, 2015). One such organisation was the National Union of South African Students (NUSAS). NUSAS was established in 1924 as a representative organisation that initially focused exclusively on White student interests (South African History Online, 2011). In 1960, when there was growing sympathy for Black students, there was an in increase in Black student membership of NUSAS (South African History Online, 2011). Steve Biko – a medical student at the University of Natal Non-European section (UNNE) – problematised White liberals' involvement in the struggle for racial equality (Mangcu, 2017). He highlighted that some Black members of NUSAS became frustrated with the organisation's inability to address oppressive structures that plagued Black students. Mangcu (2017) highlights how Biko would enter into debates about how NUSAS had resources that they could use in aid of the struggle but seemingly did not.

This resulted in Black students breaking away from NUSAS, and Steve Biko visiting a number of campuses enlisting support for the formation of an exclusively black national student organisation, which led to the formation of the South African Students' Organisation (SASO) (Mangcu, 2017). The decision to branch off from NUSAS was also motivated by the emergence of "Black pride" (Noble, 2015, p, 14) driven by the black consciousness (BC) movement (South African History Online, 2011). As the first president of SASO, Steve Biko was central in founding the BC movement. The SASO and BC played an important role in South African politics during the 1960s and '70s. Black students protested against racial practices that they were subjected to as medical students and stressed that liberation was not something black people could gain from White people (Noble, 2006; South African History Online, 2011). Biko himself was murdered by the apartheid state in 1977 (Mangcu, 2017), and for the purposes of this study it is not irrelevant that one of the enduring icons of, and

martyrs to, the liberation struggle in South Africa, was a Black medical student at an apartheid-created segregated medical school.

Notwithstanding the role of the University of Natal Medical School in the history of black activism in South Africa, Noble (2015) also highlights that not all Black medical students were politically active, and if they were, the level of their involvement was not the same for all. This meant that consequences were not the same either. Medical training for many Black students meant that they had an opportunity to financially secure their future, and for some a political agenda took precedent. Regardless of what their priorities were, it is clear that considerable discomfort and humiliation came with medical training under the apartheid regime.

2.5 Higher education in post-apartheid South Africa

After the inception of democracy in 1994, redressing the provision of education and remedying past inequalities in South Africa became a core political imperative, and there was now a need for the higher education system to democratise and equalise access (Pattman & Carolissen, 2018; Wilson-Strydom, 2018). Higher education in South Africa is still at the time of writing going through rapid change (Allais, 2017; Jonker, 2016; Mpatlanyane, 2018). Part of this change has been the attempt to deracialise HEIs and to meet the national need for new possibilities for greater inclusion and equity. Heymann and Carolissen (2011, p. 1379) highlight that the Education White Paper 3 of 1997 states *"the transformation of HE will need increased access to HE for female, black, matured and disabled students."* The White Paper focuses on three important aims (Mekoa, 2006, p. 106):

I. To develop and harness people's talents and promote life-long learning. This would aid the contribution of individuals to a society of rapid socio-cultural and economic change.

II. To provide high skills training and the development of professionals that can compete on a global scale. These individuals would also be socially conscious of the role they would have to play in shaping social transformation in the country.

III. A dedication to research and innovation, as national growth and the capacity compete globally heavily relies on the ability to produce new knowledge and improve technology.

The Higher Education system faces multiple challenges, as illustrated by the recent student protests (Luvalo, 2019). Wilson-Strydom (2018, p. 33) discusses the National Higher Education Summit that was held in 2015, and highlights that the concept of transformation was defined as "profound and radical change" (DHET, 2015 as cited in Wilson-Strydom, 2018, p. 33). However, the crisis unfolding in higher education shows us that we have not even begun to understand what that means, and raises a question such as Luvalo's (2019, p. 184): "what is the relationship between transformation and institutional culture?" Luvalo (2019) highlights that institutional culture and transformation are often discussed separately and that the answer to his question likely lies between the overlap of the two.

2.5.1 The legacy of poor education

The transition between secondary and tertiary education is great. Students should be prepared for this significant shift. Students are required to cope with a number of new challenges socially, culturally and academically (Jonker, 2016), but some students face more challenges than others. Some difficulties are exacerbated by the legacy of apartheid and apartheid education. Black students and those from other disenfranchised groups tend to experience more difficulties adjusting to higher education (Firfirey & Carolissen, 2010), with

White students tending to perform better (Van Rooy & Coetzee-Van Rooy, 2015). Black students are more likely to come from homes which are poorer, where they are first generation tertiary education students, where the home languages are not the languages of instruction (Jonker, 2016), and where there is less likely to be a financial and physical environment conducive for studying. For these and other related reasons, more Black students appear to be underprepared for the demands that come with university compared to White students. The lack of preparation further alienates Black students from academic discourse, their lecturers and peers setting up a vicious cycle (Firfirey & Carolissen, 2010).

Nkambule (2014) discusses some of the challenges discussed above, and also reflects on her own experience. She, like other authors (Firfirey & Carolissen, 2010; Van Rooy & Coetzee-Van Rooy, 2015), highlights the need for adjustment that is experienced by Black students. She describes Black students as less prepared than others for the culture of teaching and learning in tertiary institutions; many Black students have been taught to rote learn but not to organise and analyse large amounts of information critically (Nkambule, 2014). In addition, there are financial and lifestyle demands to which students that come from previously disenfranchised groups may be especially vulnerable. She notes, however, that not all Black students experience difficulties and that those that do, do not all experience the same level of difficulty. Students from the rural areas may face particular adjustment challenges and may need additional attention. The failures of national education policy implementation are more pronounced in these areas (Nkambule, 2014); in addition, students from rural contexts may not be familiar with the diverse and demanding urban context of many tertiary institutions.

In addition to more practical issues of exclusion, it is important to take into account psychological issues of exclusion. Race-related humiliation dating back to the colonial history, and more recently apartheid, has been argued to have psychological effects on black

students (Perez et al., 2012). A number of authors (Perez et al., 2012; Serote, 2011; Thackwell, 2014) have discussed how perpetuating (structural) racism has affected and continues to affect medical trainees' experiences. These include notions of (in)competence whereby black students felt that they needed to work harder than White students in order to prove their competence, with the competence of White students more likely to be assumed. Prejudice against Black students, and their perceived lack of competence, though not necessarily conscious may be normalised even in contexts that claim to be fighting discrimination. The presence of ambivalent feelings experienced by some black students was also highlighted. This ambivalence relates in part to positive feelings associated with the opportunity to train for a prestigious degree like medicine, and the awareness that while they have this opportunity, opportunities were unequal, and they themselves seen as not equal to the task (Digby, 2005; Noble, 2006; Perez et al., 2012).

2.6 Transformation in higher education

The task of transforming a racially fragmented education system that was greatly divided into a coherent and equitable system is indeed a difficult and complex task. This created a challenge for the then Department of Education (DOE[10]) to formulate a plan (Meyer, 2007). Meyer (2007, p. 59) highlights that the DOE had four major branches of post-apartheid education that would tackle specific tasks: the Education and Training Systems branch's focus was on:

i the culture of learning;

ii the building of schools; and

iii special needs training.

The General and Further education branch would

iv mobilise the continued development and lifelong learning.

[10] In 2010 the DOE split into the Department of Higher Education and Training (DHET) and the Department of Basic education (DBE). In May 2019 the DHET was in turn merged with the Department of Science and Technology (Eyewitness News [EWN], 2019).

There was a focus on early childhood learning, adult education and language in education. The Human Resources and Administration branch would deal with management development, with a specific interest in gender equity in education. The Higher Education branch was to assist HEIs on their journey towards transformation, which also included a focus on teacher education. Conversations about equity and redress are important for transforming societies. Mpatlanyane (2018) highlights that after the advent of democracy, efforts were made to spread resources more evenly through the partnering of some HAIs and HDIs. This was to aid in the demographic transformation of HEIs to reflect the ideal post-apartheid university, and post-apartheid era that South Africa was moving toward. Leibowitz (2012) highlights that the journey of creating a new university culture that embraces diversity is a complex task, and part of that task is to make students aware of the socio-political spaces that they inhabit – over and above training them for public service (Mpatlanyane, 2018). This broad project includes an attempt to instil in individuals a sense of community, tolerance and other values that are important in the building of an equitable society (Thackwell, 2014). This goes beyond merely adding to students' knowledge base, but is rather an ongoing critical process of change that empowers people (Mpatlanyane, 2018). Transformation requires a process of rethinking existing traditions (of coloniality, for example) and assessing how they fit in our society today (Ratele, 2015, 2018). Similarly, Mpatlanyane (2018, p. 6) argues for the importance of critical theoretical work, in order that *"social interventionists can adequately understand, and thus find solutions for problems and complexities in a context"*. This critical theoretical work is about interrogating entrenched institutional traditions in order to move towards a new university (Ratele, 2018).

2.6.1 Higher education and public good

Bozalek and Leibowitz (2012, p. 63) suggest that social justice is an integral part of encouraging participation in HE. They discuss "participatory parity" – *"being able to interact as peers in an equitable way in social life"* – as the central goal of social justice. Three dimensions to participatory parity are discussed, which include: the distribution of resources, the politics of recognition and the politics of representation and belonging (Bozalek & Leibowitz, 2012). What is understood as the distribution of resources recalls what was discussed earlier when we were looking at the legacy of poor education. It refers to access to technology like computers and being able to manage the financial demands of university life. Recognition refers to the way in which individuals are considered in relation to their social markers, like race or gender or ability. Misrecognition, on the other hand, occurs when people are not afforded the same opportunities to participate or when there appears to be a *"lack of respect for individuals on the basis of their social markers"* (Bozalek & Leibowitz, 2012, p. 64). The authors also suggest that in line with social justice there is a need to move away from expecting individuals to conform to the dominant traditions. They argue that what is more important is to redress misrecognition, and focus on dealing with issues creating obstacles for parity of participation (Bozalek & Leibowitz, 2012). The political dimension focuses on issues of belonging, whose voices are heard, and whose needs are provided for. It also looks at who is considered as a full legitimate member of society (Bozalek & Leibowitz, 2012).

Bozalek & Leibowitz (2012) argue that when looking at social justice, these three dimensions cannot be separated. They also stress the importance of these dimensions in increasing the participation, and informing students and administrators within the educational context (Bozalek & Leibowitz, 2012, p. 64):

> This implies that while institutional arrangements to achieve participatory parity must take into account how aspects of the three dimensions influence the current phase of an individual's trajectory, they must also consider how individuals came to function as they do.

This implies that HEIs must cater, in a consistent manner, for those that function within them, while at the same time engaging with the outside world appropriately. The values that are instilled in and practised by students should mirror those of the administrators. Higher education in South Africa has the potential to make a meaningful contribution to society and globally through careful considerations of such transformative practices (Leibowitz, 2012).

2.6.2 Rethinking the South African university

Soudien (2012, p. 32) highlights the importance of rethinking how higher education or "the university" positions itself in terms of its mission and what role it plays in perpetuating issues of discrimination. He draws attention to how difficult the task is of teaching and producing individuals who are able to critically engage with the intersecting complexities that come with race, class and gender (Soudien, 2012). There has been a lot of discussion around higher education in South Africa that looks at issues of access, as touched on above. The issue of access is important especially when there continues to be a markedly lower number of black graduates as compared to their White counterparts. Soudien (2012) argues that it is for such reasons that structural discrimination complicates the picture of the South African society.

There are a number of questions that need to be addressed when discussing what HE looks like, and in order to mobilise change (Ratele, 2018). According to Soudien (2012) such questions include how higher education measures up to the task of creating an equitable

environment when the education system, due to the legacy of apartheid, has failed to prepare some learners for university. He argues that the academy often takes a noncommittal stance when it comes to engaging with the legacy of apartheid. On one hand it seeks to rid itself of its connection to apartheid but it also struggles to critically think of ways of moving from it (Luvalo, 2019; Ratele, 2015, 2018; Soudien, 2012). Through policy, higher education has been able to start detaching itself from its racist legacy, but has been unable to fully recreate or reimagine a new higher education system that prioritises and balances the need for access and quality training (Luvalo, 2019; Ratele, 2015; Soudien, 2012). Soudien (2012) asserts that apart from a handful of academic leaders, scholars and students, the academy as a whole has not responded adequately to issues of race and racism. Mangcu (2013) highlights that the power structure at most HEIs is composed mostly of White professors. It is these White professors who create and implement policies of racial redress in higher education. He argues that it may not be sound or ethical for issues of redress to be discussed and implemented by those who benefited from the racial divide.

2.6.3 Not just a numbers game

Understanding transformation in terms of increasing the number of black students has been a topic of much debate (Pattman & Carolissen, 2018). Strong rejection of conceptualising transformation by looking solely at the demographic profile of HEIs has been expressed, while others argue for the value of monitoring statistics (Pattman & Carolissen, 2018). Ratele (2015, p. 2) argues that:

> Instead of aiming to shift the ruling symbolic, structural and intergroup traditions within universities, certain notions of integration, whether on the basis of race, gender, class, sexuality or ability, assume transformation to be the assimilation of

> Blacks into an already established set of White patriarchal capitalist regime within universities.

He adds that we ought to work against assimilation, and proposes a new way of imagining the university (Ratele, 2018). Key to his argument, discussed later, is the idea of imagination. Soudien (2012, p. 42) also suggested something to this effect: *"The discourse it [the university] needs is a brand new one that re-imagines the university on terms that are self-critical and courageous"*. What both these scholars are suggesting is that we need to imagine what higher education will look like and what the possibilities are. If we imagine no change, then engaging with issues of policy development and implementation in relation to transformation would be wasted effort.

> Ratele (2012, p. 9) takes this argument further:
>
> Transformation as racial diversity or other forms of diversity is bad for the majority of those historically outside the gates of the university because, one comes to recognise, that the image of a minority of Black students in a largely white class taught by a white teacher in a white language for what it is: a poignant reminder of the failure of our struggles for the radical overhaul of education and society at large.

In the same way in which Biko argued against the integration of black people into White spaces – where there is *"an assimilation and acceptance of Blacks into an already established set of norms and codes of behaviour set up and maintained by Whites"* and ultimately perpetuating the power dynamic (Biko, 1978, p. 24), Ratele (2015) argues that this is a big mistake. He also acknowledges that representation is important, but that representation is not enough.

Put differently, higher education and medicine were White, male dominated territory during apartheid. So if, as Ratele (2015) argues, we do not dismantle some of these structures in order to give way for what Ratele (2015, p. 4) calls *"deep transformation"*, then we will find some institutional cultures and racial discourses being perpetuated across time (Thackwell, 2014). In Chapter Four, which follows, I shall explore this issue from my personal perspective as a Black student in historically White spaces. For the purposes of this introductory section of this dissertation, it is important to note that for many Black students, the possibility of even imagining what higher education might look like in 20 years' time seems like a stretch when the current landscape looks the way it does. Higher education mirrors what is happening in society at large, and therefore is embedded in the politics that we are trying to move away from. According to Ratele (2015, p. 4), the structure of higher education at present does not allow for what he terms "deep transformation". In his view, the current systems focusses on *"bringing the poor, blacks, women, queers, and disabled"* into the existing educational system, rather than thinking about what a redesigned, inclusive system would look like. The emphasis currently, Ratele suggests, is on fitting people who currently do not fit into existing spaces, rather than thinking about how the spaces need to change to be more inclusive. This recalls Biko's comment about how education systems at his time were complicit in rendering the Black a *"perpetual pupil (and a poor one at that)"* (Biko, 1978, p. 24).

2.6.4 Community/participatory citizenship

Individuals working within the health and the social services sector often have to work with people whose lives have been [and are] adversely affected by past and present inequalities (L. Swartz et al., 2009). According to L. Swartz et al. (2009), many students and trainees in these fields have lived most of their lives in a democratic South Africa, and when

the country was in the transitioning stage, they were very young. Therefore, they did not experience the past as their parents did. They do not carry with them the direct wounds of apartheid, but the effects of the past still form part of their reality (L. Swartz et al., 2009). Students may be direct beneficiaries of the many changes within higher education. Despite the great change and the efforts towards transformation, however, subtler forms of inequality and segregation persist, though they may be difficult to pinpoint and articulate (L. Swartz et al., 2009). This implies that the way in which individuals work and talk about their experience within a specific context may be influenced by such inequalities.

I shall now discuss an example of a project designed to address these issues of how students engage with ongoing subtle inequalities that exist in higher education. Some years ago, a collaborative learning module was developed across two universities in the Western Cape, the University of the Western Cape (UWC) and Stellenbosch University (SU). The objective was to encourage South African students from various backgrounds (race, gender, institution, class and language) to work together (L. Swartz et al., 2009). Nicholls and Rohleder (2012) highlight how the students were encouraged to critically engage with how concepts of Community, Self and Identity (CSI) relate to the South African context today. This required that the students reflect from their own experiences while engaging with literature within the fields of psychology, social work, and occupational therapy (L. Swartz, et al., 2009). L. Swartz et al. (2009) highlight the importance of producing professionals who are able to draw and learn from other disciplines; individuals who are curious and critical. They also add that this becomes particularly important for healthcare professionals. Another aim was to get students into a narrative about race and identity (Rohleder & L.Swartz, 2012).

Despite the two universities being situated in the Western Cape, they have different sociopolitical histories (Nicholls & Rohleder, 2012). Inherent in this are different positionings and assumptions. SU historically catered for White, privileged, Afrikaans-

speaking South Africans, while UWC historically catered for predominantly Coloured and some Black students, where most came from less privileged backgrounds (L. Swartz, et al., 2009). Nicholls and Rohleder (2012) question the possibility of reconstructing ideas of the past that are entrenched in people. As discussed by Ratele (2015) and Soudien (2012), they wonder about what needs to be put in place in order for that shift to occur. Earlier the idea of producing individuals that are both intellectually rigorous and reflexive was discussed, and the role that they play in society then comes to the fore. The Department of Education expressed the need for HEIs to foster a sense of community within students, while preparing them to be instrumental in transformative processes (L. Swartz et al., 2009).

This takes us back to imagination or hope, as Nicholls and Rohleder (2012) suggest. They argue that in order for participatory citizenship to occur and for critically aware individuals to be produced through higher education, we need some hope. They suggest we ought to hope that change is possible and that history will not repeat itself (Nicholls & Rohleder, 2012). This seems like such an idealistic task given the daily struggles of the majority of South Africans, especially because racial dynamics have now taken on a new face, class (Nicholls & Rohleder, 2012). Gobodo-Madikizela (2015) reflecting on President Nelson Mandela's hope, also suggests that a sense of community needs to be fostered in South Africans. She highlights that at the heart of what he envisioned was the possibility of people understanding themselves as connected to others through a sense of community. She also adds that this process requires continuous dialogue to reach a point of reconciliation. Although as a nation, South Africa bears the burden of the past – an "inconsolable mourning" as described by Nicholls and Rohleder (2012, p, 114) – there may be an opportunity to move away from old narratives and hoping for change through imagination. Studies like the CSI project offer that space within HEIs, where conversations can happen despite differences. As Nicholls and Rohleder (2012) assert, this may be part of what the university (HE) can start

looking at in terms of transformation.

2.7 Medical training in post-apartheid South Africa

South African medical schools face intense pressure to ensure that medical graduates reflect the national demographic profile. Since the end of apartheid, significant measures have been taken to help improve diversity in medical training and higher education in general (Essack, Wedekind, & Naidoo, 2012; Thackwell et al., 2016). In 2014, eight of the South African medical schools had a total of 9 293 undergraduate medical students. Of these, approximately 62.2% were female while 37.8% were male students (Van der Merwe et al., 2016). In that year Black students made up the biggest single group of the medical undergraduate student population across medical schools at approximately 38.7%, followed by White students at 33.0%, while Coloured and Indian students constituted 13.4% and 13.6% respectively (Van der Merwe et al., 2016). While Black students make up the biggest group of students, and students of colour making up the majority in total across medical schools, the number is still not representative in terms of the national population, where Black people make up 80% the South African population, and thus we still see healthcare disparities (Van der Merwe et al., 2016).

With the large numbers of applications received annually, medical schools need to use selection procedures; as there are always more applicants received than there are placements available (Van der Merwe et al., 2016). Selection procedures include both academic and non-academic indicators. Employing more than one selection strategy is an attempt to ensure that equity in access translates to equity in success (Essack et al., 2012). Due to differentiated experiences of secondary education (discussed above), some students may be advantaged or disadvantaged. This would show in how learners demonstrate their ability during their

matriculation examinations (the National Senior Certificate). This necessitates varied measures of selection.

The academic measures include the National Senior Certificate (NSC) awarded to matriculants (grade 12 learners) after completing their exit examinations in their compulsory subjects for medicine, as well as the National Benchmark Test (NBT) (Van der Merwe et al., 2016). The NBT is an additional set of tests that help determine cognitive ability to further help differentiate ability amongst learners and to determine those who are more or less likely to succeed (Van der Merwe et. al., 2016). During the selection process, the non-academic requirements for selection into medical training carry between 10–25% of the total weight (Van der Merwe et al., 2016).

Non-academic indicators may include the following, which are employed at UCT and SU (Van der Merwe et al., 2016, p. 79):

1. Extracurricular activities: leadership, sporting and cultural activities
2. Region of origin: UCT does not give additional points for region of origin but students from rural areas are given the opportunity for admission at lower cut off points than the general applicants. SU allocates an additional 4 points for students from rural areas.
3. Advantage based on parents being alumni or staff members: SU allocates 2 points for students whose parents are alumni or staff.
4. Index of disadvantage makes provision for Black and Coloured students to enter at lower levels: UCT uses disadvantage indices and SU does not as it is implicit in the selection process.
5. Biographical questionnaires, personal reports or interviews: some medical schools are working to and have implemented personal reports if students achieve high results in the NBT and NSC.

There currently is no standardised way in which these criteria are applied across medical schools. Each medical school uses its own combination of the selection criteria.

2.7.1 'Pink Collar' Medicine (Mudaly & Van Wyk, 2015)

The past two decades have seen a significant increase in female representation at medical schools and in the workforce (Mudaly & Van Wyk, 2015; Thackwell, 2014). The increase of women in the healthcare workforce, termed *"pink collar medicine"* (Mudaly & Van Wyk, 2015, p. 229), and in medical education, though a global phenomenon, occurred in South Africa partly as a result of post-apartheid efforts. Similar to conversations about racial inclusion, conversations about women in medicine have also highlighted issues related to the number of women we see at higher levels of the profession and in academic medicine (Mudaly & Van Wyk, 2015). Mudaly and Van Wyk (2015) argue that gendered occurrences of discrimination are a result of how different genders attach different values (for example, quality of life or work/life balance) to the practice of medicine (Mudaly & Van Wyk, 2015). This, they argue, is a key the reason why we have not seen real gender transformation in medicine or seen in high paying specialist positions or seen in leadership positions in academic medicine. Mirroring arguments about racial transformation in HE and medicine, Mudaly and Van Wyk (2015) argue that gender mainstreaming has not been successful because what has actually occurred has been the integration of women into an already establish masculine organisational structure. With the aid of the quota system, the focus has been on the technical aspects of transformation where emphasis has been placed on the increase in the number of females accessing medical training rather than on ensuring representation in medical organisations and in senior positions (Mudaly & Van Wyk, 2015). This may serve to perpetuate the patriarchal landscape of medicine. Mudaly and Van Wyk

(2015) suggest that while South African legislation has been moving forward by the inclusion of women in HEIs, female students still experience discrimination during their clinical training. In their study, there was a difference in the way in which patients interacted with male students as compared to female students. Male students were, reportedly, approached with more respect than female students (Mudaly & Van Wyk, 2015). The culture of medicine has been highly masculine; therefore women are met with gender stereotypes about their competence and/or fall victim to sexual harassment (Mudaly & Van Wyk, 2015). Although there has been a significantly higher representation of black and/or female students in undergraduate admissions and graduation since 1994, some literature shows that these graduates are less likely to progress to postgraduate level, and complete this level of training (London et al., 2009; Wildschut, 2011).

2.7.2. Toward feminisation of medicine: not yet *Uhuru*[11] (Ncayiyana, 2011)

Feminisation of a profession generally refers to the increasing number of women in a field that ultimately leads to them representing the majority in that field (Ncayiyana, 2011). Earlier discussions highlighted that we are seeing more female student enrolments and graduations in medicine where women make up over 50% (Wildshcut & Gouws, 2013). Although this is the case, women remain underrepresented on a number of levels within the profession, such as in statutory bodies like the Health Professions Council of South Africa (HPCSA), and across specialties (but predominantly in so-called "masculine" specialties). Ncayiyana (2011) considers three ways of understanding the process of feminisation in medicine in South Africa. The first being i) feminisation by numbers highlighted above, the second referring to ii) the profession being feminised due to traits such as empathy and relatedness being valued and exercised, and finally iii) a feminised profession that does not

[11] Meaning *Freedom* in Swahili

expect women to conform to male dominant medical discourses. All three of these factors have a potential for aiding transformative efforts within medical education (Ncayiyana, 2011), but also brings to the fore some important issues on how discourses around women in medicine are constructed and perpetuated (Wildschut & Gouws, 2013, p. 37).

Mudaly and Van Wyk (2015, p. 232) conceptualise gender as a "social institution" that serves to socialise men and women for gender-typed skills and traits. Girls are often socialised into more of an expressive role, while boys are socialised into more of an instrumental role, and this tends to persist throughout an individual's lifespan (Marotz, Allen, Shaffer, & Kipp, 2014). These "natural" characteristics have an impact for the occupational space – the instrumental role tends to be more valued for the sciences thus making men "better suited" for occupations falling under the sciences, and in this case medicine (Mudaly & Van Wyk, 2015). Therefore, when women pursue higher positions in and engage with the power structures within medicine they are viewed as "superwomen" (p. 232). This assumes a position that is outside and above the norm of what women ordinarily do – giving them "relative freedom from domestic activities" (Hickman, 2003 as cited in Mudaly & Van Wyk, 2015, p. 232). What is regarded as feminine or masculine has an implication for the profession in terms of the extent to which gender is essentialised in the medical world in South Africa (Wildschut & Gouws, 2013). For example, if a desire to have children is expressed by female doctors it may put into question how committed they are to the profession, which echoes the conversation of the ideal doctor being one that is methodical and mechanical – nonhuman (Wildschut & Gouws, 2013). While there has been increased representation of women in the medical workforce, there are still instances where women find themselves not belonging or marginalised (Mudaly & Van Wyk, 2015; Ncayiyana, 2013; Wilschut & Gouws, 2013).

2.7.3 Black women in medicine

> Under the system of traditional law and culture which was reinforced by apartheid ideology, Black women were situated at the lowest and most disadvantaged position in the racial and classed structure of society (Licardo, 2018, p. 231).

General conversations about transformation in higher education have focused predominantly on race, and the "presumed homogeneity of racial and gender experiences within the university" (Maodzwa-Taruvinga & Divala, 2014, p. 1962). Maodzwa-Taruvinga and Divala (2014) argue that this serves to silence the experience of Black women in academia. This implies that realities and discourses that are heteronormative tend to be aligned with institutional power, and those that inhabit such dominant gender positions are more likely to experience HEIs as welcoming spaces (Carolissen & Kiguwa, 2018, p. 2). Msimanga (2014, p. 2025) talks about Black women in HE as experiencing "a perpetual mismatch between the promise of potential and agency and the reality of blackness and woman-ness in academia". In contemporary South Africa (SA) Black women are most under-represented in Science, Technology, Engineering and Mathematics (STEM) (Liccardo, 2018). Liccardo (2018, p. 231) argues that the racialised gender gap in these fields has serious implications for the country's socio-economic transformation agenda. She further argues that these fields lead to socio-economic mobility, and the limited engagement in these fields by Black women means limited engagement with power structures, meaning less agency.

2.8 Transformation of medical schools

In societies where countries move towards being more democratic, questions of transitional justice come to the fore. Central to these is the idea of accountability to society as

a whole (Wildschut & Mayers, 2018). In South Africa, one of the strategies used to facilitate the country's transition was to hold a Truth and Reconciliation Commission (Wildschut & Mayers, 2018). In South Africa, the Truth and Reconciliation Commission (TRC) was held from 1996 to 1998 (Evans, 2016; Wildschut & Mayers, 2018), with aims to establish unity within the nation by addressing the nature of the human rights violations that came with apartheid (Pityana, 2018). Such violations include "killings, torture or severe ill-treatment, or any acts that seek to or that advance such acts" (Pityana, 2018, p. 196). A *"truth-for-amnesty"* model was used where those identified as perpetrators were given an opportunity to truthfully state the political conditions under which violations were committed, and if these fit the political objective at the time they would be given amnesty (Evans, 2016). In addition, the TRC was the first of such commissions that afforded an opportunity for survivors of these social ills to share their experiences (Evans, 2016).

The TRC also had special hearings for sectors in society (Ewert, Baldwin-Ragaven, & London, 2011; Wildschut & Mayers, 2018). The aim of these hearings were to address and attempt to understand broader social factors that gave way to gross human rights violations (Wildschut & Mayers, 2018). The legislation that put together the TRC required it to give a thorough account of these violations and the context in which they took place. The TRC was also to give recommendations for the prevention of future violations (Wildschut & Mayers, 2018). An investigation on the health sector's complicity in the perpetuation of apartheid took place (Ewert et al., 2011, p. 2):

> The health sector, through apathy, acceptance of the status quo and acts of omission, allowed the creation of an environment in which the health of millions of South Africans was neglected, even at times compromised, and in which violations of moral and ethical codes of practice were frequent, facilitating violations in human rights.

Ways in which health professionals contributed to the creation of such an environment, and ways in which some actively participated in the inhumane treatment of patients along racial lines were examined (Wildschut & Mayers 2018). Much of this attention was focused on medical doctors, but some scrutiny was also directed to other health disciplines like psychology, nursing and dentistry (Wildschut & Mayers, 2018).

Wildschut and Mayers (2018) make reference to how the case of Biko's death showed the way in which health professionals chose to align themselves with the state instead of adhering to medical ethics. After being tortured in prison, Biko suffered traumatic brain injuries that ultimately led to his demise (Wildschut & Mayer, 2018). During TRC proceedings evidence of the district surgeon declaring Biko fit to transfer to another prison surfaced, despite there being obvious signs of acute brain damage (Wilschut & Mayers, 2018, p. 3):

> The semi-comatose Biko was driven to the prison alone, handcuffed, and naked on the floor of a police Land Rover. Biko died the following day in the prison, lying unattended on a floor mat.

Wildschut and Mayers (2018) also stress that there were many cases like this, with Biko's being the most highly publicised. The TRC also highlighted that the culture of health professions not taking accountability for human rights violations resulted from the foundations of early medical and health training (Ewert et al., 2011). The commission therefore recommended that, included in the curricula across South African medical and allied disciplines, should be a curricular focus on the promotion of human rights. In response to this, the University of Cape Town (UCT) developed a Health and Human rights programme in the school of Public Health and Family Medicine. A Train-the-Trainer course was also established in 1998 that would promote human rights training across other

institutions of higher education (Ewert et al., 2011). The course was aimed at increasing trainers' proficiency in health and human rights, and it covered a number of themes, including institutional transformation.

Other institutions, like the University of Witswatersrand (WITS), conducted an internal reconciliation commission with similar proceedings to the TRC. The Internal Reconciliation Commission (IRC) was introduced at WITS' Faculty of Health Sciences (FHS) to target racial discrimination and to facilitate institutional transformation (Goodman & Price, 2002). Initially the IRC intended holding a self-reflective process including its faculty members. The process would serve to explore how the medical school perpetuated a discriminatory agenda, focusing especially on the training of medical professionals and healthcare services (Goodman & Price, 2002). According to Goodman & Price (2002), in 1997, issues of difference were still very prominent for faculty members. Divisions were experienced, possibly through differences in perceptions. White staff members may have failed to understand the grievances of Black staff members, with the latter feeling as though their experiences were being minimised (Goodman & Price, 2002). Another goal of the IRC was to reconcile WITS medical school alumni with the faculty, as the alumni felt a lack of connection with the institution. The hope was that the IRC would create an opportunity for the alumni to voice the injustices of the past, and that through this process the FHS could deal with injustices and begin reparation. The final aim of the IRC was to explore how and why some of the inequalities continued to occur (Goodman & Price, 2002).

2.8.1 The lived experiences of race in medical schools

As highlighted above, UCT's FHS has been working toward transforming medical education and the training environment since 1998. Erasmus (2006) highlighted that such efforts included a reconciliation process where there was an acknowledgement of

discriminatory practices on the part of the medical school. She also adds that a new curriculum was then introduced in 2002. The newly introduced curriculum saw a shift from a purely bio-medical model to a more bio-psycho-social approach to understanding illness. As discussed above, the FHS then supported research on how medical students experienced issues of race in the training environment. This was in response to accounts of racism that were expressed during the reconciliation process (Erasmus, 2006).

According to London and Perez (2004), while the number of Black medical trainees has increased in medical schools, the training environment has to a degree replicated racial discrimination seen in the broader South African context. They also highlight that it is important for us to understand how Black trainees experienced medical schools in the past, so that we can work towards creating a more welcoming space for all. This will also serve to redress the inequalities of the past, and day-to-day struggles that occur due to race (Perez & London, 2004). As others highlighted above, Erasmus (2006) notes that structural redress or transformational justice is dependent on issues of equity and access being addressed. This ought to be considered when looking at ways in which the environment can be improved for the training of medical students.

The legacy of medical training under apartheid influences how Black medical trainees experience their environment and how they are positioned as Black doctors. A discussion on Black subjectivity is an important one to have, and it will be explored in a later section of this dissertation. However, it is worth mentioning some related aspects as we look at some findings highlighted by Erasmus (2006). Medical students experienced racial divisions within the classroom setting and in the institution at large, as the norm. The comfort of staying within their racial groups provided a sense of security and belonging (Erasmus, 2006). Divisions permeated the classroom and campus life. This, according to Erasmus (2006), was explained in terms of a preference to exist within familiar friendship settings. Erasmus (2006)

further argues that this is a result of how people were segregated geographically during apartheid, as racial mixing was prohibited. A student reflected on the sense of inferiority that they felt in the classroom setting (Erasmus, 2006, p. 53):

> No coloureds or Blacks will ask questions because they just weren't confident enough. It's not our setting …. We don't have all these things at our school. It's almost a stranger attitude … you withdraw into your shell where you rebel.

These settings can also exacerbate a sense of inferiority and insecurity due to implicit acceptance of White supremacy (Erasmus, 2006). Subtler forms of exclusion are now replacing the ways in which Black doctors were overtly being excluded. According Erasmus (2006) the degree to which Black students were being included was related to their being in an "observer role". The observer role implies Black students having to witness the academic engagement of their White counterparts and their White trainers, which further privileges White voices. An example was made of a student describing the experience of Black trainees as oscillating from being ignored to their presence being glorified, which served to reiterate that they were "the exception to the norm" (Erasmus, 2006, p. 54).

Erasmus (2006) further highlighted how the relationship between White trainers and black students may be strained by power dynamics. An example in the study by Erasmus (2006) highlighted that some trainers regarded the role of Black medical students to be limited to interpreting for the White students and trainers, when these students and trainers could not communicate with patients across language divides. According to Erasmus (2006), it was due to these difficulties that black medical students felt more comfortable in classes where there were predominantly more black students than White. This allowed for them to learn without a sense of inferiority. The idea of black students' identity being understood as

having to assimilate to survive is something that stems from within, but also in reaction to the environment within which they are trying to exist. This relates to a student's testimony in Aryan Kaganof's film, *Opening up Stellenbosch: From Assimilation to Occupation* in which the student uses the notion of having to "die to himself", as he puts it, in order to survive as a black student in Stellenbosch University. It is, borrowing from Erasmus (2006), the position of having to alienate themselves from their "true" self in order to inhabit a space they feel they do not belong in.

Erasmus (2006) also looked at denial, resignation and indifference towards issues of race, and notes that despite the evidence produced, staff still denied that race was a problem, and further argues that this plays a huge role in the perpetuation of racial dynamics. Erasmus (2006) interpreted this as a denial of the past and a resignation to separate realities.

2.9 The experiences of black medical trainees and medical specialist (registrar) training

In examining the experiences of black medical trainees in the USA, Liebschutz et al. (2006) note that, though many medical trainees report mistreatment in the form of verbal abuse and harassment, racial minorities, particularly black trainees, report higher rates of mistreatment (Liebschutz et al., 2006). Financial stressors tend to be higher for this group, which may add to the strain involved to improve their knowledge and skills, especially to meet the demands of medical school (Liebschutz et al., 2006). The authors make reference to a survey of practising physicians in Massachusetts, where over half of the black respondents indicated experiencing discrimination on the job. For them, racism occurred in the form of disrespect from co-workers and difficulties in advancing professionally (Liebschutz et al., 2006).

Four themes emerged from the findings in this study: discrimination, social isolation/social support, differing expectations, and consequences/coping strategies. The

salient issue key to each theme was the experience of being part of a highly visible minority (Liebschutz et al., 2006). The authors report that all the participants of this particular study mentioned their minority status; for example one reported:

> At least once at a conference, I look around the room and I realize that I am the only person of color in this room and just by the basis of that I feel different (Liebschutz et al., 2006, p. 1443).

The authors noted that black residents (the term for registrars in North America) across all disciplines at the northeastern US academic medical centre shared these experiences and perceptions of their training (Liebschutz et al., 2006). These experiences result from cultural difference, interpersonal discrimination and underrepresentation in a predominantly White setting (Liebschutz et al., 2006). The ideas presented by these authors are echoed in other sources (Breier & Wildschut, 2006; Martinez, Mclure, Eddy, & Wilson, 2011) that note that mistreatment or alienation during residency is common, particularly for minority groups.

2.10 Understanding the culture of medicine

2.10.1 Prejudice in medicine

There have been efforts made toward equal access into medical schools globally; however, subtle prejudices seem to still occur within the medical profession, both in the training of medical students or as a result of a cultural clash between doctors and their patients (Ansell & McDonald, 2015; Chapman, Kaatz, & Carnes, 2013). Ansell and McDonald (2015) highlight that there is some evidence that shows that doctors' bias influences the way in which they approach and treat patients. This bias may be a result of limited intercultural contact and stereotypical ideas about certain groups (Chapman et al.,

2013). Therefore doctors' preference to interact with doctors and patients of the same racial and cultural groups may be an unconscious one (Ansell & McDonald, 2015). Doctor's unconscious bias may contribute to the way in which disparities are perpetuated within the healthcare setting, especially because the people who are more likely to experience difficulty accessing equitable healthcare are also likely to face other forms of social marginalisation (Chapman et al., 2013). Chapman et al. (2013) warn that bias does not necessarily prove bad patient outcomes, but it can be one of the ways in which health disparities are perpetuated. They also highlight that we ought to factor in the patient's experience of perceived poor communication and lack of care.

In the United States, studies show that African American patients were more distrustful of White doctors, particularly those engaged in medical research (Clark, 2009). Clark (2009) highlights that African American patients expressed more anxiety about the possibility of experiments and/or drugs being administered to them without their consent. While fewer African American patients are represented in clinical trials, Clark (2009) points out that for the above reason they are reluctant to participate in studies. Covert ways in which people are discriminated against are important to note as they may influence patient care. According to Clark (2009) serious steps need to be taken to address racism within the medical profession and a need for establishing an understanding between physicians (who are still predominantly White) and patients of differing ethnic groups. If these issues are not properly addressed, there is a danger of disparities taking different forms and deepening.

Barriers in healthcare provision have received attention and have been documented globally (Thackwell, 2014). There are many reasons as to why these issues persist and reinvent themselves – a long history of racial discrimination, the affordability of adequate healthcare, and fewer opportunities for professional advancement for members from minority groups (Clark, 2009). There have been a number of calls for cross-cultural training to be

incorporated into medical training (Beagan, 2000; Clark, 2009; Hipolito, Malik, Carpenter-song, & Whitley, 2012). Clark (2009) argues that an internal process of self-evaluation to prevent prejudices from influencing clinical practice can achieve this cross-cultural awareness.

2.10.2 Diversity in medical education

As suggested before, students and trainers bring their own set of values and ideas with them, and Swanwink (2010) suggests that these can be used to create awareness around the diversity of human experience. He further argues that the lack of consideration of diversity often leads to the over-diagnosis of particular conditions, which may lead to the mistrust of healthcare providers. For example, there was a concern in the United Kingdom that schizophrenia was overdiagnosed in people of African and Caribbean origin, and there is evidence to support this claim, with less robust but similar evidence regarding African-Americans in the United States of America (Gurak, Maura, de Mamani, de Andino, & Rosenfarb, 2018; McGovern, Hemmings, Cope, & Lowerson, 1994). As highlighted above, the patient's likelihood of seeking help from a healthcare provider is dependent partly on the patient's assessment of the doctor's level of competence, including cultural competence (Swanwink, 2010). According to Swanwink (2010), there are a number of ways in which training in diversity can take place. He suggests that this could be an exchange between the students and trainers rather than having trainers simply teaching diversity (Swanwink, 2010).

In the United States, many residents reported a lack of cross-cultural training (Hipolito et al., 2012). While there is evidence of racial disparities in healthcare being documented, it is problematic that there is also evidence of residents reporting a lack of preparedness in their capacity to deliver cross-cultural care (Weissman et al., 2005). A trend in teaching cross-cultural care is apparent in efforts to equip healthcare providers with the

necessary skills to effectively care for diverse patient populations (Hipolito et al., 2012; Swanwink, 2010; Weissman et al., 2005).

2.10.3 The culture of medical training

In previous decades; the profile of medical doctors looked very different from what it looks like today. The picture of medical students and doctors before represented White upper class men who often came from families of doctors (Ncayiyana, 2011; Thackwell et al., 2016). Today, however, the demographics of medical students and doctors have changed. Increased diversity in medicine is one of the positive steps towards addressing some healthcare gaps. Some of these gaps relate to how patients who differ from their traditional physicians (middle class, White, heterosexual male) often were not treated effectively (Thackwell, 2014). Beagan (2000) makes references to exclusionary practices within medicine that mimicked social classism and how that impacted on the care of certain individuals. For such reasons, there was a pull toward increasing the number of physicians that represented more of a realistic picture of society.

Homogeneity in medicine was prominent before the 1990s globally, but today we see the admission of diverse groups of people entering medical training (Beagan, 2000). Beagan (2000) explores the extent to which homogeneity of physicians was a result of the group being fairly homogenous when entering medical training and the extent to which it is a product of the training itself. She also investigated the process of assimilation that takes place at medical schools and the impact this has on students. Some of the accounts from the participants suggested that because of the intensity of the training, they are forced to be alike, as most of their time is spent predominantly within the training environment. This implies that the training has a homogenising influence (Beagan, 2000).

The pull toward homogeneity in medical school seems to be related to taking on a

new reality and to some extent leaving behind what students were before entering medical school. According to Beagan (2000) the pressure to conform is not completely about time pressures and the excessive workload, but also about a number of other factors. Some that she highlighted included feeling uncomfortable about the adoption of some aspects of the culture of medicine and to not be ostracised for not conforming.

Medical students may fear being othered or standing out for reasons other than competence (Beagan, 2000). Students may conflate the need for learning standardised treatment protocols with the pressure to be a particular kind of person, and may lose some aspects that formed part of their identity prior to medical training (Beagan, 2000). They may adopt a certain persona that differs significantly from what their loved ones recognise; or may become more (or less) culturally conservative (Beagan, 2000). Beagan (2000, p. 1258) describes a process of letting go of *"non-medical"* parts of the self in order to assume the developing professional identity. This may apply to aspects of both racial and gender identities (Beagan, 2000; Riska, 2010).

2.10.4 The isolation of minority students

A supportive environment is important for favourable student outcomes. The medical environment can at times underrepresent those who come from minority groups. The lack of cross-cultural awareness and shared experience may lead to the isolation of certain students (Boateng & Thomas, 2011). Boateng and Thomas (2011) highlight that within medical education there is a huge interactional component, particularly between consultants and students. Minority students tend to be less interactive, and as a result they can sometimes be seen as unmotivated or unknowledgeable. This may lead to poorer performance appraisals and this could affect throughput rates. The authors suggest that more effort must be put into the social integration of underrepresented minority groups into the institutional culture

(Boateng & Thomas, 2011). They further argue that it is the responsibility of the trainers and medical education policies to develop curricula that emphasise diversity and professionalism (Boateng & Thomas, 2011). Sullivan and Mittman (2010) agree that there is value in a curriculum that focuses on issues of diversity within the medical system. However, they also argue that this may be a short-term solution that may not necessarily aid in alleviating the social exclusion that these students may feel. They further argue that the other contributing factor is the lack of mentorship in medical schools as a result of a lack of representation of minority faculty members. Mentorship is important as it provides a supportive environment and encourages career advancement.

2.10.5 Race and ethnicity in medical student achievement

The field of medicine has been associated with hard work, personal sacrifice, and success of trainees being attributed to factors such as motivation and academic capacity. Woolf, Rich, Viney, Needleman, and Griffin (2016) argue that there continues to be considerable stigma attached to the experience of difficulties during training. This would leave trainees feeling inadequate and unsupported. In recent years, attrition rates and throughput within medical school have gained interest. Some literature in medical education currently focuses on the differential attainment between ethnic minority students and White students. Vaughn et al. (2015) also highlight that this is evident throughout higher education and not just in medical training. They further indicate that a link has been made between underperformance and ethnic minority students, and the implications of this for equal opportunities within medical education. Lionis (2015) argues that while some focus has been placed on social disparities, these issues have not yet received adequate attention. He further reports on findings indicating that medical students from non-western countries training in the Netherlands were more likely to perform at a lower level than Dutch students. Attrition

was reportedly more likely with these students as well. While some literature points to social inequality as a factor for underperformance of minority students, Vaughn and colleagues (2015) argue that this cannot be the only cause. They also highlight that this issue is highly complex and we need to interrogate a number of factors that may be at play. The question raised by these authors is whether the problem occurs at an examination level or at an experiential level.

Adjusting to medical education is difficult for all students, but more especially for those coming from a lower social economic status, as they may be exposed to more day-to-day prejudices (Vaughn et al., 2015). Vaughn et al. (2015) suggest that there may be a link between performance and students' social interactions. They further argue that social factors become very important because students' having a sense of belonging may promote good performance in medical school. Establishing good working relationships within the training setting may help in developing this sense of belonging and have an impact on how students experience medical training (Vaughn et al., 2015). Interaction with trainers and mentors can also help with students adjusting to the unfamiliar medical setting, however the dynamic between students and trainers is not always experienced by students as positive and encouraging (Vaughn et al., 2015). There is a general belief that trainers' bias could influence the way they perceive students during training, however Woolf et al. (2016) caution that trainers were not always necessarily biased. They also suggest that trainers need to be aware of themselves and the potential for unconscious bias occurring during training. Woolf et al. (2016) recommend that time must be invested in improving the relationship between trainers and students during medical training.

A few scholars (Isba, Woolf, & Hanneman, 2017; Vaughn et al., 2015; Woolf et al., 2012) within medical education research advocate for a method of investigating individual relationships, the social context and how these may have a bearing on identity formation,

individual success and health. Looking at both relational issues as well as individual factors can aid in our understanding of behaviours that take place in different social and occupational settings (Isba et al., 2017). Woolf and colleagues (2012) argue that performance in medical school is also influenced by what they describe as the "hidden medical school" which relates to social networks within medical school and relationships within it. As a result social network analysis (SNA) has become very popular within the social sciences and medical education. SNA allows for a description of how social processes influence individual performance (Isba et al., 2017). Vaughn and fellow-authors argue that social networks become a system where resources may be shared. They also look at the tendency of interacting with people of the same ethnic group, and argue that this has been observed in medical school settings for decades (Vaughn et. al, 2015). The importance of social networks and their influence on performance in higher education has emerged as a topic of interest in research. Woolf, Potts, Patel, and McManus (2012) suggest that the most prominent finding in social networks research is that the formation of friendships is typically based on demographic similarities. The tendency of gravitating to individuals of similar backgrounds is described as homophily (Vaughn et al., 2015; Woolf et al., 2012). Both Vaughn et al. (2015) and Woolf et al. (2012) argue that the process in which this homogeneity is formed is complex.

Medical training, especially in clinical years, is less about rote learning and more about inhabiting the culture and practices of medicine. This is why mentoring and peer relationships are important. The idealisation of senior colleagues and having access to social capital within relationships amongst clinicians of varying skill levels allows for the development and reinforcement of trainees' identities as doctors (Vaughn et al., 2015). Feelings of not being able to access senior colleagues or peers who are accustomed to the medical world can serve to alienate lower-achieving students, which can lead to less

participation and risk of drop-out. Such experiences are more prevalent among ethnic minority students. The authors highlight that this explanation of underachievement among ethnic minority medical students is in contrast with academic ability. Lionis (2015) argues that these gaps in social capital seem to persist through to residency. It is for this reason that it is worth exploring the degree to which gaps in social capital and homophily hinders performance in medical schools, especially because they have a direct impact on increasing diversity within the workforce.

In a study looking at differential attainment in postgraduate medical students in the UK (Woolf et al., 2016), findings indicated that trainees were anxious about living up to negative stereotypes. The findings suggested that minority postgraduate students in this particular study felt some psychological pressure knowing that they may be exposed to prejudice. There was also evidence of trainees doubting their own competence and questioning whether they were as smart as the local trainees (Woolf et al., 2016). One of the black students reported not knowing whether it was their level of competence, their level of confidence or if it was their race that was the problem. She later reflects that this may have an impact on the way she sees herself and how she regards herself as a doctor. The negative experience and the underperformance of ethnic minority trainees may be attributed to a number of factors. However, it is evident that the way in which they form their identity, the way they perceive themselves and their level of competence also warrants more investigation.

2.11 Locating this study in recent history in higher education in South Africa: Fallism and beyond

2.11.1 #RhodesMustFall: Conversations on decolonisation in higher education

On 9 March 2015, a politics student, Chumani Maxwele, threw human faeces on the statue of Cecil John Rhodes on the UCT campus. This was what many view as the beginning

of the student protest, Rhodes Must Fall (RMF), at UCT's upper campus, with students calling for the removal of the statue of Cecil John Rhodes (Chikane, 2018; Francis & Hardman, 2018; Mpatlanyane, 2018; Nyamnjoh, 2015). Nyanmjoh (2015) highlights that this was not the first time the presence of the statue at UCT and its implications were a point of discussion, but that there had not been formal calls to have it removed. The student protest started a strident conversation about the need to decolonise the education space (Francis & Hardman, 2018). The students were urging the university to sever its ties with its colonial past (Francis & Hardman, 2018).

2.11.2 #FeesMustFall: The fight for free education

In October 2015, Wits announced that there would be a significant rise in fees for 2016 due to the government subsidy allegedly not being enough to cover the university's expenses. This gave rise to the Fees Must Fall (FMF) movement starting at Wits in Johannesburg (Chikane, 2018; Pillay, 2016). The call was for a free, decolonised higher education system accessible for all, as the implication of fee increases would serve to marginalise those who are economically disadvantaged (Pillay, 2016). The protest had spread nationally by mid-October with a collective message from students about how the poor were being excluded (Vandeyar & Swart, 2018, p. 2).

2.11.3 #OpenStellenbosch: Language politics

South Africa has 11 official languages but most of the universities in South Africa have at most two languages as the media of instruction, with most universities teaching in English (Oostendorp & Anthonissen, 2014). Until recently, the language policy at Stellenbosch University promoted the commitment to the preservation and promotion of Afrikaans as an academic language (van der Waal & du Toit, 2018). Afrikaans was

historically the predominant medium of instruction on undergraduate level while English was used more for postgraduate lectures (Oostendorp & Anthonissen, 2014; van der Waal & du Toit, 2018). Until fairly recently, classes on the undergraduate level would largely be offered in Afrikaans with, in recent years, interpretation services offered for those who are not first language Afrikaans speaking. Afrikaans is the most common home language in the Western Cape Province, where SU is situated, but many Black South Africans are not fluent in Afrikaans. They are first language indigenous language speakers, and learn English as a second language. For most of them, Afrikaans would be at best a third language, which is difficult in itself, but there is also an ideological component to the question of Afrikaans. It is a myth that Afrikaans is a "White" language (most first language Afrikaans-speakers are not White), but this myth was perpetuated during the apartheid era, with the government aggressively promoting Afrikaans. Part of the spark which ignited the 1976 uprisings in South Africa, uprisings which arguably signalled the beginning of the end of apartheid, was Black scholars' resistance to being forced to be educated through the medium of Afrikaans. So, despite the fact that Afrikaans is a local and predominantly black language, it is associated with Afrikaner nationalism (van der Waal & du Toit, 2018). Historically, furthermore, SU was closely associated with the apartheid government, to the extent, for example, that P. W. Botha, a reviled National Party president of the country, served as chancellor of the university.

There has been a lot of discussion about the pace at which SU is transforming. In post-apartheid SA, SU has struggled to rid itself from its Afrikaner Nationalist legacy (Mpatlanyane, 2018; Oostendorp & Athonissen, 2014; van der Waal & du Toit, 2018). Mpatlanyane (2018, p. 9) highlights the following about the structures at SU:

> The infrastructural features of the university, in addition to the institution's demographic profile, suggest a sense of nostalgia that negates the diversity in experiences, livelihoods and histories of the people that constitute that space.

She further highlights that physical representation and experience of space – statues, building names, communication and the language thereof – does something to the psyche of those inhabiting that space. The environment influences one's sense of belonging. So, it was no surprise that in 2015 a group of black students mobilised a movement called *Open Stellenbosch* to address such spatial politics, more especially language politics.

2.11.4 Understanding Fallism

Kahn (2017) views the years since 2015 as a post-apartheid existential crisis, located primarily in, but not exclusive to, the higher education domain. Much of the fallist movement focuses on calls for a "free and decolonised university" (Maldonado-Torres, 2016, p. 4). I discuss the concept of decoloniality in the chapter that follows, but in terms of context, part of the fallist endeavour is aimed at what its proponents would call rehumanising people and decolonising the mind (Maldonado-Torres, 2016).

The student protests, Rhodes Must Fall and Fees Must Fall, are situated within higher education, and they mirror complicated broader issues within the country relating to social injustice. Due attention needs to be given to the complexity of the context in order to attempt understanding black subjectivity. In other words, it would be a great injustice to not consider how our country's traumatic history influences black people's current identity in higher education and other contexts (Gobodo-Madikizela, 2015). These movements established a need for the exploration of the social construction of race and how issues relating to race, like racism, are perpetuated and reinvented.

In February 2018, UCT's Institutional Reconciliation and Transformation Commission (IRTC) embarked on its inquiry following the turmoil on its campuses. The IRTC was asked to look into and make recommendations with regards to the following: "institutional culture and practices, including decolonisation and any that entail unjust discrimination, domination or violence including sexual violence", especially as it relates to "institutional culture, transformation, disability and any other matters which the university community has raised over the years or may wish to raise" (IRTC, 2019, p. 1). The student protests over the period of 2015–2017 were a reflection of issues within higher education such as students being denied accommodation at student residents despite receiving notification that there is space, and the remarkably high fees, among other things (IRTC, 2019). The protests also brought to question the pace at which transformation was taking place at HEIs as well as the lack of decolonisation at South African universities (IRTC, 2019). The IRTC (2019) highlighted a number of issues after having reviewed all submissions. Some of the important points relevant to this study include the following:

I. The university's management failed to respond with sensitivity to the students' plight and experience of the university as racist and structurally violent.
II. Instead of engaging with the protests with sensitivity, management was preoccupied with removing students from where they stood in protest and did so in violent ways including contracting in private security companies.
III. No submissions to the inquiry indicated that UCT is not a racist environment.
IV. While there is an increase of Black academics occupying lecturer and senior lecturer positions, there still remains a huge gap in terms of race and gender representation, particularly at the level of full professorship.

The IRTC (2019) highlights the devastating impact of the political landscape of HE (located within these movements) over the past couple of years. One of the points that stands out and becomes of particular interest for me is the troubling state of HEIs, and, in particular, of UCT. The commission highlights the presence of emotional tensions and mistrust between students and HEI management, between staff members within the academy, and between staff and students. They importantly highlight that this divisiveness is along racial lines.

2.12 Concluding comments

These student protests highlight the urgency to dismantle unjust structures that prevail within higher education. They also brought to the fore the need for a deeper understanding of students' lived experience (IRTC, 2019; Wilson-Strydom, 2018). The IRTC (2019) criticised UCT's management for not responding appropriately to the student movements, and of course the appropriate response would aid the pace at which transformation in HE moves. Wilson-Strydom (2018) highlights that this type of transformation is not merely about stating that everyone has the right to access HE, as words without action are merely words. It would require the active "removal of various unfreedoms" that leave certain people at the margins (Sen, 1999 as cited in Wilson-Strydom, 1999, p. 36). In the next chapter, I examine some theoretical work which may help us understand and address the complex issues at stake.

CHAPTER THREE: THEORETICAL ORIENTATION

In this chapter I consult a large range of theoretical resources. The table below shows each and what they address theoretically.

Coloniality and Decoloniality	**Critical Race Theory**	**Race Trouble**
Intended to address broader social structure	Looks at institutions	Addresses daily interactions

3.1 Coloniality and decoloniality

Coloniality and decoloniality are becoming key terms in contemporary psychological scholarship (Maldonado-Torres, 2016). Although colonisation has in many contexts long since been dismantled, remnants of its effects continue to be identified and experienced. Maldonado-Torres (2016) offers a conceptual differentiation of terms. He argues that colonisation differs from coloniality, and that decolonisation differs from decoloniality. He highlights that colonisation and decolonisation represent a specific historical period, whereas the terms coloniality and decoloniality refer to ongoing issues which may in part be legacies of periods of colonisation and decolonisation. Coloniality and decoloniality may exist regardless of whether a society is in a current period of colonisation or postcolonisation (Maldonando-Torres, 2016). Earlier in this study I made mention of South Africa's colonial history and its significance. However, for the purposes of the theoretical discussion on the lived experiences of Black people today, specifically Black registrars, I will be using the terms colonialty and decoloniality.

3.1.1 Coloniality

Ndlovu-Gatsheni (2015, p. 486) argues that the process of decolonisation "failed to … effectively 're-member' Africa after over 500 years of 'dismemberment'"; leaving fertile ground for ongoing coloniality to occur. Quijano (2007) argues that coloniality refers to the current reproduction of issues of historical domination (see also, sentiments echoed more recently by Maldonado-Torres, 2016; and Mignolo & Walsh, 2018). Coloniality refers to the solidification of systems of "civilization" that serve to legitimise White superiority (Maldonado-Torres, 2016, p. 1), and where the relationship between the west and others continues to be one of implicit colonial domination. This may no longer be legislated but may persist in terms of power relationships (Quijano, 2007). Carranza (2018) argues that, as a result of the colonial enterprise, we-people of colour (the colonised) have internalised distorted and dehumanising views of ourselves where proximity to Whiteness assumes civilization, respectability and progress.

3.1.2 Decoloniality

Mignolo and Walsh (2018) discuss how decoloniality involves ways of thinking and being that resulted from, but may to a degree also contain elements which may have preceded, the colonial enterprise. They conceptualise decoloniality as follows (Mignolo & Walsh, 2018, p. 17):

> Decoloniality necessarily follows, derives from and responds to coloniality and the ongoing colonial process and condition. It is a form of struggle and survival, an epistemic and existence-based response and practice – most especially by colonised and racialised subjects – *against* the colonial matrix of power in all its dimensions, *for* the possibilities of an otherwise.

Maldonado-Torres (2016) in a similar light refers to decoloniality as the direct response to remnants of the colonial world and its structures, which includes the university, where segregation comes back in many forms – for example, through the charging of student fees which exclude or place undue burden on formerly colonised groups, or through other forms of fee increases and structural exclusion. Maldonado-Torres (2016) reflects on how the youth come to assume the role of questioning the current social order as it presents itself now and what it might look like in the future. Unfortunately, these youth (especially if they are of colour) are then seen as problematic or troublesome (Maldonado-Torres, 2016). Maldonado-Torres (2016, p. 2) further discusses this by stating the following:

> In societies with a segregationist/colonial past and with a present of systemic inequalities … responses to the youth as "menace" typically start with rejection and indifference, but after pressure from students it can transform to benevolent neglect disguised as "urgent action".

3.2 Race–ism, Race Trouble, What Race?

Racial categories and racialisation

The reality is that in South Africa, and perhaps in most parts of the world, the colour of our skins retains a great influence in terms of people's lived experience (Alexander, 2013). People continue to categorise themselves and others along racial lines and this is due, in part, to South Africa's deep racial history, where racist ideologies under the apartheid regime, and regimes before that, saw the promotion of White supremacy and Black inferiority. The legacy of these ideologies still influences the complex identities of South Africans today. Recent efforts to transform the country have resulted in a focus on equality, but authors like Collins (2015), have highlighted that the lack of engagement with race and racism in post-apartheid

South Africa serves to perpetuate covert discriminatory actions. The other difficulty faced in literature about race and racism, according to Collins (2015), is in the conceptualisation of terms. She cautions that *"race is not racism"*, and that both constructs carry specific and different historical meanings related to specific power constructions (Collins, 2015, p. 47). Here we are challenged to really think about whether simply adding *"race"* to everything we write necessarily strengthens our theoretical understanding of all race issues including racism (Collins, 2015).

Race appears to have a ubiquitous presence in politics in many societies. In South Africa, formal racial categorisation results partly, though not exclusively, from its apartheid history, where the Population Registration Act of 1950 demarcated three racial categories (Posel, 2001, p. 62):

I. A White person is one who in appearance is, or who is generally accepted as a white person, but does not include a person who, although in appearance obviously a White person, is generally accepted as a Coloured person.
II. A native is a person who is in fact or is generally accepted as a member of any aboriginal race or tribe of Africa.
III. A Coloured person is a person who is not a White person nor a native.

Posel (2001) argued that the vague nature of these definitions was instrumental to the process of racialisation, which was essentially a bureacratisation of regimes of power, requiring the labels to acquire a fictive specificity. These definitions were based on the subjectivity of ordinary people with their prejudices; married with the law and what has come to be termed "race science" (Walters, 2018, p. 29) to ensure the implementation of racial categories. As a result of decades of racialisation, the idea of distinct races in South Africa has become a norm, a "habit of thought and experience" (p. 56). Race during apartheid only embodied degrees of

privilege whereas in post-apartheid South Africa it is also the site of re-dress (Posel, 2001, p. 75). So while some reluctantly engage with the reality of a racialised country, racial categories are a "fact of life" for many South Africans (Alexander, 2013, p. 116).

3.3 Critical race theory

Critical race theory (CRT) emerged as a way of critiquing dominant discourses within the discipline of law (Salter & Haugen, 2017). CRT challenged the notion of racial discrimination being an unfortunate consequence of racially biased individuals within an otherwise objective legal system (Salter & Haugen, 2017). CRT challenges the colour-blind approach to addressing problems relating to racial inequality. Delgado and Stefancic (2017) argue that the colour-blind approach serves only to resolve issues pertaining to overt racism. CRT, rather, puts emphasis on the subtle ways in which racial discrimination permeates day-to-day institutional structures, and is in fact fundamental to them. The concept of race, according to the social constructionist framework, spawns from social thought (Delgado & Stefancic, 2017). Therefore, we need to acknowledge that racism has a historical context and that individuals, particularly those who belong to minority groups, are social actors positioned within a complex network of other actors and ideas (Gillborn, 2015). The basic tenets of CRT as outlined by Huber and Solorzano (2015, p. 255) are:

1. Centralising race, racism, and multiple forms of intersecting oppressions experienced by people of colour.
2. Challenging dominant ideologies that justify the foundation for research on communities of colour.
3. Centering and utilising experiential knowledge as the foundation for research on communities of colour.

4. Utilising an interdisciplinary perspective that draws across and within the boundaries of academic discipline to answer research questions.
5. Encompassing an unapologetic stance for racial justice for communities of colour.

An interesting way of expressing the agenda of CRT has been presented by Huber and Solorzano (2015) – one of making the implicit, explicit. These authors discuss a theme borrowed from sociology, *"making the society visible",* in other words, a commitment to illuminating social realities (p, 224). They further highlight a need for a visual approach to CRT in education. This will not be discussed in a lot of depth here, but they highlight some critical elements that are worth mentioning.

3.3.1 Critical race theory and education

Howard and Navarro (2016) suggest that race has always been a factor to consider in terms of access to education and highlight that while improvements have been made, disparities still exist. CRT within education has been used as a theoretical and methodological tool to disrupt conventions within pedagogy. It also allows for the exploration of the experience of students of colour and concerns that they may have while challenging the illusion of fairness and equality (Howard & Navarro, 2016). South Africa has an obligation to be inclusive, therefore issues of access into HEIs has been of focus. Soudien (2012) questions how HEIs in South Africa are to achieve this when the legacy of apartheid education has limited the preparedness of certain groups of people for university (p. 37). Howard and Navarro (2016) highlight that in addition to making known the persisting inequalities within education, CRT also provides an analysis of how race often intersects with other forms of discrimination.

Intersectionality is one of the key components of CRT. Intersectionality as a theoretical framework offers an understanding of an individual's experience at a micro level and how multiple identities (race, SES, dis/ability) can intersect in such a way that reflects power dynamics of power and oppression (Bowleg, 2012; Gillborn, 2015). This is the understanding that social identities do not operate in siloes but constantly intersect and influence each other. Kiguwa (2014) highlights that intersecionality engages with the multiplicity of subjectivity, and this allows for us to start our analysis from any point - be it race or class, and critically examine how that interacts with other social categories. She further develops this by asserting that intersectionality "seeks to engage the fluidity of subjectivity and therefore pays attention to the contexts of different entry points" and how issues of power are produced and reproduced at the intersection (p. 56).

Intersectionality concerns itself with social inequality and the factors that precipitate and maintain them, and social inequality is complex and changing (Gillborn, 2015). Similar to Kiguwa (2014), Alexander (2013) highlights the dynamic nature of social categories. He argues that they can be deconstructed, reshaped, and that one can move from one identity to another. He suggests, for example, that race issues influence socio-economics and vice-versa, and highlights how members of previously disenfranchised groups are often economically marginalised whilst experiencing racial prejudice. He further asserts that it is not easy for marginalised groups to rid themselves of the stigma of inferiority and the socio-economic issues that accompany it. Alexander (2013) also suggests that divides deepen over time, and that the perception of inferiority is often internalised by minority groups, which further reinforces the divide.

3.3.2 Critical race theory and medical education

Both internationally (Ferrel, 2017) and locally (L. Swartz, Rohleder, Bozalek, Carolissen, Leibowitz & Nicholls, 2009) there has been the recognition that students need to be aware of factors that aid the perpetuation of structural racism. Ferrel (2017) discusses that medical education today is not adequately equipped to deal with structural racism within the discipline, and that physicians ought to also understand such issues and their implication for healthcare gaps. Efforts have been made to include some content relating to healthcare disparities, but Ferrel (2017) argues that there is far less critical engagement with issues affecting people of colour. Ferrel (2017) argues that introducing CRT in medical education will equip doctors to meaningfully engage with and interrogate power structures both inside and outside of the hospital. She also highlights that they will be better prepared to treat patients of colour.

3.4 Colour-blindness on the race front

The agenda of what may be termed a colour-blind ideology is to promote the treatment of individuals based on character and not the colour of their skin (Collins, 2015). It refers to the idea of deeming individuals as equal as possible regardless of race, along with the claim that race holds little social meaning (Warikoo & de Novais, 2014). Some (Collins, 2015; Warikoo & de Novais, 2014) argue that while the intentions of scholars who adopt the colour-blind frame may be positive, and intended to disrupt the status quo, colour-blindness may also be the reason why certain injustices persist. Warikoo and de Novais (2014) highlight that the colour-blind ideology is a result of explicit racism transforming to subtler versions. This may be a result of discomfort, and perhaps reflects a reluctance to engage with issues of race and racism in contemporary South Africa. Perhaps what is being highlighted

here is how Whiteness can be protected through the discourse of diversity, as this may promote assimilation rather than encouraging deeper transformation (Hikido & Murray, 2016; Pattman, 2010; Pattman & Carolissen, 2018; Ratele, 2018). For example, though some may wish to argue that medical education should be fair and therefore colour-blind, it remains the case that while training medical institutions in South Africa have seen the racial and gender diversification of its undergraduate trainees, the training is still dominated by Whites. Therefore, medicine still operates as a historically White space (Hikido & Murray, 2016). The lack of acknowledgement of race and the power structures inherent in such contexts may serve to sustain White supremacy. Colour-blindness in this context is not simply a refusal to see skin colour as an issue, but rather a refusal to see historical and contemporary power imbalances as issues. Racism and racial hierarchies are issues of power and not of pigmentation – the question is not one of colour as an issue, but of what colour has been made and is made to mean, along with the implications of these meaning for how different lives are lived.

3.5 Racial microaggressions

Microaggressions are defined as "derogatory slights or insults directed at a target person or a group who are members of an oppressed group (Torino et al., 2019, p. 3). They represent bias and can be communicated both implicitly and explicitly (Torino et al., 2019, p. 3). Racial microaggressions have been defined as subtle verbal or behavioural insults aimed at people of colour. These are usually brief (unconscious or deliberate), belittling remarks directed to people of colour because of their race (Sue et al., 2007). Forrest-Bank and Cueller (2018) suggest that due to the complex and stressful nature of racial microaggression, it may be a very harmful form of discrimination and, as a result, can cause psychological distress over time. Reports of symptoms of anxiety, paranoia and depression have been noted

(Holder, Jackson, & Ponterotto, 2015). The stress and complexity is in the way these microaggressions occur within subtle daily exchanges, and therefore may be dismissed as harmless or innocent (Sue et al., 2007). However, the authors highlight that these racial slights have an effect on people of colour on a cognitive level. Racial microaggressions can take on many forms and are not limited to encounters between people (Sue et al., 2007). The authors argue that even the built and symbolic environment that one is exposed to can create the experience of microaggression by it making someone's racial identity insignificant by the exclusion or presence of things that do not represent certain racial groups. Three types of racial microaggressions are identified: (i) microassault, (ii) microinsult and (iii) microinvalidation (Sue et al., 2007, p. 274).

i. Microassault refers to actions and statements that are intended to do harm such as name-calling and avoiding certain individuals, for example referring to someone as "oriental" (Sue et al., 2007, p. 274). These often occur in slightly more one-to-one, private situations where it would be hard to prove that the perpetrator was indeed guilty of racism.

ii. Microinsult refers to offensive statements that lack racial sensitivity. An example given by the authors is when a person of colour is asked *"how did you get your job"*, which is not necessarily intended to be offensive but said in a particular context can be racially charged.

iii. Microinvalidations are characterised by statements that are dismissive of the experience of people of colour, for example, "apartheid was so long ago, and we should all just move on" and "All lives matter" in response to racial issues raised in relation to the legacy of apartheid and the Black lives matter movement (Sue et al. 2007).

The situations highlighted above illustrate how racial discrimination is perpetuated in invisibility. Sue and colleagues (2007) highlight that racial microaggressions are often explained away or alternative explanations are given making them difficult to identify and challenge. They further point out that it becomes difficult for the victim of these microaggressions to communicate their experience in a way in which perpetrators may view as legitimate. They report that people of colour may describe a vague sense of being targeted (Sue et al., 2007). Racial microaggressions may create an unconscious psychological dilemma for both White people and Black people. The dilemma is that both parties may move away from the situation with a bit of unease when (for White people) an accusation of being racist is made, and when (for Black people) one is left with feelings of suspicion or threat wondering if the encounter was truly racist (Durrheim et al., 2011).

3.6 Race trouble

Many of the daily experiences of South Africans have been interpreted through the lens of race. Durrheim et al., (2011) have questioned the extent to which transformation efforts in South Africa (SA) today are reaching the goal of *"becoming a non-racist society, among other noble goals"* (Alexander, 2013). Durrheim et al. (2011) also highlight how complex this question is. They have conceptualised an aspect of the issue of race and racism in contemporary SA and have termed it "race trouble". Race trouble, according to Durrheim, Greener and Whitehead (2015, p. 86), "draws attention to the structuring of interaction around particular issues, how 'race' and 'racism' organise social and institutional life, the practical and material consequences of this organisation, and the way these change over time". Therefore, race trouble provides us with a way of analysing racial discourse that is constructed through interaction. One of the key benefits of this framework is that it focuses on the minutiae of the day-to-day racialised experience (Hook, 2012) and, in addition, looks

beyond the binary of "racist" and "not racist" (see Thackwell, 2014, p. 31) perspective and sees race as troubling for all (Durrheim, et al., 2011).

3.6.1 Black trouble

Negative stereotypes about black people continue in both explicit and implicit ways. Durrheim and colleagues (2011) argue that some stereotypes about black people cut through all classes and serve a different function, for example to criticise black leadership. Durrheim et al. (2011) highlight how some media tend to portray black leaders as being incompetent or corrupt. The fact of media stereotyping makes it very difficult to engage with genuine and substantive issues of corruption in the country, which should definitely be addressed. The stereotyping about corruption may be related to deep-rooted discourse about black people's inability to govern themselves. People (both black and White), genuinely concerned about corruption, may be silenced through their awareness that they may be accused of reproducing racist stereotypes. This silence may then subtly enable corrupt practices and undermine what has been achieved to improve the lives of black people. The authors also suggest that this is related to a deep-rooted discourse about black people's inability to govern themselves. In earlier work, Armour (1997, p. 26) referred to something he termed "black tax" to describe the hidden cost of being black as a result of stereotypes about black people in the United States. He further explains that, just like tax, racial prejudice is ongoing, unavoidable and ought to be dealt with. This concept is one of the underlying themes throughout the movie *Something New* (2009). A dialogue between the interracial couple captures what is meant by black tax:

Brian: Hard day?

Kenya: Annoying. This client is a trip. I have to go back into the office tomorrow and he's second-guessing everything I do. I have to double-check my work just in case. That old black tax.

Brian: black tax?

Kenya: Yeah, you have to work twice as hard just to prove yourself equal.

This dialogue highlights the difficulty black people sometimes face because of racial stereotypes. In this example, Kenya's experience was also compounded by gender stereotypes. Stigma can also occur when black people feel like their White acquaintances are treating them like honorary Whites (Durrheim et al., 2011). The Black middle class often experiences this, where there are references to their levels of education, the way in which they speak English and how they behave as compared to other less educated Black people. The trouble occurs when ambivalence is experienced due to their identity being constructed by their White counterparts (Durrheim et al., 2011, p. 45).

Self-stigmatisation occurs as a result of negative associations of blackness, which is a result of the way in which Black people talk about and with each other. For example: "African time" which implies that Black people are always tardy and late. Another: "Oh! Muntu omnyama!" an expression directly translated as "Oh! Black person", which implies that Black people often make blunders due to being uneducated. These stereotypes are often articulated and perpetuated by Black people, which serves to self-stigmatise (Durrheim et al., 2011). Alexander (2013) suggests that unless we address race thinking, the racial and social order will prevail.

3.7 Racial stereotypes and women

The silencing of black women's voices in the professional space may be partly due to the presumed homogeneity of racial and gender experiences, so it is necessary that the raced and gendered experience of black women in such spaces is explored (Maodzwa-Taruving & Divala, 2014). Some of the barriers for black women within the workplace occur because of racist stereotypes compounded by intersecting gender stereotypes (Wildschut & Gouws, 2013). Stereotypes of intellectual inferiority and perceived bad attitudes often get in the way of their progressing to executive positions (Holder et al., 2015; Ncayiyana, 2011). This may lead to feelings of being undermined and black women experiencing a number of tensions. In the academy in South Africa, for example, where black women remain underrepresented they are also likely not to be taken as seriously (Maodzwa-Taruvinga & Divala, 2014). Therefore, the tension experienced happens on both a personal and political level that shapes the black woman's professional identity. Women in corporate America have reported feeling the pressure to constantly prove their competency and at times are subjected to surprised looks from their White colleagues when they disprove initial assumptions (Holder et al., 2015). This may limit black women's access to social capital within the workplace, thus creating a sense of invisibility (Holder et al., 2015). Black women sometimes adopt adaptive coping mechanisms that assist in dealing with implicit racial slurs and behaviours within the workplace. This is a process called "armouring", a form of socialisation for black girls that teaches them how to be resilient in the face of racial discrimination. This includes being presented with certain attitudes and behaviours that are considered socially appropriate for two cultural contexts. This aims to promote a sense of self-worth and grace in a context where Black women are often undermined because of their race and gender.

3.8 Black consciousness & understanding black South African subjectivity

Steve Biko, who became politically active at a very young age, attended the University of Natal Medical School where he co-founded the South African Students' Organization (SASO) (Mgxitama, Alexander, & Gibson, 2008). In the book *I Write What I Like*, Biko (1978, p. 20) writes:

> The integration they talk about is first of all artificial in that it is a response to conscious manoeuvre rather than to the dictates of the inner soul. In other words the people forming the integrated complex have been extracted from various segregated societies with their inbuilt complexes of superiority and inferiority and these continue to manifest themselves even in the 'nonracial' set-up of the integrated complex. As a result the integration so achieved is a one-way course, with the Whites doing all the talking and the blacks the listening.

Biko (1978) clarifies his position by adding that he is not suggesting that segregation is necessarily the natural order, but cautions against hasty movements towards racial integration. Mangcu (2013) later echoes this idea by critically examining how a policy of racial redress is proposed and implemented in South Africa. Both Mangcu (2013) and Biko (1978), at different historical times, view efforts to achieve racial integration and redress as driven by White people who regard themselves as progressive and nonracist, and who may, from their point of view, hold noble ideals. Mangcu (2013) problematises the idea of having such policies being conceived and implemented by, predominantly, Whites who may hold a position that is subjective and discriminatory, but without full awareness of this (Mangcu, 2013). In other words, "expecting the slave to work together with the slave-master's son to remove all the conditions leading to the former's enslavement" (Biko, 1978, p. 20). Ratele (2015), drawing on Biko's assertions, argues that ideas of integration based on assimilating

black people into already established White institutions should be strongly opposed. However, he also highlights the need for further discussions on transformation and integration.

Biko suggested that Black people in South Africa have a 300-year-old sense of inferiority to overcome (Hook, 2004). This sense of inferiority not only lowers their self-confidence, but also threatens their self-hood, rendering them passive (Hook, 2004). He proposed that Black people be rehabilitated by instilling them with a sense of dignity; pumping life back into their empty shell and ultimately restoring their sense of pride (Biko, 1978). Hook (2004) reiterates that Biko was not ultimately opposed to integration in South Africa; he draws attention to how Biko energetically emphasised that this ideal would be flawed and unrealistic until Black people become more critically aware of their positions through an "inward-looking process" (Biko, 1978, p. 29).

3.9 In sum, yes, Black lives do matter!

In this study I am concerned, not only with understanding Black subjectivity, but also with moving toward suggestions on how to improve Black lives and their experiences. This becomes of particular importance when we look at the medical training environment and how Black students experience it to an extent where Black medical students can fully occupy and trust their competency within the medical fraternity. Restoring confidence through a decolonial, and rehumanising process (Maldonado-Torres, 2016) we can restore the integrity Biko (1978) suggests we have lost.

There are a number of co-occuring and intersecting realities that shape the experience of Black registrars completing their training at historically White institutions. This study initially concerned itself with answering a broad societal question: how do we improve healthcare in South Africa? Then it evolved into questions about the demographics of

medical professionals in South Africa: what has medicine and democracy been able to achieve up until now? What do our doctors look like? What languages do they speak? These questions led to the focus of this study: the experience of training to become a specialist doctor in spaces that historically denied access to Black students. This asks fundamental questions about the training environment and transformation processes in post-apartheid medical training (the political) and the extent to which access and citizenship is experienced by students, in this case registrars, (the personal) within their training environment. The extent to which Black registrars feel a sense of belonging and at home in their training institutions has an implication on their professional development. Therefore, it was important for me to try capture their experience in an in-depth meaningful way. One that does not necessarily reduce experience to an average, but seeks to gain deeper insights into what it is like to train and advance in a context that does not always feel welcoming.

CHAPTER FOUR: RESEARCH DESIGN AND METHODS

4.1 Introduction: Research approach

I have chosen to locate this study within a critical qualitative approach. In this chapter I will highlight issues relating to qualitative research methodology and the use of this approach in the social sciences, particularly in psychology, and in this study. As a researcher, I want to understand the subjective experience of Black people within a particular context and how they negotiate their positions within their social world. I recognise that in undertaking this task I need to move away from binaries such as the researcher/researched divide. I am not neutral about the issues I am researching. I position myself as a *"racialised subject"* opposed to an objective observer (Serote, 2011, p. 80) and with the realisation that there may be unconscious bias that I may bring to the research process. As I shall show, the analytic approaches I use take account of this complexity. This complexity has ethical implications, and I end the chapter by looking at the ethical implications of my study.

Qualitative research is not in itself necessarily critical, and it has at times served to reinforce some mainstream ideas in psychology (Gough, 2015). However, particularly since the 1960s, qualitative research has been used to explore ways in which social change can be promoted. Feminist researchers have been instrumental in the development of experiential methods within qualitative research. This was with a drive towards taking subjective accounts seriously, seeing them as data, and encouraging reflexivity (Gough, 2015). A turn in social theory – influenced by Foucault – saw the emergence of research ventures centred on discourse. This was a way of challenging dominant discourses and their impact on disenfranchised groups (Gough, 2015).

From the 19th century, some qualitative research has set out to understand race and the politics of power (Denzin, 2017; Rohleder & Lyons, 2015). More recently, qualitative research within the social sciences has focused less on the study of categories such as race

and gender and more on the processes of change within and between these categories (Denzin, 2017). Though much qualitative research is concerned with understanding human experience, this is easier said than done. Exploring and writing about the human experience is a challenging task, especially when we are attempting to describe the daily experience of marginalised individuals (Richards, 2008). Through narrative data that explores attitudes, experiences and beliefs of a particular group, the researcher may be able to approach a picture of subjective experiences using a qualitative methodology (Liebschutz et al., 2006).

My own research is fundamentally concerned with understanding experiences. For this reason, I have adopted a qualitative approach. My concern is both with understanding the talk and experiences of participants, and also with considering what the data may tell us about broader questions such as transformation in higher education in South Africa. In terms of design, my study does not fall into a neat category. In some ways, my work can be viewed as a multiple case study (Stakes, 2005), but because of the broader political concerns this is also a study about power and how it is used, which links the work to discourse analytic approaches (Potter & Wetherall, 1978). My interest in understanding processes of exclusion and discrimination has led me to work within a critical qualitative research tradition. In terms of contemporary approaches to qualitative research, Denzin (2017) suggests that now is the time when researchers should be engaging in critical research that matters in people's day-to-day lives; research that is committed to addressing inequalities in the domains of health, education and the economy. He further explains that this type of inquiry is not merely qualitative research but rather an ethically responsible research endeavour and that it includes some of the following goals (p. 9): placing the voices of people at the centre of the inquiry, illuminating sites for change, and working to influence policy. Critical scholars highlight that the social world is interpreted and that people are constantly interpreting their own and other's experiences (Denzin, 2017). This is why it is important to understand how power

relations are represented and experienced through discourse. Given issues of power in the research process, it is important for me as a researcher to consider my own subjectivity in the research. The study was guided by attempts to answer the following research questions:

1. *What are the experiences of some black registrars in historically white training institution, in the Western Cape?*

2. *What are the issues they identify relating to transformation and institutional culture? What suggestions do they have for improvement in this regard?*

4.1.1 Subjectivity as a resource

I am a young Black health professional researching the experiences of young Black health professionals. Clearly, there are resonances between my experiences and those of my participants. Critical qualitative research draws attention to the complexity of social phenomena, and the researcher's subjectivity is part of the social phenomenon itself. In this tradition, a researcher's subjectivity is not simply a source of bias, but a potential resource for understanding the research material (Gough, 2015). This does not mean that bias is not an issue, or that insider status is by definition unproblematic. If subjectivity is both acknowledged and reflected on, there may be benefits to be gained from what Gough and Madill (2012, p. 382) call a *"reflexive scientific attitude".* This encompasses being open to including the personal within the research design, with an interest in both participant and researcher subjectivity. This attitude is in keeping with decolonial approaches to psychology, which require black researchers to acknowledge and take account of their own investments in the research they do (Maodzwa-Taruvinga & Divala, 2014; Maodzwa-Taruvinga & Msimanga 2014). Though reflexivity may assist research to be more critical as it challenges the idea of the researcher being detached from the process, there is some danger that self-reflexivity may shift the focus from the researched to the researcher. My primary interest in this study is not to explore myself but to understand others. In order not to allow self-analysis

to detract from the research problem, a separate personal reflexive chapter has been added to this dissertation. In keeping with traditions that value reflexivity, I believe that this account helps situate my work, and allows for a contextualisation of my findings and conclusions.

4.1.2 Study setting

The study took place in Cape Town. Most of the interviews were conducted in Cape Town, as this is where most registrars from both Stellenbosch University and the University of Cape Town lived at the time. One of the participants met me at the practice I was working from in Claremont, while most of them preferred that I meet them closer to where they lived as they met with me when they were not working.

4.1.3 Participant selection

The study set out to recruit the approximate total of ten to 12 Black medical registrars from both the University of Cape Town (UCT) and Stellenbosch University (SU), both male and female, and who are current registrars at the two medical schools in the Western Cape (see Table 4.1.) Participants were selected based on ease of access. The study excluded supernumerary (non-South African) registrars to only include Black South African registrars. A study (Peer, Burrows, Mankahla, & Fagan, 2017) conducted at UCT suggested that there are personal, and especially financial, challenges faced by supernumerary registrars that could result in a qualitatively different experience of the training environment. A snowball sampling method was used for this project, relying heavily on the assistance of members of the Harambee organisation (I will discuss the organisation below) that had easier access to students. The aim of this study was not to gain generalisability from a set of people to illustrate averages of experience. Rather, it was to gain insights into the meaning of Black experience and how this is negotiated within medical specialist training (Lyons, 2015). The participants recruited are training in a variety of medical specialist disciplines, as it has been

argued that different specialties have different micro-cultures (Breier & Wildschut, 2006). Some difficulty was encountered during the recruitment process with SU registrars. There are still significantly few Black registrars at SU, which was a huge factor. Twelve registrars from SU were contacted via email with a very low response rate. Subsequently, eight SU registrars whose cellphone numbers were acquired through Harambee were contacted by phone calls, and ultimately six were recruited. At the time of interviews only five from SU were interviewed as one registrar withdrew participation. The recruitment process at UCT was far easier as there were more Black registrars. A medical officer known to me indicated one name that I could approach for participation. They agreed, and snowballing came to effect as they indicated colleagues that may be interested. Six UCT registrars were recruited and interviewed. Nineteen interviews were conducted in total.

Table 4.1

Demographic Characteristics of Participants Using Pseudonyms

Participant	Gender	Institution	No. of interviews
Siyanda	F	SU	2
Phila	F	SU	1
Mteto	M	SU	1
Mandla	M	SU	2
Thuli	F	SU	2
Nonhlanhla	F	UCT	2
Tokelo	F	UCT	2
Lulama	F	UCT	1
Tshepiso	F	UCT	2
Tumelo	M	UCT	2
Zama	F	UCT	2

4.2 Method of data collection

Interviews are used to gain detailed accounts from participants about the topic under investigation. They provide descriptions of a person's experience (Lyons, 2015). In-depth semi-structured interviews, where questions were mainly open-ended, were used, guided by an interview schedule (see Appendix A). The style of interview was mostly conversational in an attempt to get the participants to provide me with a narrative of their journey through medical education while highlighting things that would be interesting for my study. Therefore, a commitment was made to balance my agenda with allowing room for what was important for them to share, rendering the process democratic and flexible (Gough, 2015). Semi-structured interviews were useful as they allowed me to hear the participant speak about their experience, as the questions asked functioned as triggers that encouraged conversation (Willig, 2008). Semi-structured interviews are widely used in qualitative research, as this allows for analysis in various ways. As a clinical psychologist I used reflective skills during this process.

4.2.1 Individual interviews with Black medical registrars

A total of 19 interviews were conducted with registrars from SU and UCT. An effort was made to conduct two interviews with each participant, and each interview was approximately an hour long. While this was difficult, with some not being able to commit to two interviews due to their busy schedules, low attrition rates were experienced. The reasons for two interviews per participant was primarily to give participants the opportunity to reflect on key issues and the research process, to deepen rapport and trust over time with me as the researcher (I am a trained clinical psychologist), and also to allow participants the opportunity, should they wish, to engage more affectively with material discussed. Interviews mostly took place at a venue and time most convenient for the participant, which in most

cases were in confidential surroundings at their work sites. Interviews were audio-recorded and transcribed for analysis and interpretation. The interviews were wide-ranging and started with discussion of the participant's decision to become a medical doctor, up to current experiences. The reason this narrative historical approach was taken is that personal history provides an important context to understanding current challenges and achievements (Gergen & Gergen, 2008; Gibson, 2015).

4.2.2 Focus group

Following the individual interviews, a focus group discussion based on some of the key themes raised was conducted. The purpose of the focus groups was for respondent validation. Respondent validation suggests that the researcher goes back to the participants with tentative themes, and the findings are then refined in light of the participants' reactions (Silverman, 2013). A total of six current registrars from both UCT and SU were recruited based on willingness and availability to take part in a group – and an hour and half discussion was facilitated. Focus groups use the interaction among participants as a form of data (Willig, 2008). The researcher takes on a facilitative role gently facilitating the discussion for the purposes of data collection. This group process provided a platform to address questions about the attitudes regarding registrar training and ways in which participants jointly construct meaning were observed. Focus groups provide an alternative to individual interviews that is less artificial, strengthening the validity of the data (Willig, 2008). This process was audio recorded and transcribed for analysis. Data that emerge from this process was also used for interpretation purposes.

4.3 Method of data analysis

4.3.1 Thematic analysis

Thematic analysis (TA) is used for identifying, analysing and interpreting meaning through patterns (Braun, Clarke, & Terry, 2015). TA was used to initially summarise and organise the data into clusters and themes (see Appendix B). With this type of analysis, data are organised into identified themes, and patterns are recognised through continuous reading and re-reading (Braun & Clark, 2006). Thematic analysis allows for rich descriptions for the narrative report and uses the data for interpretations, which would attempt to answer various aspects of the research questions (Braun & Clark, 2006). This analysis aims to determine the meaning of categorised themes that emerge from the data (Yardley, 2004). Data from the interviews and focus groups were entered into Atlas.ti., a data management software that assists with the analysis of textual data. The data were coded with an eye for identifying common experiential themes within the text. Experiences that counteract or disrupt these trends were noted. The six-step guide to doing TA was followed (Braun & Clarke, 2006; Braun, Clarke & Terry, 2015, 2019):

1. *Familiarisation*

This phase requires the researcher to immerse themselves in the data with an appreciation of what they are engaging in as it is. At this point it is not about attaching any label or making extensive notes (Braun et al., 2019). It is about looking at the data and, in my case, it included listening to the audio recordings, making brief notes about important discourses. After transcriptions were done it also involved reading and re-reading the data in text and I started noticing interesting discursive features.

2. *Generating codes*

This phase denotes a more systematic engagement with the data in order to make sense of it. This phase of analysis involves organising data into codes through the

organisation of data into clusters of similar content. An inductive approach was used to generate codes. For this phase of analysis a research assistant and I did the coding in order to have a more reflexive approach to TA (Braun et al., 2019). This is with the understanding that as the researcher I go into the inquiry with some form of a theoretical lens, which may influence the emergence of meaning. A process of sending clusters back and forth to one another occurred in order to qualify the codes.

3. Constructing themes

At this phase in the analysis themes are constructed "at the intersection of data, researcher experience and subjectivity, and research questions" (Braun et al., 2019). Initial themes were constructed in line with the theoretical orientation. Themes I settled on were those that allowed for a meaningful narrative to emerge that answered the research questions.

4. Reviewing themes

This is the revision stage where the quality of the constructed themes is looked at (Braun & Clarke, 2006; Braun et al., 2015, 2019). This phase was a difficult one – one that my supervisor would likely call "killing your darlings". I had to decide, as Braun and Clarke (2006) suggest, whether a theme was indeed a theme or just a code. Some themes made sense conceptually but could not survive as stand-alone themes, and had to be left out or combined with another. Braun and Clarke (2006) suggest also looking at each theme against all the data in order to spot overlapping themes and to also see how themes interact with one another (Braun et al., 2019). Themes were tabulated with quotes from different clusters in order to have a visual representation of how themes relate to the data as a whole. The textual fragments that most closely describe the experiences that have been shared by the participants were selected and grouped according to themes. The predominant themes created a picture of how Black medical trainees understand themselves in a specific social context and the narratives that accompany these positions.

5. Naming Themes

The exercise of naming and defining themes comes from having carefully engaged with the data and defining the scope of each theme (Braun et al., 2015). The name of the theme is important as it gives the reader an indication of what to expect. The terms used were informed by the theoretical positions chosen (Braun et al., 2019).

6. Producing the report

This phase is not just about writing up the data but also to further determine whether the themes are appropriate in answering the research questions (Braun & Clarke, 2006). It also determines the direction the research is likely to take. This can be considered the final phase of analysis (Braun et al., 2019). This phase determined the type of existing research to be engaged with and the connections thereof, as this has implications for the discussion on findings. Again, the theoretical underpinnings determine how the data, at this point, is discursively presented (Braun et al., 2019).

4.3.2 Psychosocial studies

As discussed above, deriving meaning from patterns within the data and how interview data are read is a subjective process. For this reason, this research has some social constructionist underpinnings, and as such looks at what is said as constructed and influenced by the socio-historical context (Young & Frosh, 2018). Reflexive awareness has grown to be an important feature in qualitative research (Young, 2011), therefore a psychosocial studies lens was used to further analyse the data. One of the important features of psychosocial research is how it does not separate the personal from the public (Taylor, 2017). Gibson (2015) argues that it is possible to respect the narrative integrity of, and recognise the co-constructions of interview data, while drawing on the clinical psychologist's armamentarium of insight drawn from psychosocial studies, which is based on psychoanalytic theory. Here,

interview data is taken as is, and then through a discursive analysis is looked at for connections, contradictions (if any), silences, and invites the feelings of participants while taking into account the researcher's responses (Taylor, 2017). The affect – otherwise known as the emotional – can be seen as disruptive (Young & Frosh, 2018). This is the kind of disruption that is welcome in this type of research, therefore it was important for me to add this element of analysis to this study – an analysis that is *"specifically attuned to breakdowns in narrative form – moments that are marginal"* (Young & Frosh, 2018, p. 200).

Psychoanalysis has been used to interrogate the persistent nature of racism (Young, 2011). This approach demands that I be reflexive about my own emotional investment in the construction of data, and in the format interviews took. In this analytic model, supervision by a researcher trained in these methods was essential, as was a high degree of self-reflection. Young (2011, p. 48) highlights the following with regards to reflexivity:

> Reflexivity therefore becomes more than simply describing the researcher's investment in their work, rather the interview is understood as a developing out of a context in which the dynamic relationship between the researched and researcher co-constructs the unfolding narrative.

It is for this reason that a personal narrative on the journey through psychology is included in this body of work.

4.4 Ethical considerations

Ethical approval for the study was obtained from the Health Research Ethics Committee of the Faculty of Medicine and Health Sciences, Stellenbosch University (ethics reference number: S16-02-031). The data from this study yielded sensitive and personal content. This may have resulted in medium risk for the participants, hence it was important to

try limiting the possibility of unanticipated harm. With this in mind, participants were invited to volunteer for participation in the study by form of a letter that outlined the purpose of the study and their potential involvement. Participants signed a consent form after reading the information provided to them outlining the procedures (Willig, 2008). I am a trained clinical psychologist and therefore had the experience to assist with many of the emotional aspects of interviewing. Two registrars reported that they needed psychological services, and they were referred to providers that they felt most comfortable seeing. They indicated wanting to be seen by Black psychologists. All confidential data is being kept in a secure password protected computer. Care has been taken to ensure that identifying information of the individual registrars is unrecognisable when data are published.

4.5 Concluding comments

This study took on a contemporary qualitative approach – aware of its subjectivities and bias – noting how they can be limiting, but also as resourceful tools to understanding lived experiences of a particular group. Especially, when I am part of that particular group and, in this instance, a Black health professional pursuing a higher degree. This bias and emotional investment has been recognised and deliberately included in the research process. As such, it was important for me to also situate myself within the research process.

CHAPTER FIVE: SITUATED KNOWLEDGE AND PRACTICE

INTRODUCTION

This chapter includes an article I have published in the South African Journal of Higher Education (Shabalala, 2018). This body of work is included here because it helps situate me, a Black clinical psychologist in South Africa, within the current study.

FEELING SOME TYP'A WAY: A YOUNG BLACK WOMAN'S EXPERIENCE OF EDUCATION IN SOUTH AFRICA

"Feeling some typ'a way"

When I walk around Stellenbosch, particularly areas closest to the university, I immediately feel *some typ'a way* (type of way). Now, I could put it differently, but I cannot fully articulate the feeling, and all I know is that it is uncomfortable. When I tried to describe this feeling to my (White) supervisor when he asked me what it meant, I was tempted to say, "nobody knows, but it's provocative"[1] which is true, but I thought that was enough hip-hop for one session. Shelbe (2013, 16) describes *some typ'a way* as a set of strong, complex feelings mostly associated with anger, disappointment and sadness. There are undoubtedly many factors that predispose me to feeling this way within that setting, however, what interests me is the internal dialogue that takes place as soon as I set foot on campus and how I manage issues of difference.

In pursuing this study, the process has been emotionally evocative for me because I am constantly confronting my complex positioning as a young Black female psychologist. For example, I represent the small number of Black students who have been fortunate enough to have easier access to education – I have gained a lot from policies such as affirmative action (Alexander, 2013). However, our country's traumatic history (which I have not

experienced directly) still seems to carry some weight in terms of my day-to-day experiences. I have experienced wanting to fit in to a setting where there are only a few Black people, and I would try as far as possible to assimilate to the context while attempting to preserve my Blackness. As a result, I embody "different shades of blackness" in different situations and contexts (Maodzwa-Taruvinga & Msimanga 2014, 2061). Changes in theory over time have led to more contemporary understandings of culture. Emphasis is placed on how cultural identifications are porous and ever-changing. People may inhabit multiple, and at times contradictory, cultural positions simultaneously and these may change in different situations (Swartz, 1998). Developing understandings of how people are positioned is important. It is particularly important to engage with how multiple positionings work together to influence the experience of Black people. The article looks at moments where I have had to negotiate whether I stand in solidarity with my fellow Black people or if I dare to have a differing opinion. Maodzwa-Taruvinga and Msimanga (2014) discuss what they have conceptualised as processes of *essentialising* the Black experience and *differentiating* the Black experience. Their experience of being foreign nationals and academics at a South African university highlights moments where they were expected to stand in solidarity with other Black academics in challenging structural inequalities faced within higher education while at times being excluded by local Black academics because of perceived preferential treatment given to foreign Black academics by Whites Maodzwa-Taruvinga and Msimanga (2014, 2060). They described this experience by making an analogy of a swinging pendulum, which resonates with me. I have often felt ambivalent about where I fit in, as there have been times where I have felt excluded by other Black people because of the schools I have attended or how I spoke English.

In this article, I discuss the complexity of my own positioning, using an autoethnographic approach and tracing my own history. Parts of this article may make for uncomfortable

reading, which is to be expected with employing an auto-ethnographic approach. This is in line with the emancipatory discourse feature of auto-ethnography where I am allowed to say the "unsayable" (Richards 2008, 1722). I choose to speak about emotion in as candid a way as possible as Richards (2008) has suggested. It is also in an effort to challenge dominant discourses that have, in the past, served to marginalise certain groups of people (Gough 2015). This approach also allows for a richer description of the individual experience and makes it possible for certain assumptions about the human experience to be interrogated (Richards 2008). One of the features of contemporary academic writing in auto-ethnography is that it disrupts the conventions. Jones (2016, 229) highlights that the "critical" feature of critical auto-ethnography teaches us that theory is not a "static and autonomous set of ideas". He further explains that theory and storytelling constantly influence each other. Critical autoethnography commits itself to a collaborative dance between theory and storytelling and allows us to engender and embody change (Jones 2016, 230). Some queer theory is discussed in Jones (2016) as he highlights how its disruptive nature influences the style of writing that is found in critical auto-ethnography. The format of the article and the style of writing employed is unconventional and at times informal, which is in line with critical auto-ethnography.

SETTING THE SCENE: EARLY DEVELOPMENT AND PRIMARY SCHOOL

I was born, and lived, in a township for the first 11 years of my life. As semi-dramatic as that opening line is, I have no horror stories about growing up in the township. Despite resources being limited and being raised, at the time, only by my mother, I was happy and healthy. I cannot say I have experienced apartheid, nor did I grow up hearing traumatic stories about it. However, there would be passing comments about White people that I would pick up when the adults were talking and they were never positive. I went to a multi-racial crèche in 1993,

and in 1996, I started grade 1 at a predominantly White school. In earlier years, some Black children would have to repeat grade 1 or 2 because of their lack of proficiency in English. I asked my mother once how it happened that my cousin, who was two years older than me, was in my class, and she explained that he still had to improve his English. I travelled out to school every day by bus with my mother, but there was a school directly opposite to where I lived. At times, I would wonder why I had to wake up so early to get to school when there was a school less than five minutes away. I soon got the sense that I was in a privileged position, and fortunate that my mother could afford me better education.

Walking from the bus station to my house was anxiety provoking. I did not like having to get home when the school children from the school opposite my house were still around. There was a sense of animosity I felt from them, I was always teased for being small, for being scared and for going to a former Model C school. Some children in my street went to predominantly Indian schools, so I also did not really relate to them either. I became very aware that the education that I was afforded was better and that it took a lot of sacrifice from my mother.

I coped well academically, and my mother was able to assist me with homework when I needed it. What was difficult was the compulsory extra-mural activities and sports, at least one of each, as was stipulated in the school rules. I dreaded swimming because it always felt like I was drowning, and as a result I hated physical education (PE) in summer. After school, I played hockey (while most of the other Black girls played netball) and I liked it, but this meant I would have to get home late because I would miss my regular bus. At times my mother would try to organise for me to get picked up by my uncle or a relative because we did not have a car at home. Practice was compulsory, and so were games. I, like many other children that lived far from school and whose parents did not have cars, knew that we would

have to pressure our parents to find a way for us to be there or we would have to suffer the consequences; being demoted, benched or even detention.

When I was in grade 6, my mother and I started looking at high schools. She considered where I wanted to go; we also explored fees and the distance from home. It dawned on me at that point that education was directly linked to finances. After many conversations, my mother and father agreed that I would live with him and attend school where my half-sister was. I went to an all girls' private school; it was a traditional Anglican school and at the time with very few Black girls. It was a relatively small, conservative school with a strong Christian ethos. A sense of community and fellowship was encouraged, however in my second year of high school (standard 7) the grade went into what psychologists call a storming phase. We were less cohesive, and as Black girls we became defensive. Because we represented the minority, as Black girls we stuck together, and we had a sense of familiarity that comes with speaking the same language. However, we noticed that the White girls would become suspicious of us when we spoke in Zulu. Although it was not an official rule, we were discouraged from speaking Zulu during school hours as it was considered rude to others that did not speak the language. It felt like we were fighting a losing battle at a point, but we shied away from calling it discrimination or racism. I know I felt quite ambivalent about racial dynamics when others felt strongly about our right to speak our language as it came naturally to us, and we were not doing it to exclude anyone.

The tension became very apparent during school camps where we would group ourselves on the bus and in the dormitories. The teachers, again, would discourage us from speaking Zulu and we obliged. When they were not looking, we would do so deliberately and loudly to the annoyance of our White classmates. I felt that I had to stand in solidarity with my fellow Black girls, especially because I did not want to be considered a traitor, but I also did not

want to rock the boat with the teachers. We had two Coloured girls, four Indian girls, and we were six Black girls out of a grade of 52. Girls of colour were out-numbered; the Black girls felt ostracised, the Indian girls' silence was deafening, and the Coloured girls did not know which side they fell on. Despite noticing the tension, the teachers did not do anything, until one night a racist comment was made by one of my White classmates after being frustrated with our deliberate defiance. We immediately stopped talking and confronted her, which brought her to tears. I was infuriated, and that night I was no longer ambivalent. After camp, we were sent to the school counsellor who tried to reunite the grade again. We protested and asked why it was acceptable for the Afrikaans girls to speak their home language at their leisure while we were shamed for speaking ours. We were told that the majority understood English and Afrikaans, and we would have to comply with the ruling. After some time, we lessened the use of Zulu when in the presence of our peers and things seemed to normalise until we had to choose subjects going into grade 10. We were told that English 1st language and Afrikaans 2nd language were compulsory, and we were free to choose all other subjects guided by the aptitude test we took and feedback from our teachers. Only one learner in our class was exempt from doing Afrikaans, and this was because her primary school education was not in South Africa, so she could do French or German as an alternative. French was a subject that was offered by the school, but if she elected to do German, she would have to get a private teacher in and still get her full credit. I did not think anything of it, as I was competent enough in Afrikaans and it was how things were. However, my comfort with taking Afrikaans was not shared by three of my fellow Black girls. My best friend was also competent in Afrikaans, but felt that if an exception could be made for an international student (as she would not be competent in the language), why was the offer not extended to the Black girls that struggled with Afrikaans. She further pointed out that some schools, including those on the Independent Examination Board syllabus like ours, had the option of

taking and being examined in Zulu as an alternative to Afrikaans.

The responses from the headmistress and the grade head varied from, but we chose to go to that school knowing what the curricula structure looked like; to the school does not have the capacity to offer this; to those girls being looked at as if they were antagonists. Eventually they were told that if they found their own teacher, and paid privately, they would be able to take Zulu as a second language instead of Afrikaans. I felt anxious and ambivalent again, I knew that I would struggle with Zulu, as I had not taken it as a subject before. I lived in the boarding establishment, so I would not have my parents to help me either. I knew I would not fail, but Zulu literature would be challenging. I decided not to drop Afrikaans, but felt that I was missing out on an experience, and to an extent I felt that my Blackness was diluted. For the rest of high school our grade seemed to repair the rupture and maintained pseudo-homogeneity.

UNDERGRADUATE TRAINING

During my undergraduate training, I was enrolled at the University of Pretoria (UP). Moving into my residence at university was exciting. I met my roommate, who was Coloured, and we bonded over being from Kwa-Zulu Natal. We both started noticing that Black girls were placed together, and similarly White girls. There was no other Coloured girl in our year, and they placed us together because we were from the same hometown (and only after checking with the Coloured girl's mother if that was alright). As weeks went by, we noticed that Black students formed a minority across disciplines and faculties on the main campus, while on the campus we lived in, the education campus, we saw more Black students. There was a men's residence closer to main campus that was allegedly only for Black male students, which had just closed, and those students were then reallocated across men's residences. The rumour going around was that the resources were poor at that residence and they had to find a way to

house the male students without ruining the 60 per cent White/40 per cent Black policy at residence. It was very confusing as to what the actual housing policy was (although this could have been easily read up on) because of rumours that were spread around it. The rumour was that no more than 40 per cent representation of Black students would occupy the residence, and I, like many, believed it to be true. This made integration difficult; I gravitated towards Black and Coloured students and was wary of White, Afrikaans students, especially those who elected to attend Afrikaans lectures.

The rumours progressed gradually throughout my undergraduate studies. Some of my friends and I started to think that we had to compete with each other in order to be allocated into housing the following year, and to get into the honours programme. We believed that our race was considered before our capabilities. This pulled me further away from White students, but I also secretly hoped that my marks were among the top achieved by Black students in order to secure my place. It was a confusing time for me; there were some White students (predominantly English) that I got along with, and I was a good student but felt not good enough. It felt a little like “culture shock”.

This made my journey through anthropology more interesting as we were discussing ideas relating to culture, race and South Africa. The professor was talking about culture and race in post-apartheid South Africa. Although I cannot quite remember what he asked, I remember describing how I had experienced culture shock during my undergraduate studies at that university because racial discrimination seemed so blatant. Having briefly forgotten about my grade 9 year, and the difficulty some learners faced with Afrikaans, I described coming from a tolerant, conservative all girls’ school that believed in unifying us. I described being shocked at the racial tension at UP. The professor asked if every part of me as a Black girl was embraced at my high school, or whether I had to assimilate to gain that tolerance.

Memories of some of the difficulties I had faced in my education up until that point flooded. I remembered the helplessness I felt as a township girl, the anger I felt in grade 9 and the ambivalence I felt when I chose to do Afrikaans instead of Zulu. I soon realised that, as a Black female, my position was far more complex.

POSTGRADUATE STUDIES

In my honours year as a psychology student things were even more competitive. The class had shrunk considerably, and we were aware of how difficult it would be to get into a master's programme. At this point the White students were so aware of our supposed powerful position, where we were likely going to be chosen over them because of being Black and, in my case, female. This gave me a sense of comfort, but I also did not like the undertone of what was being said. It felt to me like my potential and academic progress was being undermined by the quota system. I appreciated that more women of colour were getting opportunities, but I also wanted to be recognised for the hard work that I had put in up until that point.

I applied to two programmes, master's in research psychology and master's in clinical psychology. I was reluctant to apply for clinical psychology due to horror stories I had heard about the selection process. My true intention was to apply at Stellenbosch University because I did not think I would get into an Afrikaans institution, and would finally get a chance to take that gap year. I also thought I would not get in because I was too young. To my surprise, I was shortlisted and invited to the selection process where I was cautiously optimistic. The selection process was anxiety provoking, and feelings of being out of my league set in. However, I got through the week, and by the end of that week learned that I was selected. I was very excited and definitely shocked. I sent a message to a friend; let us call her Phumla, who was in the honours class with me to inform her of the good news. In excitement,

she shared the news with our class. She conveyed the congratulatory messages, but she also informed me that some of the White girls in our class then made a comment about me getting in because I am Black. I was so disappointed to hear this, and although I was proud of myself, I could not help but wonder to what extent this was true or rather how much of me being Black swayed the decision to admit me into the programme.

A fraction of us received placement invitations with the majority of those being invited into the research programme. I was the only Black student in my class that made it into a clinical programme, and I felt somewhat ostracised by my peers, both Black and White. Although I was always prepared and did well in my honours year, I carried with me doubt and anxiety as I went into my master's.

I had inspected the mailing list to see if I could spot another Black name, and I realised I was the only one. There were three Coloured people in our class, but in my head that did not count; I was the only Black person in the class and I was terrified. This reinforced ideas I had of being selected for the programme for the university to maintain a political correctness. When I met some of our lecturers and classmates, they all commented on how tiny I looked and how young I was, which made me feel even more out of place and inferior. This was not because of the reception at the programme, but rather my own insecurities. I was not sure I could compete at that level, and was horrified at the possibility of being that Black girl that was given an opportunity and failed. By the end of the orientation week we had been given readings that took up a quarter of my very small bachelor apartment. I felt so overwhelmed by Friday and regretted not taking that gap year. One of my classmates reassured me that we were all feeling the same way as we cried together. I appreciated her saying that, wiped my tears and was determined to work hard. I also irrationally thought that because I was especially selected for quota purposes, I could not give the department reason to regret

selecting me. In the second week, we chose our community projects. These would form a large component of our final marks, and ran throughout the course of the year. We had heard a bit from each lecturer that supervised the placements, and from there we would choose which projects we wanted to do. One of the community projects was based in Kayamandi, a Xhosa community in Stellenbosch. As soon as the project was introduced my classmates looked at me, like it was a no brainer that I would go into that community. Before learning about what the placement was about, it felt to me like a decision was made for me despite us being told anyone could do whatever project. I asked myself, what if I was Setwana speaking, then what? I would still face some challenges. Fortunately, I liked what the project entailed.

I struggled a lot during my master's year; my academic writing skills still needed to be developed, and writing psychodynamic formulations seemed like a skill set way beyond what I was capable of. In retrospect, I had placed a glass ceiling over my head and my inferiority complex grew from task to task. I believed I was the only one struggling, because others' admission to the programme was based on merit, unlike me. My current academic mentor reassured me during research supervision that the department selected me on merit, and that even if the quota was a factor, it was not the only reason I was there. Some of my supervision sessions, both clinical and research, felt more like supportive therapy, which served to contain me for a bit. Despite feeling exposed, I pushed on. I was asked at point if I wanted to go on the two-year track, also because my research topic was considered too big for a mini dissertation. I was adamant that I wanted to stay on the one-year track. I had to prove that I deserved to be there.

Still determined to pass, the year went on and we were informed that we would have to apply for internship placements. We visited the hospitals that offered internship training to get a sense of where we wanted to apply. We were also told that spaces are limited at each of the

placements, and I knew I had to get myself ready for yet another contest. Shortly thereafter, we were all invited to interviews at the placements. The first internship interview invitation was for a historically Afrikaans hospital that still caters for a mostly Afrikaans population. I remember asking my clinical supervisor if I would have to conduct psychotherapy in Afrikaans. She said no, but also indicated that the population was largely Afrikaans. Although I had a basic understanding and could speak some Afrikaans, I did not feel comfortable. The first thing that made me uncomfortable was the fact that I would not typically engage in a conversation in Afrikaans, and the second reason was how Afrikaans is spoken of by many Black people. It is largely associated with apartheid and I have heard reference to it being called "the language of the oppressor", a language that was imposed on Black people.

I still went to the interview, somewhat distracted because I had to be back on campus later for a client. The reception was warm and not too intimidating; they explained that there was a representative from human resources to ensure that the process was fair and equitable. The interview was not too bad, for the most part, until they pulled up my application form and saw I indicated that my Afrikaans was poor. I purposefully indicated my proficiency in Afrikaans as poor, so that there would not be an expectation for me to speak Afrikaans. They highlighted what I had indicated, and I asked if it would be a problem. They said no, but cautioned about the expectations from some patients and asked how I would handle this. I responded and said, for the sake of rapport building, I would allow the patient to speak in Afrikaans, ask them to try to explain in English when I did not understand and would ask if I could respond in English. One of the interviewers then asked, "maar, hoe is jou Afrikaans?" I reluctantly responded in Afrikaans, "ek probeer maar net". They all delighted at the fact that my Afrikaans was not as poor as I endorsed it to be, and the interviewer added that she could tell I had spent some time in Pretoria. Apparently, I spoke Afrikaans like they do in Pretoria –

I ironically refused to speak in Afrikaans while I was in Pretoria. It felt as though a lot more time was spent on the language issue. It led to me thinking that in order to survive that placement, I would have to assimilate. I was not against assimilation per se (I was not that critical a thinker yet), I was afraid I would fail at it. I knew I was not comfortable consulting in Afrikaans. It was difficult enough trying to counsel adolescents in Kayamandi in Zulu; I could not imagine attempting to do so in Afrikaans.

In other interviews my language proficiency was highlighted in terms of what I could do. I took pride in being proficient in more than two languages: English, Zulu, Xhosa, and basic Setswana, but also started noticing the word "diversity" being thrown around. I started becoming very aware of that and became less comfortable with it, as it reinforced my fear of being hired solely on the basis of me being the diversity within the department. Here, I use this word ironically to indicate that I represent a diversity in that I was a person of colour but in my experience I came to embody the whole enterprise of diversity – what I have chosen to call "being the diversity". I would silently get angry when some lecturers would allude to what an asset I would be because of my race and language proficiency. My classmates would also comment, saying it should not be difficult to place me, almost as though I had no right to be anxious about whether or not I would get a placement. My experience of what was being said was not positive, regardless of whether it was meant to be or not. The recurring thought for me was: "I will never be taken seriously as a psychologist in South Africa". This goes back to what I mentioned earlier; that if I am chosen for equity's sake, I will never know if I am truly competent enough to be there.

I never spoke about my fear or anger, but expressed my anxiety about not being able to pass the year. They reassured me the best they could with the limited information I would give them in terms of my emotional experience. I started becoming very ill towards the end of the

year with irritable bowels and migraines, which is consistent with being anxious. There were depressive moments, which I was reluctant to share for fear of exposure and I wanted to make sure the supervision frame was maintained. I got placement offers, and before I knew it we were preparing for our final oral examinations. For the first time, I spoke freely about how difficult my master's training was and how alone I felt at times. I had not planned to be so candid, but I felt they needed to know where I struggled and where I felt more support could have been given. I became very vulnerable during my oral, but I did not sit with any shame or guilt because I knew that was the end. Despite my difficulties, and perceived incompetence, I was one of five that graduated within the minimum required time, from a class of ten. I was very overwhelmed on graduation day and had the diarrhea to prove it.

The following year I started my internship at a smaller hospital with a range of experience. I chose that placement because it seemed less intimidating and had more people of colour in the department than the other sites. As interns, we had a lot of autonomy with opportunities for learning to take place. I made a commitment to trust what I had learned, and myself. I also received positive reinforcement, which I was able to metabolise and gained some confidence. My research supervisor stayed in touch and he made a commitment to become my academic mentor. We soon started looking for opportunities to further my studies. I am not sure what he saw in terms of my potential, but for me it was an opportunity to gain more confidence. I thought pursing a Ph.D. would prove to me, and others, that I belong in that space. The thought of pursuing my Ph.D. contained my anxiety regarding what I believed others felt about my presence in the university, the master's programme and in the hospital.

The final phase of my training was my community service year. This is an initiative where the primary aim is to extend healthcare services to all South Africans, but more specifically in areas that were and still are underserviced. This was in response to many medical doctors and

health professionals leaving the country after qualifying. The idea was for them to give back to the community for a year before pursuing their careers abroad or privately. This mandatory community service year also applies to clinical psychologists. I completed my community service at a township hospital where the racial demographics were more favourable, as in more Black people. I no longer felt a sense of being under constant surveillance or scrutiny. I had less supervision, and relied on some of my colleagues for feedback on cases, but I felt an incredible sense of confidence. Our department was made up of a few psychologists; two of us were community service psychologists. We had one White, Afrikaans female psychologist who seemed to mirror some of my experience in Stellenbosch. She and I became good friends and often spoke about issues of race and belonging, with me being more curious than she was. What struck me about her was that she seemed to have an ability to take the context in her stride. I used to wonder if she felt any discomfort, and if she did, how she handled it.

We had a discussion about her experience, because I was very curious to hear if her experience indeed mirrored mine. She told me that she was aware that she was different and that at times would need to compensate for that difference. She expressed that she felt a need to work hard to challenge stereotypes relating to Afrikaans people in our country. As an Afrikaans woman, she expressed being quite sensitive to the legacy of racial segregation, but also feeling as though she did not want to be held hostage or overcompensate for who she is. I remember being quite envious of her ability to distance herself emotionally and, sometimes in the face of cultural discomfort, physically. I did not know how to do that; I did not know how to not take the discomfort on. It seemed to me that she had a certain security about her identity that I did not possess.

I became increasingly motivated to do my Ph.D. in order to start exploring Black subjectivity. Shortly after registering as an independent practitioner, I moved to Stellenbosch to pursue my

Ph.D.. My mentor told me about two projects that he is involved in; although he had given me an option to choose one that resonated the most with me, he also had an idea as to what I would gravitate towards. I chose a project under the auspices of the Harambee organisation. The Harambee organisation is a non-profit organisation of Black medical specialists. The overall project conducted by the Harambee organisation aims to improve and enhance healthcare systems in South Africa through the investigation and evaluation of race as a potential factor that pertains to outcomes in medical specialist training. We are interested in patterns of overt and covert exclusion of Black people from what has historically been a White enterprise (the practice of medicine in South Africa) (Thackwell et al. 2016; Thackwell, Chiliza and Swartz 2017). This sounded like an important project, but the other motivation was that I would have an opportunity to work with and learn from people that look like me and are professionally successful. Not only had they succeeded, but they were each respectable in their own right. Being in a room with these Black specialists, despite them all being male, gave me a sense of hope. I could see that they were respected, and in terms of my subjectivity, that opened up the possibility of being respected within my field as a Black professional. This is also due to the fact that I had direct contact with these professionals which opened up an opportunity for mentorship to take place. As highlighted in Thackwell et al. (2017), mentorship has been seen as one of the important factors for success and career advancement of junior professionals.

ON BORROWED PRIVILEGE

When exploring race as potentially one of the determining factors when it comes to throughput rates, it lends itself back to the legacy of apartheid education and racial discrimination under apartheid. Having to engage with transformation literature and, inevitably, with the past, remains one of the most difficult and emotionally taxing tasks of my

study. As previously mentioned, I was familiar with South Africa's apartheid history, but I have no memory of living in those times because I was too young. However, reading up on it for my literature review and having to consult multiple sources that outline the history continues to make me feel very uncomfortable and relatively angry. I feel angry at the injustice of what many of my Black forebears had to endure and at the contemporary legacy. In terms of schooling and access to better education and opportunities, I have been very fortunate. I feel that I now need to evaluate my position and be critical about what constitutes that privilege. There are a few things that I find problematic with this borrowed privilege, and I frame it that way because it appears to have a "terms and conditions apply" disclaimer. As a result of this privilege, I do not have a clear sense of my Blackness, a sense of security in my Blackness. I do not wish to essentialise here, but in my experience it feels important to me to have an understanding of who I am as a Black person and not to hide or deny what I experience to be an important part of my identity which is often effaced in the professional context. I have not quite figured that one yet; it feels as though I have been acculturated in a direction that seems to demand that I dilute my Blackness in order for me to belong. Fanon suggests that maybe the solution is to assert myself as a Black person and to not go through life having to overcompensate for being Black:

"I resolved, since it was impossible for me to get away from an inborn complex, to assert myself as a Black man. Since the other hesitated to recognize me, there remained only one solution: to make myself known." (Fanon 1952/1986, 115).

I have been less aware of when and how I move in and out of my Blackness before, but now I have the understanding that my identity as a Black woman is constantly being negotiated within different contexts. So, I wonder what the implications of this are; am I to accept the new kinds of marginalisation such as issues of access into higher education and healthcare

disparities that take place because I have been so privileged or do I join the Fees Must Fall movement that challenges issues of access, race and the socio-economic divide (see Davids and Waghid 2016)? This may appear to be a self-indulgent question but it is not an unimportant one because within the context of the experience of many Black professionals, I come from privilege. It's complicated; it's confusing and uncomfortable. A part of me wondered if I had a right to talk about certain injustices, like issues of access into higher education institutions, when my experience has been fairly smooth, but maybe it is true that "the way out of a problem is to be conscious of the problem" (Mamdani 2012, 91), and perhaps that's the starting point for me.

CONCLUDING THOUGHTS?

I would like to be able to sum this all up neatly, but I feel in a state of deep ambivalence and I continue to feel this way. As I articulate this, my question really is (and I am not in the position to answer): is this just my ambivalence or is it part of a bigger picture? The work of Maodzwa- Taruvinga and Msimanga (2014) seems to suggest it is part of a broader context, but I have written this article partly in the hope to open up a discussion about the complexity of race, which I have experienced quite deeply, within the academy.

5.1 The insider researcher: Concluding comments

The inclusion of this article was both as an acknowledgement of my bias, and also my subjective experience. It was also in acknowledgement that the participants treated me as an insider, which has implications for the data. How conversations took place and how meaning as a result was construct, is a direct reflection of how the participants viewed me as an insider and not just a researcher. There were instances where the style of interviewing oscillated from pure inquiry to a conversation on shared experiences, which I welcome. This may be seen as threatening to the credibility of the study, but this also links to what is considered to

be knowledge (Roulston & Shelton, 2015, p. 336), and moving towards understanding the "personal in relation to the social, and the desire to change the world" (Bell et al., 2019, p.1). In the next chapter I introduce interview data, making minimal discussion on the themes that have emerged.

CHAPTER SIX: RESULTS

6.1 Introduction

This chapter presents the interview and focus group data. The themes that emerged through thematic analysis were defined and organised under the headings and subheadings presented here. For more detail on how the themes were organized and arrived at, please see the table in Appendix B). The aim of this chapter is to present the data as is and not to enter into a discussion as yet, though I acknowledge that with research of this nature, there is an element of overlap between results and discussion – even my way of organising material reveals something of my own interpretation of the data. The interviews were structured in a way that allowed for a narration of the registrars' journey through medicine up until the time of the interview. Broadly, the themes speak to experiences of adjusting to undergraduate training and the training environment, followed by a discussion of registrar training as such. As we shall see, discussions of undergraduate experiences tend to focus on issues of access. In order to illustrate issues participants face in becoming medical specialists presents an aspect of one participant's story so that a longer narrative can be presented. Finally, the participants discuss what transformation means to them, and to the question whether and how it can be achieved.

6.1.1 Complexities faced on the road to becoming a doctor

6.1.1.1 Financial challenges

Participants reflected on childhood experiences that influenced the decision to study medicine and their journeys leading to medical school. A number of factors regarding the difficulties and complexities on the road to medicine were reported. Many participants discussed financial constraints, with some highlighting how the lack of finances growing up

made it difficult for them to access higher education. Zama, for example, reported that she was always encouraged to do well at school because education is important but financial constraints made it difficult for her to get into a HEI. She expressed considerable frustration regarding the fact that she had the ability and passed well but that her parents could not afford to send her to university. She reported that a family member, after she had passed Grade 12, the final school year, said: *"... you passed so well and I am so sorry you can't go to school* [in this context the word "school" refers to university]. *Here is a R10*[12] *note to celebrate."* She later emphasised the importance of financial planning and finding information about available scholarships and bursaries.

Some participants reflected on how difficult it was to cope with financial constraints during their undergraduate training. A substantial portion of participants relied on financial aid and bursaries to get through medical school. Later, Zama reflected on how lucky she felt to have had the help of a bursary, but also alluded to finance being an obstacle for effective transformation:

> You know they [the bursary] went with me till the end [of her undergraduate studies]. I was lucky, I was very lucky...very, very lucky you know. I mean fees must fall[13]! So, I was very lucky that's why I really, really, really believe in fees must fall.

Though financial aid and bursaries assist students, they may still experience financial challenges. Tshepiso reported that she had to find ways of stretching her financial aid every month in order to survive:

> So if you had your tuition covered, your residence covered, then there was like – you had to compromise between meals and between other things like that. You need to survive the month. So over time we kind of had to try and live within a small budget

[12] At the time R10 was probably equivalent to roughly $1.50 (US)
[13] Referring to the student movements calling for free education

> in a foreign place (referring to being in the Western Cape Province when she is not originally from there).

Registrars sometimes had to do clinical work in settings far from where they lived, and those without transport had to rely on other students for lifts in their vehicles. Mandla reported how difficult it was for him and that it was yet another factor to consider and work around during training:

> I think the only person who had a car in my six years I can count them, I saw about five people who had cars, so when you had to travel ja... it was quite tough… but myself when I choose a group in third year, I chose a partner who's got a car – it was a white guy. So ja, that made things easier because wherever we went I just tagged along with him.

6.1.2. Dealing with the consequences of poor quality schooling

Some of the registrars had experienced poor quality schooling. They highlighted that not being exposed to certain things in high school made it difficult for them to adjust to undergraduate training. Tshepiso reflected on this:

> Undergrad was a lot challenging cause I mean, I studied in like uh rural school system, so from primary up until high school. So the kind of teaching you get is very different to varsity.

In order to support students entering university with these kinds of academic backlogs, some universities have support structures like extended degree programmes. Tshepiso discussed her admission into the FHS' extended programme:

> They had then an extended programme into medicine cause I figured they decided that you know you might be bright but at a Black school but then compared to somebody who came from like I don't know…. Yeah so then got accepted into the

> extended programme *mara* (but) – so the thought of success was like seven years. So the aim was then in the first year they cut then the clinical years uh three years and then we do it over four years and then they integrated some of like you know computer um literacy – the stuff that we were never really exposed to. In the beginning it sounded great cause you just happy to be accepted in UCT but you didn't understand what it all meant or what it came with. So then, very soon like after first year you realise oh shucks like this is just a class of Blacks.

Tshepiso believed that the extended programme (EP) was stigmatised. It felt to her and her classmates that the programme, however well intended, looked like a remedial programme just for Black people, as there were only Black students in the EP stream. She reported that she and other EP students felt a degree of shame about being in this programme:

> Then you know you *sukkel* [Afrikaans word for struggle] along and then, then you come across some nasty lecturers who then label you as the "BEE"[14] curriculum so as if like you guys are – are imbeciles, we need to reiterate certain things moreover so that the new guys eventually get them because you are so disadvantaged.

6.1.3. Differing experience for those who went to privileged schools

Some participants, by contrast, reported to have received quality education in school and they found it relatively easy to cope with academic demands. Mteto reported that he had a lot of options to choose from in terms of what to study but that he initially did not think of medicine due to it not being as financially lucrative as other career options. Those, like Mteto, who reported having less trouble accessing higher education spoke more about the difficulty choosing a career and how it took some time to find themselves within medicine.

[14] BEE stands for Black Economic Empowerment. It is an aspect of redress that focuses on Black empowerment. In this context it is said in light of having to embody the diversity enterprise.

Tokelo reported that she had difficulty settling into a discipline until she received guidance from the student-counselling centre that suggested she enroll for health sciences:

> I registered for computer science in varsity but it actually wasn't okay for me – like, I didn't enjoy it, so like the next week I went into the microbiology, ja and then that was also not okay, but then they told me you can't de-register it's too late, so then I went to the student counselling and…you know what else is here I do want to be a doctor, but I don't. You know the dead people story, everything was just like no, but that's not my thing so I went to the student counselling thing and the career thing and then they sort of did a profiling thing and they were like oh you should be in health sciences

She also reported that due to this uncertainty, she felt dissatisfied with doing medicine for a long time. Similarly, another registrar, Tumelo, reported feeling somewhat depressed because he was not certain why he was doing medicine and reported not connecting to the discipline for a long time:

> I went through a terrible period of depression in my fourth year and I actually started seeing patients and seeing what this is about and I felt that it was way too late to change and I decided that…go with it till you found...a space...to make peace with.

When the word dissatisfaction was used to describe his experience, he quickly clarified that it was more than just dissatisfaction for him:

> Not just dissatisfied like, why am I doing this? Why am I here? I actually don't want to do this! So, first year, third year, final year, internship and then in community service things started changing.

6.1.4. The internship and community service experience

For many registrars, the internship was very challenging and demanding of them especially for those who interned far from home. Tumelo explains:

> Internship was terrible; internship was terrible because also I moved to Polokwane[15]. I had a few patients die on my watch because I had nobody to help me sort it out not like, and like those things sort of stuck by me and then there were things like just being away from Cape Town for a long time.

Themes of a search for identification or belonging came out where registrars spoke about moving out of the Western Cape for internships to where there are more Black people. Tumelo spoke about being Sepedi[16] but having grown up in Cape Town, so for him going to Polokwane was perhaps a way for him to gain a sense of identity, and maybe even home:

> It was also for entirely personal reasons uhm, I am Pedi speaking but I grew up in Cape Town so I moved to Polokwane because I wanted to learn properly how to speak Sepedi, I speak Sepedi but like for the last few years I speak Sepedi in my little nuclear family and when I speak Sepedi with other people you can hear the differences

Similarly, Tshepiso spoke about being excited about being placed in Johannesburg because she felt little attachment to Cape Town because it is not home for her. She reflected that she was particularly looking forward to seeing more Black people in middle class spaces:

[15] Polokwane is a small city and capital of the South African Limpopo province. It is approximately 1700km from Cape Town and in a much poorer province than the Western Cape, with many governance and service delivery challenges, including in the area of state healthcare delivery.
[16] Sepedi is commonly spoken in Polokwane but hardly at all in the Western Cape.

> That's why I went to Joburg [Johannesburg], and it was fantastic like for the first time you're surrounded by Blacks and things are great and all that and that.

Interestingly, as she reflected, she had what seemed like an introspective moment of wondering if her experience of discrimination can be fully accounted for by race only. She, in her account would often speak about her intersecting identities and how dynamics relating to these identities influences her experience of being a doctor depending on the space she occupies. For example, she reflected on having started her internship at a Gauteng province hospital and that hospital had predominantly Black staff and served a Black population primarily. Tshepiso spoke about feeling like an outsider and that there were negative attitudes towards her because she was a UCT alumnus:

> …and having said that, now I don't know whether it's my personality? Now you get discriminated [against] because you from UCT. I was like – like what did I do to anybody?

Most of the registrars reported that they felt like they were more independent during their community service year. Some reported that it is within that year that they decided on specialist training, but also highlight that there were complexities that came with working in places where most doctors would not naturally elect to go. Some also reported that they would have roles additional to being a doctor due to the community setting they were in. Nonhlanhla described how at times she felt like she was doing more social work than medicine:

> You'd have a clinic under a tree, it was really cool but then I didn't really feel that I was a doctor. I felt like a social worker cause then most of the issues that I attended to was finances so people not taking their medication cause they can't afford it and why they don't have a grant yet so then I have to sort out grant issues.

6.1.5. Language as an obstacle or an asset

Difficulty with language

Adjusting to both English and Afrikaans as a medium of instruction during undergraduate training was reported as a factor influencing how difficult it was to cope with entry into higher education. Adjusting to Afrikaans, especially at Stellenbosch University (SU), was reported to be particularly difficult. Mandla reflected on how he and other students were often frustrated by how prominent the use of Afrikaans was in lectures despite there being students who are not first language Afrikaans speakers:

> It was tough to adapt. You had to learn and sort of become independent because you had to rely on yourself, but also got irritating because we did have the right or the freedom to raise your hand say to the lecturer please explain in English but after a while it becomes tedious as well.

He also added that despite being asked for clarification in English at times, lecturers would still revert to speaking in Afrikaans, which did not motivate him to speak up when he needed help. Similarly, Tshepiso reported on how the interaction with her peers would sometimes be problematic in that she would have to remind them that she was in the room and that she did not understand Afrikaans:

> I was like…no, no, no, no, no, no! I was like, "um sorry guys in case you've missed me I'm Black I don't speak Afrikaans".

Language as a barrier seemed to also be evident during hospital visits where some students would miss out on bedside learning opportunities due to the interaction between the consultant and patient being in Afrikaans. As mentioned above, Afrikaans is commonly spoken in the Western Cape, so it is not unusual for the doctor-patient interaction to be conducted in this language, which is the first language of most patients. However, the emphasis on consultations being in Afrikaans has implications for what registrars who are not very familiar Afrikaans can learn and the extent to which they feel excluded. Mandla reported that they needed to adapt to that in order for learning to be more effective:

> You sort of notice that as well, how it affected your education, uhm... second year we started going to hospitals, even the surgeons, you would find guys speaking Afrikaans. So you will be at that side with the patient and the person would be speaking in Afrikaans, which makes it quite difficult again to learn I mean uhm…in that setting again, you sort of adapt.

When asked if she felt language was an obstacle or whether she felt any discomfort with Afrikaans, Thuli reported that at times it has made her feel like leaving Tygerberg Hospital (the main training hospital at SU):

> I have been very like conflicted, where there have been moments, moments like where I have been like I don't need this. I can go to another place where there are more people that look like me, like people that are…actually don't give a rat's ass about Afrikaans, English, whatever you know, we can all converse in one language and it's not a big issue

Sanda expressed frustration at the fact that at times even clinical notes would be written in Afrikaans. She reflected that she felt the hospital was not inclusive:

> If the hospital was an inclusive hospital then they should say if you are writing a referral letter, English is the language that we use to communicate, just like you say you write your notes in black ink and that's a requirement, then the rule should be English is our medium of communication. There's stuff like that at Stikland (another of the training hospitals at SU), notes are written in Afrikaans.

Sanda also reflected on the social implication of the language barrier within the clinical setting. She spoke about casual conversations that are important for team cohesion and relatedness happening in Afrikaans, which then in turn excludes some. She expressed frustration about how invisible she felt at times. She also added that she does not think this is done intentionally all the time, but that there is a lack of mindfulness at times on the part of her colleagues:

> Ja, you just not there, you just don't exist. I think part team cohesion is topped by the odd conversation of soccer or uh, a TV programme, so as much as work is going on in the work space but there's those odd conversations where you would laugh about something or there's a joke, or a patient did this and all that happens in Afrikaans. So, if you don't speak the language you always kind of like an outsider. I don't think maybe people are doing it on purpose, ja, you know I just think it's how it is and uhm, ja, Stellenbosch! *(Laughing)* it's how it is...

Difficulty with adjusting to language at university was not limited to Afrikaans. Phila reported how difficult it was for her having Afrikaans as a medium of instruction for some

lectures during her undergraduate years, but she also highlighted that she also struggled with English as well:

> So the language was… I mean people assume that in high school you've learned English, so you should be fine, but they don't take into account stuff like that. So, the accent, the way people speak – it's still an adjustment so you don't go to lectures on the first day and you understand everything the professor says.

Language acquisition as an asset

Some registrars, by contrast, reported that Afrikaans was not an obstacle for them. Some even reported that learning Afrikaans and being somewhat proficient in Afrikaans was useful, especially when they started having patient contact. Zama had attended most of her schooling at Afrikaans schools: *"we have this closeness with Afrikaans people because now I went in an Afrikaans primary school, Afrikaans high school".* She reported having an affinity with her Afrikaans colleagues due to being able to converse in Afrikaans. One of the registrars reported that he started learning Afrikaans due to being exposed to it and found it to be a useful tool to have when in contact with Afrikaans speaking patients for rapport building:

> The language I use it 'cause I picked it up, I am actually quite… I can speak it now. But I usually use it for my patients' benefit say if I get uh a Coloured lady who can't speak English, in order to get things smoothly, I will speak Afrikaans.

There is no university in South Africa that trains medical students through the medium of an indigenous African language[17].

6.1.6. Training institution/location and the influence on quality of training

The University of Cape Town (UCT) and Stellenbosch University (SU) have reputations for being academically rigorous and prestigious, with UCT consistently performing as the top African university in international rankings, and SU consistently named the most research-intensive university and in the handful of top universities. Therefore, for many registrars, the decision to specialise at these universities and their associated hospitals was also due to the attractive element of academic excellence. Mteto reported that the standard he experienced during his undergraduate training at the medical school at SU during undergraduate training was the reason he wanted to go back and learn more:

> Excellence, *ja* (yes), excellence. Stellenbosch is mind-boggling. They pull out excellence and I think in undergrad, that's what I experienced. They focus a lot on excelling. They're not…you're not here just to pass, you here to excel. Um and they, they do their damnedest to make sure that you reach that level.

He further added that in his experience of specialist training at Tygerberg Hospital consultants are easy to access for help both clinically and with his research:

> There's no lack of support – um you've got a challenging clinical problem, down the hall you've got this place and you've got that place – email that person, they will sort

[17] The University of KwaZulu-Natal has made it compulsory for students who are not familiar with isiZulu, the most commonly spoken language in KwaZulu-Natal province, and in fact the most common home language in South Africa to take a proficiency course in isiZulu, and there is some discussion of offering classes in that language. Nevertheless, at the time this dissertation was being completed, this language policy remained contested and resisted by some students (http://www.thedailyvox.co.za/ukzn-holds-firm-on-zulu-language-policy/).

> of help you. *Ja* (yes), they sort of know how to do… I mean, I mean even now with research, which I said I struggled a lot with, I found a lot of people that you'd say, "listen I've got this problem, I don't know how to do this", they will direct you, go and read this book or go to this person, this person does this research in this area.

Along similar lines, Sanda spoke about how long and difficult her journey through specialist training was. She alluded to her training being far easier after having restarted her specialist training at SU due to the resources available. She reported that she had been failing at her previous institution due to a lack of resources and support:

> So there were no posts available, then there was a post that became available uhm in Port Elizabeth[18] (PE) and uhm…you want to specialise, so okay Port Elizabeth fine, also going there because with the belief that it doesn't matter which university you… I supposed it shouldn't matter what university you go to, but in terms of South African universities are not the same, you know…but because I didn't want to waste time, so I just thought oh ja, fine, ja so I did psychiatry in PE for three years. But then the university that the psychiatry specialty was… I suppose the university, *(sigh)* the teaching university is Walter Sisulu[19], uhm…ja not so great in terms of resources, not so great in terms of staffing…so I started doing my exams and uhm I did them over and over again. I failed.

[18] Port Elizabeth is the largest city in South Africa's Eastern Cape province, the poorest province in the country (http://www.worldatlas.com/articles/the-richest-and-poorest-provinces-of-south-africa.html). Port Elizabeth is about 750km from Cape Town. The dominant languages in the Eastern Cape is isiXhosa, and a substantial proportion of Cape Town's Black population comprises economic migrants from the Eastern Cape or their descendants.

[19] One of SA's historically Black universities, and one that is perceived to not be as academically strong (Kwizera, Igumbor, & Mazwai, 2005).

She explained that despite having to do psychiatry from the beginning again, at SU she was now in a position to show her capabilities and be exposed to resources and consultants at SU. She reported that her registrar training at SU felt like she was given a second chance:

> For me it's great being at Stellenbosch, for me it's like a privilege just being at Stellenbosch, I mean, it's like, like we said it was a second chance for me – actually studying psychiatry and actually doing it right, so I am always grateful that I actually got that chance.

Some of the data seemed to allude to some registrars feeling that being outside of the Western Cape was more favourable. Some registrars experienced Cape Town's as unfriendly and foreign culturally. Mteto reported on the level of friendliness (or lack thereof) he experienced in Cape Town and how this was different from the Eastern Cape. He also added that this led to feelings of being homesick:

> Um…for instance if I can recall an event – something that struck me – so, I, where I come from, home, you greet everyone. When you walk down the street, you meet somebody; [even if] you don't know them; you greet them. Um, so I found, people of Cape Town just don't greet. You know but this is rude.

With a similar sentiment, Nonhlanhla, reported that she did not necessarily want to be in Cape Town but went to UCT due to its academic appeal. She further added that her day-to-day experience of Red Cross Children's Hospital, the children's hospital associated with UCT and world-renowned for its standards, (not pertaining to her training necessarily) was not pleasant:

> So I found that um there was this *nje* (I don't know), I just found – I just found Red Cross… I used to say to my friends "I can't feel the heart of Red Cross". I can't feel the heart of Cape Town, whereas in Mpumalanga in as much as I was in the ditches there I could feel the heart of Witbank.

However, soon after she explained that the pull towards specialising in the Western Cape was due to its reputation of having an efficient medical system. She reflected on having attended *"a morbidity and mortality audit that happens for children in South Africa",* where paediatric statistics were presented. She reported that her agenda is to get quality training in order to influence policy and implement what she had learned "when she has a voice" in areas less resourced and that are outside of the Western Cape:

> What was highlighted in the stats that they were presenting is that Western Cape had the best stats, and um everywhere it was just shining. And then so because I wanted to specialise in this – when I do qualify to have a voice that's directed and can influence change, I'm like so if that's where the good things are happening then I need to go there and glean and see what they're doing differently so that I can go back and be able to implement that. That was me back then shame my heart was so pure and so good. But it was basically the stats of Western Cape.

She further added that for her, it was more than just going to an institution that was academically rigorous – that it was also about being able to compete on a global scale. Nonhlanhla spoke about the level of reverence that one achieves with being in an institution like the University of Cape Town:

> So I felt like it was also a bridge to like global and I expected, obviously, academic excellence and um to get yeah a degree from a place that's more revered than other places. And anyways the only children's hospital[20] is here so then you sort of do have authority to say…and you just yeah. You just, I think it was just um yeah I must say I mean didn't quite think about the empathic bit for UCT. It was more um how do I build a bridge between yeah where I am and getting to where I would like to be, the future and that is just by saying I've been here.

Zama reported that she decided to specialise at UCT to fulfil her dream of pursuing her studies at the prestigious institution because she felt she was no longer limited by circumstance. She had been working as a doctor and now had the funds to embark on her specialist training:

> I was capable but because of finances I wasn't able to place myself in places where I felt like I wanted, I went for what I was given you understand, so now I am postgrading [doing my postgraduate studies] and I have finances and I can choose; hell no! I am choosing, I am *gonna* [going to] choose UCT.

6.2. The meaning and expectations ascribed to a doctor

6.2.1 Becoming a doctor – changing identity

Some the registrars reported that the reality of what it means to be a doctor began to sink in when they started going into the hospitals at the end of their second year of undergraduate training. Others reported that it was with the level of autonomy that they had in their internship and community service years that they started feeling the change in

[20] Red Cross Children's Hospital in Cape Town was the only children's hospital at the time of interviewing. Nelson Mandela Children's Hospital has since opened in Johannesburg

identity. Tumelo reported that while these were teaching stages, the hospital setting showed him the reality of what he were signing up for:

> I would say probably being in the hospital – the biggest thing that challenged you was the fact that now you needed to be serious about what you were doing um you were dealing with patients, it was no longer theoretical stuff – half excited, half anxious.

Some reported that the culture of helping those in need and being able to assist patients helped them grow some confidence. Most registrars reported that being in the hospital setting also changed their perception of what they had imagined medicine was. Some reflected on how medicine is considered "glamorous", yet it is not. During the interview process I addressed each registrar by "doctor" especially because of my familiarity with the clinical setting and inherent hierarchical structures that exist. However, Sanda insisted that she wanted to be called by her first name and this became a point of discussion due to her looking somewhat uncomfortable with the title. She then verbalised this discomfort: *"I was saying to you I actually cringe at being referred to as a doctor"*. When she spoke about the discomfort with being called "doctor", she related it more to what people perceive it to be rather than the actual practice of medicine. *"Maybe it has parts, part of it has to do with the fact that...I suppose the idea that that's not what it's made up to be. It's not what it turns out to be".*

6.2.2 Social pressure and the question of status

Sanda later also mentioned some social pressures associated with being a doctor. She spoke about still driving her first car, a Volkswagen Polo, *"like 2009 model not even the recent Polo",* she added. She reported that she has a lot of responsibility, as a first generation graduate, and can therefore not live the socially expected glamorous life. Added to that is the greater social expectations from family and the community as well. The same registrar further

spoke about the pressure she feels from people outside of her family as well to help in changing the circumstances of the family. She reported that she could not start thinking about building her life yet because she still needs to see to her family, especially because it is known that she is a doctor:

> Ja and uhm… I suppose you expect the Mercedes and the BMW's then…still driving my first car which was a Polo uhm…ja it's just not… I think maybe…oh I suppose that's one of the reasons like I say I actually don't identify…besides other reasons; but I thought that I would… I thought a huge part of why I don't actually see myself as a doctor or don't like the label of a doctor was because maybe there wasn't something significant that I had done at home you know like solve a big problem for my mom like the fact that we did not have a home…one bedroom flat like almost ten years she was renting so eventually I was able to buy a house for my mom uhm…ja. It felt good for a while and I never felt that maybe I can have something to back up the fact that I am…I suppose success comes in different ways, uhm…but of course there is that pressure from the community uhm…so now your daughter is a doctor.

6.2.3 Medicine and the politics of appearance

Some of the pressure also seemed to relate to conforming to the expected physical appearance of a doctor. Tumelo mentioned that his dreadlocked hair was mentioned by a visiting doctor and again by a patient. He satirically mentioned that when rapport was built with a patient (frequently older Black women) that there would be mention of his hair being seemingly unkempt:

> So I have admitted you, we have started some sort of treatment plan, you are on your way to getting better and now you have confidence to say, *"maybe you can do*

> *something about your hair"*…but it's also just like old Black women who will say stuff like that.

He also went on to mention that he did not feel any pressure to cut his dreadlocks, especially because he is frequently wearing a scrub cap as a surgeon. Zama reported that the suggestion about her changing her appearance came from a lecturer. She reported that she had a case presentation and was wearing a shirt with Steve Biko's face on it and her hair was in densely locked dreadlocks known as Bongo dreadlocks:

> Then my clinical year started and then I went, I am wearing a Steve Biko shirt and my hair is like three years...it's like bongo dreads and this one uh specialist asked me, White male, "are you trying to be a doctor or are you trying to be a politician?"

She reported being confused about the lecturer's question, as she was anxious about the case she had to present. She reported that he later clarified that his question was regarding how she was dressed:

> Now I am presenting my case so I am, like got confused, like what is he talking about because I am presenting my case and then he said, *"I am talking about the t-shirt"*...you know and then I got…then I realised that I can't go to the hospital with my "change divide" shirt, my Steve Biko shirt. I bought relaxer[21] with my friend and she relaxed my hair and I called my mother and said, *"I am starting work now at the hospital and they don't like untidy hair"*...you know I was very complicit allowing…something just didn't feel right, I didn't realise that this is institutionalised racism, I did not realise. I did not have the words to say that.

[21] The participant is referring to a chemical hair straightener

Zama later reflected that her complicity was due to her being from a small town and not wanting to "rock the boat" because she was fortunate to be studying, especially at UCT. She commented on the culture of medicine that can strip one of parts of their identity. This phenomenon is not unique to Black doctors, but the way in which she expresses it warrants attention later on in the discussion:

> As a doctor, you are not a human being, you don't have political agendas, you don't have that, I have to strip myself of that; I am a vessel of medicine that has to appear in a certain way that has to perform this function and that's the message that I got.

She reported that despite wanting to take part in certain student protests (first at the University of Free-state (UFS) and again at UCT with the Fees Must Fall movement), as a doctor she could not because she had to appear as apolitical, which again needs to be reflected on later.

6.3. The reality of racial and gender dynamics

6.3.1. Issues of race trouble

Some of the data speaks to patterns of exclusion in notionally diverse institutions, and in our case SU and UCT. Zama initially took a medical officer post at SU and reflected on the reaction she got from a friend after telling them that she was going to SU:

> Someone said to me, "are you going to take this job? You not gonna go, everyone will say that you are quota"[22]. I said I will work to prove that I am not a quota; like work, try to prove myself.

Tokelo reported, *"I know there were racial dynamics to begin with but that's not why I am here."* For her the reality of racial dynamics was a given that she would have to adapt to in order to reach her personal goals. Many of the participants highlighted that racial dynamics and instances of exclusion have occurred during both undergraduate and postgraduate training. Some registrars reported that in some situations they are naïve or blind to racial dynamics due to the types of schools they went to, prior socialisation, and in some instances being used to being amongst the minority students at school. When Nonhlanhla was asked about her experience of medical school and whether race or racism was a factor contributing to how she experienced her training environment, she replied, *"Basically the way that you experience racism is based on your own experiences".* She explained that she believes that we experience race issues based on our social positioning and what we have been exposed to. Nonhlanhla also added that in terms of her cultural background as a Zulu woman, she was raised to follow instructions and adjust to the situation as it is:

> I mean and like I said for me it's just a – the way that I grew up and just not challenging things or just looking into… It's just this is what the elders have said and you will go in this order.

When probed about how she handles it when she does experience things as racist or exclusionary, she responded by saying: *"just be normal and don't cause chaos".* Nonhlanhla

[22] This refers to a widespread perception that institutions have quotas for how many Black trainees they will admit, and that they will fulfil racial quotas without regard to competence of applicants to courses in the health sciences. It appears that these views may be commonly held even when in reality no quotas exist (Traub & L. Swartz, 2013).

further explained that she would only start thinking about these issues in more depth once her colleagues would highlight that things are unacceptable. Tokelo reported that she did not have negative associations with White Afrikaans people and that her being oblivious to racial dynamics during her undergraduate training was due to where she grew up and being exposed to people of different races and living among them:

> Another thing I've realised about me, because I grew up in the Free State and then Lesotho[23] as well where there is no like…in Lesotho there's not much of racial stuff and in the free state we lived in Welkom for a while, and our neighbours were mostly Afrikaans people and we got along with them. I mean it was like, our house is here, the next house is an Afrikaans person, the next house is a Black person.

She later reported that her first encounter of problematic racial dynamics was when she entered university in Kwa-Zulu Natal. Tokelo reported that these racial instances were between Indians and Black people. She reported that during her postgraduate training there have not been instances where people were being particularly discriminatory towards her. Tokelo also reported that she goes through *"every differential"* before concluding that an interaction is particularly racist or discriminatory. She reported that her Black colleagues, as well as her husband, tend to be sensitive to what may seem as racist:

> I have friends that are very sensitive to it, even my husband, I mean my husband is very sensitive, very, like extremely…and I am like why do you think that is [racist], and also like the other thing is when I ask people…why do you say that, like why do you think it's racial and then they don't have much substance to give to me.

[23] The Free State is a landlocked province of South Africa and it is adjacent to the very poor country of Lesotho, which is entirely surrounded by South Africa.

Most of the registrars did speak about racial dynamics at medical school. Nonhlanhla spoke about this but also added that one needs to find ways to try manage under the circumstances because of there being no other alternative but to cope with the situation:

> Of course, there's always racial dynamics. But if I can put it…there were people who were challenging um I mean I still think that there are. I can't run away from it. Um…but you quickly learn to develop a thick skin and say listen you can't help it much. You can't help it much um some people are just the way they are.

Thuli reflected on how isolating it is sometimes to not have another Black female in her department. She spoke despondently about how she felt that the racial dynamics were not going to resolve any time soon:

> There are issues; definitely, I think race is still a big issue, I don't know if we will ever get past it. I think it's still an issue; I can only speak for my experiences and where I am now. Like, for me, I am the only Black female [in the department] and most days I don't go to work feeling oh my gosh I am the only Black female, but I have days where I feel if there were other Black females would it make a difference? Would I feel like a minority? Will I be drawn to them? I think that's something we do; you tend to gravitate towards the same… What I can say is that my relationships with my Black colleagues are different to my relationships with my White colleagues. I mean there's definitely things where we relate and I am like oh my goodness I can relate I have been there. I think there are issues but I don't know if it's…when I think of Stellenbosch, a lot of, I don't know, sometimes people… I mean why is it just one Black female? Is it because people are not applying? People of my colour are not

> applying because they feel I don't want to go there or they do apply and they are just not taken? Uhm, because in a way, I feel like that is something that has to change, I mean if it's because people don't apply then I mean we can't necessarily blame White people for that.

Nonhlanhla reported that she coped by trying to interact with everyone and eventually she learned what was expected of her, but not without upsetting some people along the way:

> It's just that you needed to mingle. And I think the more you mingled the more you sort of got everybody's point of view. Of course you bruise a couple of people here and there because you don't know their culture. But after a while you sort of two or three years down the line sort of have an idea what's to be expected.

The data showed a number of instances where the registrars reported working far harder due to them being aware of their Blackness and the associations that may exist that they needed to fight against. Nonhlanhla explains:

> Nonhlanhla: Ja, so then I think the demand, there is demand. No, no, no actually there is demand that everyone goes through whether you are Black, White, Indian, pink, blue – those are the demands and then there is a lot I think as a Black, there is a specific, I won't lie there is a specific thing that I don't know what it is but there is that as a Black female, there is that you need to watch the kind of service you deliver, you need to. You can't just be calling off sick randomly, you need to watch your work ethic purely because there is that thing of okay, if you miss a few days of work you will probably be deemed…you know…
>
> Nokulunga: lazy?

Nonhlanhla: ja *(yes)*

She further reported that she at times felt apparent resentment due to perceived favouritism. She spoke about a weekend where she was on call and went in despite being sick. She reported that no sympathy was shown toward her but it appeared that her White colleague received a lot of attention and sympathy despite not having seen as many patients. When she was asked why she did not take time off she responded by saying the following:

> Well it wasn't really up to me, I mean I'd like to go but the sympathy is more towards the White registrar. I mean if you're working a weekend then you must do rounds. Then it was me on Sunday doing rounds but not on call cause I was on Saturday then the other person was doing rounds, and so now they were post call and it was like Erika has to go, Erika has to go – she's post call. Oh my God Erika has to – she's still here? Erika you must go. And I'm like but I was here yesterday, and Erika hasn't even seen half the amount of patients that she's supposed to see at this point in time… I've been very oblivious to things and uh but yeah I've gotten a lot of sensitisation especially from my friends' personal experiences, and then… but yeah so when I look deeper then I see the subtle things that I probably wouldn't have thought about before, but I mean why was it a priority for her and not me?

Nonhlanhla spoke about finding it difficult to decide whether some situations were due to her being a black female registrar or if the consultant had an affinity with her colleagues and not her for reasons other than race. She reported that she believes that she is well liked but often gets confused as to whether some of her experiences are subtle versions of racism. She later spoke about not knowing whether she would feel differently if she had a person of colour in her corner:

> So I'm just, I'm just thinking in the context of if I had someone my colour who had my back, how different would that be and I don't think, in my experience, I experienced something, yeah, different.

Sanda reported that she has experienced subtle versions of racism during her training at SU. When asked how she dealt with it she reported that it was the nature of the context and that one needed to grow accustomed to it:

> I think the other thing is to always like – sometimes you just let things go, like not bother you because you can't fall apart every day. You're not going to survive. *Ja (yes)* you just kind of like push through every day.

Many of the participants reflected on the nature of racial dynamics being quite covert. It appeared that at times it was difficult for them to identify specific instances of things being overtly racist, but they nevertheless had a visceral sense that racism was occurring. One of the SU registrars reported that she will always be suspicious of the system or her environment, but will likely not speak up about anything she experiences as discriminatory. When Sanda was asked about how she feels when she does experience something as exclusionary, she responded by saying:

> Ja I mean it makes me angry, you feel homicidal at times, you know uhm, but you don't have the, I suppose because it's not in your DNA to speak up and you basically boil and simmer and as times go by, it passes or it becomes less and less, but for us we will always be suspicious of the systems, ja.

Tshepiso reflected on her experience of integrating with the "mainstream" group after having been admitted into the extended programme for medicine. As previously mentioned, there was a lot of stigma around being in the extended programme and a lot of assumptions about

their capacity. She recalled a time when they had to do a group assignment where their group members complained that their progress was being stunted due to having the two members from the extended programme:

> I remember this other time – this I think this was like one of those like you know like eyes wide open. Fourth year, it's gynae, we doing a project but I thought it went well, in a group of six we were two Blacks and then one, one, no two Coloureds and then two White girls, but according to my assessment they were very lazy … They reported to their – to the tutor at that point in time that they are not happy doing the project with us. We're pulling them down – the reports and everything else like literally like behind our backs. And they pulled them out, and we were so, so, so offended 'cause what had happened is we had done our part – like the poster, the report and all that and the part that was left to be done was their responsibility and they had not done that. So they then pulled them out and we was like what the hell is this like even the lecturers are supporting this.

She reported that during undergraduate training she did not have faith in their lecturers and felt that she could not rely on them for support. She alluded to her and her Black colleagues having to work harder out of fear that they would be negatively evaluated. She reported that her perception was that White students would not have to put in as much effort to get good grades and despite the effort they put in, they would just get a pass:

> Tshepiso: The people who would like suck their thumbs throughout their career they would pass with good marks and you would work 10 times harder just to pass – just to pass – and I think that's one thing that stayed with me when it came to UCT. I was like I don't know what it is but the Black dudes work – work extra extra hard just to make it.

> Whereas then the Whites were just sailing through whereby we don't really know what it is but…
>
> Nokulunga: What is that thing that says you need to work 10 times harder? Is it because you will be negatively evaluated or?
>
> Tshepiso: I think so.

She alluded to this being a common perception where Black students felt that they were being negatively evaluated because examiners would be able to tell that they are marking a Black person's paper because of their names. She reported that there was a call for students to no longer put identifying information on their papers for tests and exams in order to limit bias:

> I remember like at some point we wanted to then jump on it when the SRC (Student Representative Council) up on upper campus (this is the main campus, about 3km from the medical school) started saying that you know the way they the evaluation system at UCT, 'cause like I think everybody else had moved away from that, where you write your [name]… They wanted it just to be student numbers.

Sanda also echoed the sentiment that Black registrars had to work ten times harder in order to prove their competence:

> I think if I can speak from my context it would be nice to be in a place where people don't always second guess what you do or who you are. It would be nice to like uhm... I don't know if you ever experienced this, but like to me sometimes it's a thing like when you start off at a place or as a person of colour sometimes uhm…you *kinda*

> [kind of] have to work ten times harder just to prove that I can do what the others can do, if not better, you know and I feel, like why does it have to be that way.

Some reported that while being aware of certain racial dynamics they reportedly chose to not react. Tshepiso reported that she saw that those who did align themselves with the SRC seldom made it through their studies:

> So, it gets raised in you to not be so vocal about such things 'cause they could literally destroy your career. I've seen so many of my friends that didn't complete their year.

Sanda expressed something to a similar effect: *"I mean it's a fact that if you are…if you become troublesome in the programme, if you give people headaches, you might not make it."*

6.3.2. The politics of quietness

Mandla reported that he realised in retrospect, especially during clinical rotations, that at times cultural factors would be mistaken for incompetence. He explained that Black students being quieter during rounds would be interpreted as them not knowing what is going on, and as a result they would be scored lower:

> I think for us Black…Black students, which is why and now at my level I sort of try to educate my err…if I've got a White intern or a White err students, even some of my consultants the ones I am friendly with, you know I will tell that; try to make them aware that Black people are different – we come from a different culture whereby it's about respect – it's about being taught you always speak when you are spoken to, you won't interrupt elders when they are speaking. You always going to have that shyness, so when we came in our third year, we came in with that shyness because we were surrounded by professors and consultants, specialists so you in your level, so you will – always held

> back and then the guys will make a mistake of thinking you don't know because say a question will be asked in a group of people, we will keep quiet because we were taught don't be forward, don't go blurt out things unless you are asked directly what is what.

Mandla also reflected on the tendency of keeping quiet and erring on the side of invisibility saying that one does not get in trouble if one is not seen:

> Nokulunga: *Sjoe*! So, would you rather be on the side of being invisible rather than being seen?
>
> Mandla: Invisible is safe.

6.3.3. The impact of nurses and patients

The data also showed that racial dynamics occur on multiple interpersonal levels. Sanda reported that her colleagues make an effort to not be discriminatory along racial lines. However, she made reference to a situation where nurses appeared to be showing preferential treatment towards her White colleague:

> Not necessarily between uhm, colleagues, I mean I think they work hard to make you feel comfortable, but for example uhm, let me give you stories, we work in a particular ward and it's a White colleague and me; a white nurse would offer the White colleague coffee and then sort of… like you are not there.

Some of the registrars reported that patients would also sometimes refuse to be treated by them. Sanda added that she felt that progress or transformation was happening too slowly:

> If they are transforming they are slow I suppose, I mean you get instances, it happened twice like in a space of six months where you get patients refusing to see a Black doctor.

Mandla reported that one of the patients opted to speak to an intern instead of him because he assumed the intern was more senior and this was presumably because he was White.

6.3.4. Problematic dynamics within groups of people of colour

The data also suggested that there are difficulties amongst registrars of colour as well. Nonhlanhla reported that as medical officers there tends to be a competitive flare when it comes to interviews for registrar posts and people being suspicious of one another:

> My friend who's Indian um she got a phone call and then like she's talking but she's also walking away um and then she starts asking after that, "Oh um where do you get this book". Then I'm like okay what's going on and she's like – she's been called by the nursery um there's interviews on Monday. And then so I'm like oh okay I didn't know anyways where you get that book that she wanted to *swot* (study).

She later clarified that she felt that her friend was not upfront about the details but wanted to know where to find the book in order to study. She then added that her friend was being stereotypically "Indian" – untrustworthy:

> The point is my friend was being sneaky with the information, but I have since also schooled her that you don't do that. But anyways those are all Indian tendencies, we know those people now.

Some registrars also commented on the treatment of supernumerary registrars. Supernumerary registrars are non-South African doctors that are enrolled for specialist

training at major training institutions in South Africa. Our government does not remunerate supernumerary registrars (SNRS) during their training in South Africa; they receive remuneration from their respective governments (Peer et al., 2017). While the experience of SNRS tends to be qualitatively different than those of South African registrars (SARS), it is useful to mention the difference in treatment for them too. The data suggests that some Black South African registrars become very frustrated by how fellow African individuals are treated. Nonhlanhla expressed the following:

> There are differences in treatment in terms of how they are treated um yeah, poorly. Which is another – "like really? Is this the beacon of hope?" and this is supposed to be like the bridging gap between – and this is how you treat other people? There shouldn't be a distinction that "oh there's a South African reg. and there the supernumerary", but it is distinct.

She added that in her opinion there are no tensions between Black South African registrars and the supernumerary doctors: *"I think amongst each other [SARS and SNRS] there's no tensions"*.

6.3.5. Gender issues

Data showed that issues relating to gender are also a reality for the participants within the medical world. Some of the registrars spoke about the difficulties faced as Black registrars being compounded by being female as well. Thuli reported being the only Black female in her department and reflected about feeling as though she was not trusted initially and needing to prove herself in order to gain that trust:

> I mean I am the only Black female in my department and people will be like "oh okay who are you and what are you capable of", and there was also that distrust in the beginning you know which fades away over time 'cause when people feel you can do

this…but it is annoying, and like you say, now you feel okay I need to perform even more.

Tshepiso recalled an inappropriate incident between her (an intern at the time) and a senior Medical Officer during her internship. It should be noted that her internship was not at the institutions that are of focus in this study, but this incident came up as part of a discussion about women in surgery. She gives an account where she was discouraged to pursue surgery and this after interactions with men within surgery. She reported not keeping quiet during a case presentation of a patient who had died after she had handed over, and the male MO tried to suggest that this happened under her care. She reported that he physically manhandled her and she reportedly felt overpowered by him, and that the interaction was of gender dominance:

Tshepiso: Meeting is adjourned and then you could see there was like tension. I was like okay we'll sort it out with the head of department and with him, like on the side. But, as I walked out he came to me (laughs). He was tall – he carried me like you know when your feet are dangling.

Nokulunga: With your lab…what is it called your white coat thing?

Tshepiso: I think I stopped wearing that white coat thing long time ago… but then with my clothes like he was carrying me – like I was so scared. I just looked at him and I spoke back. I was like I'm not gonna keep quiet like do whatever that you wanna do but I did not kill the patient but I handed him over to you and I don't know what you did. And then, I think after a while he realised that this is inappropriate and stuff, he put me down and he walked away. And I remember like I was so confused I was sitting there shaking, crying, pacing up and down the stairs like you know when you're thinking compose yourself – got to the wards I was like no I can't walk like this and then I walked back I

> was like I'm going to the clinical manager then I'm like no I can't do this let me compose myself. Then someone was watching me – it turned out that the clinical manager was there and he's seeing me pace up and then he calls me he's like what's happening and then I just went to his office and then I like cried. I cried like oh *(sighs)*. So then that was my personal experience as well in surgery, male-to-female, like realising that shucks like I think these people are serious like they're serious that surgery is not for females. I was like oh well screw him. Like I like surgery like what are you *gonna* [going to] do?

She later added that after her community service year, after having been curious about paediatrics, she had a gnawing feeling that surgery was for her. Tshepiso reported that the head of department of surgery discouraged her when he said that females are not good at surgery:

> Head of department there told me "I don't think that females make good surgeons". He said that to me. And I'm like what the hell is this? I was like well if the head of surgery has decided then I have no chance of going into surgery now.

She reported that while she was discouraged to pursue surgery for specialist training, she still wanted to do procedures regardless of what they were. She recalled a community project where they were doing medical circumcisions and she was running this because there was not much interest from other medical officers. However, she reported that there were stumbling blocks in that regard as well:

> They're now doing the whole like traditional *koma* (circumcision ceremony) thing and I think they were introducing now this whole thing of like come – you do your medical circumcision then you go – yeah. So now for that year I think there was nobody interested. Now I was like I'll do the "circies", I'll do it anything just to operate. And then the first day I got there – they had booked – like there were lists – I would get there, get

> myself ready and then all the boys like left. All the boys left, I think I managed to do only three out of 10. And then the following day a few didn't come I only did like a few and stuff and then…then eventually the clinical manager wrote and we had this long meeting that apparently the community announcing that *koma* – it can't be run by a female (laughs) I was like what the hell is this? (laughs)

She later added that these struggles were discouraging at first but she eventually fought to get into a programme and pursue her passion despite the messages that females do not make good surgeons.

Lulama spoke about her experience starting a registrar programme heavily pregnant. She reported that the fact that she was pregnant did not seem to be a problem for her seniors, but that she sensed negative attitudes from her peers due to the perception that they would have to pick the work that she would not be able to do:

> Well, from the seniors' point of view being pregnant wasn't a problem. It is not a disease so it's fine, that is why they gave me the post. They knew that when you are pregnant you are not mentally retarded or physically disabled, but from my peers… The programme I was joining, the registrars looked at me like it's the most bizarre, nonsensical thing that I have ever done, that any human had ever done. Taking a post whilst she's pregnant; well not only because they were considering my feelings or the stress I would go through, because if they knew I can't do a call then it's going to be more on their plate. So, that was more of what they were worried about, for them and not for me.

She reported having already heard from her friends that had started the programme that there had been rumours and that she then mentally prepared herself for some negativity. She also reported feeling a bit isolated when she first arrived:

> Well, I had already mentally prepared myself 'cause like I had friends already in here that I worked with before, previously. So they would sort of like tell me what people are saying and what the talks…all the rumours that are going around. So in a way I've known what I was expecting and what I was going into and that I am going to go there at work and go home, that's all. So that sort of prepped me, *ja* (yes). Obviously when I arrived I felt isolated but I am comparing to now that I know people, it's a busy place and everyone is busy with work and by the time you leave it's almost evening. You are done with all the work in the ward, there is no time to socialise, but when I came I was alone, there is no tea room where you sit and meet up etc. and already you've been labelled when someone meets you at the corridor they talk about you and ignore the pregnant fairy that has just joined…you understand, it was kind of ja…it wasn't a nice experience, but hey.

She then spoke about having to adjust to being back at work after having been on maternity leave. When she was asked whether she felt it was more difficult for mothers or female doctors in general, she responded by saying that she felt that the system does not cater for a good work/life balance:

> Yes, it is hard. The system does not cater for doctors with families, does not cater at all because if you do bad apparently they can't take anyone like if you are a woman. If you look at many doctors, female doctors, most of them don't have families, most of them don't have kids so you've got this system never allowed them with kids, it was not accepted that you become pregnant and you take time off. So people have sort of transcended from that but it's still not that friendly and supportive; when you say your child is sick, we work with kids obviously and they sort of take it lightly as if like your child can't get sick.

6.4. The complexities on the road to specialisation

For this theme I have chosen to use a story-telling approach to reporting in order to set the scene for this theme as it contextualises some of the themes being discussed, and it is consistent with the emancipatory theoretical underpinnings of the study (Shabalala, 2012). In this particular story, the registrar speaks specifically about certain difficulties that speak to issues of access, identifying mentors as well as some of the emotional experiences that can be experienced when trying to get into a programme.

This is Zama's story. She gave an account of how difficult it was to secure a registrar post once she had moved to Cape Town to take up a medical officer (MO) position in order to ultimately get into specialist training. She reported that she had been given hope that if she took up the MO post that she would be in a better position for her to then get into an interview process. She recalled her thought process at the time. She had dreamt about pursuing her studies at UCT and this was finally a possibility. She sat across from me reflecting on what was then the decision to move to Cape Town and the risk that she might not be chosen:

> Will they pick me? Will they really pick me? Me? Me? I did not cum[24] my degree, I... I speak English and I have a lisp and the words don't come and I make spelling mistakes. I, you know, like will they pick me?

Her description was so very rich, and it felt as though I was in the moment with her as she thought about this big move to Cape Town. She then also mentioned that she had been offered two registrar posts, one at the University of the Free-State (UFS) and one at the University of Witwatersrand (WITS). She narrated the dilemma she was faced with. Does she take up the MO position that does not guarantee her a post or does she start with one of the

[24] In this slang usage, to "cum a degree" means to be awarded a degree *cum laude.*

registrar programmes? She likened it to an option of standing in a room, perhaps a room where all the greatness happens but not being able to fully partake in the greatness, and taking a seemingly faster route and getting to the podium quicker but it may not be as great:

> You know, and someone says you know come uhm…how can I put it? Come stand in the room, come stand in the room, you know. You are not on the podium yet, but come stand in the room. Okay, I would rather go stand in that room than stand on the podium at UFS or WITS, no I am going to go there.

Needless to say, she relocated to Cape Town and started her MO post but found that her expectations were not met at all. She speaks about having been met with stumbling blocks and being very frustrated and perhaps regretting having made that decision:

> So, I came here and like there's push back…push back…push back. All the promises I was told; I am going to get interviewed – nothing like that. The same person that made me move here in a space of three weeks, three weeks for a post and told me that you will get your interview for a reg. [registrar] post, was like, "I think…why don't you consider going, doing locums? I mean they're not going to have an interview for a long time. They are not going to have an intake for like a whole year", and then I realised that people here were MOs [medical officer] for like nine months, a year, two years before they joined the programme. I am like what? I've been an MO for two years already; I don't have two more years. I've done, I've written my first exam in MO already, I have an expiry period where I will have to write this exam again. What did I do? I should have gone to WITS, what did I do? I should have started in Kimberley (a small South African city), what; I could be finishing in two years had I started in Kimberley, what did I do? What was I chasing, what did I do?

The devastation, as she described what seemed like a trauma, was palpable as she said, *"what was I chasing?"* She reported feeling a sense of regret because had she chosen the other posts, she would be completing soon, but instead she was met with a number of obstacles. She then described what seemed like feelings of ambivalence because while she was faced with these obstacles she reportedly could not help but feel a sense of awe and being fortunate. These feelings, she reported, were due to her being in the presence of some important names in medical research:

> (Silence) and in the same breath, the same – okay I shouldn't mention names – the same person that wrote the book that I was holding like a bible in Kimberley, I am talking to him. So the same person that wrote the scores we use, was showing me how write exams. Now I have to deal with the realness of this like every day and be like, "I'm so lucky, oh my god, I'm so lucky". I want to stay here, but no they're pushing me, they don't want me around, and now this person is telling me I must go locum, locum? I have no interest in private medicine, no interest, I've never.

Her narrative is not only rich in description but in emotional content as well. She described being overwhelmed with anxiety after the consultant suggested she looks for locum positions in the private sector:

> The day that man said that to me I got into my car and drove down the N5, I had a panic attack in the car, wearing my yellow blouse. I called my friend, I screamed, cried…I couldn't breathe, I couldn't breathe I was like what, what's happening…did I mess up (laughs), did I mess up? Big opportunities that came and missed me…did I mess up? Did I take the wrong turn? Did I mess up thinking I am chasing a dream?

Zama reported that after a while she was then assisted by two Black consultants who helped her secure an interview. Even when she was given the option to go to the other institutions

again, she held onto the dream of doing her specialist training at UCT although it seemed that there were so many hoops to jump through before finally starting the programme:

> Remember I was telling you about the supervisors that wanted me to join in with someone else's PhD? He took me to the side one day, cause he used to see me walk to the corridor, he was like, "hi, do you want to specialise? I see you working here." I was like yes, yes… He introduced me to another Black senior there, like "no ways we gonna figure this out", you know, and I told him that this man told me [to locum]… he was like no! And WITS called again, and UFS called again and I was like look at God! Then I am like okay, like what now? He is like giving me a guarantee that a lady will call you in six months and they all come back.

Zama's account shows how she had this dream to specialise at the prestigious university of Cape Town, but was met with a number of obstacles despite being assured that she would get an interview for the programme.

6.5. The nature of specialist training

All registrars agreed that specialist training is gruelling and many also reflected on how this has been made harder by the research component now being compulsory (Master of Medicine). Many reported on the workload being tough, and trying to balance their clinical work as well as the academic and teaching demands was also challenging. Nonhlanhla expressed that the level of pressure they feel is excruciating, "*so much pressure, I cannot explain the pressure in words".* This suggests that there are a number of pressures inherent in specialist training. A different participant acknowledged that this pressure exists for every registrar (especially at the start of specialist training), but added that in her opinion the pressure is compounded when one is a person of colour:

> You're new you don't know what to do, you're not sure, you don't know everybody and stuff, so like any other new person would feel. I think it was a whole lot harder being a person of colour.

She later added that when she had to do a call alone she experienced feelings of self-doubt and found it helpful knowing that she was not alone in feeling that way. She also commented on the competitive nature of the clinical environment that does not allow for people to be as honest about how they are coping with the demands of specialist training:

> I spoke to this Indian registrar and I said I don't know if I can do this, I am very nervous to start my calls on my own, so he said to me (I think he picked up I was very worried), "we all feel that way, you are not alone", I think it's unfortunate where people don't necessarily say I am not okay today, whatever you go through no one will share it with you. Everyone always creates that environment that oh you are the only one, so he just reminded me that we all feel that way, you know, and I think that helped, I wish we were like that more to each other but we are not and it's a bit of a competitive environment

Sanda reported that it is difficult to relate to White registrars. She also expressed that she felt that there are social pressures that are faced by Black registrars that are not necessarily experienced by White registrars:

> It becomes even difficult to interact with your classmates; like your fellow registrars who are majority uhm, half European descent. They have a different life story you know, they… I've been to uhm…some of their places it's uhm…unbelievable you know, and they got, I suppose they've got life figured out, uhm…they are married and they are having kids, they drive nice cars and they live in nice houses that they own and for you as uh, you know, Black or African it's not your story. Ja, I mean uhm, I

> have to worry about stuff that they don't worry about so uhm…if we study for the same exams, but those exams don't uhm…happen in a vacuum, you know, because I suppose as an individual you not all about school, you are not all about work, uhm…we have to worry about our parents, it's the opposite in terms of their parents, they worry about them.

When they were asked about supportive structures, there seemed to be mixed responses. Some seemed to feel as though consultants were available and ready to help while others felt that consultants were not accessible. This seemed to vary according to the specific specialty the registrar was training in as well:

> The consultants were…surgical consultants are of course not accessible. (Laughs)… Surgical consultants a little bit further, neurology a little bit further I would say.

Sanda spoke about not being able to react in a situation that felt unfair and that they were not supported by their consultant. She also alluded to it being especially difficult when the consultant is White and it appears that maintaining the relationship with other departments was more important than them feeling supported:

> Sanda: I will give you an example, it's like stuff will happen that will drive you up the wall right but you will stop yourself from reacting or you will catch yourself from reacting because for example this situation that I am thinking about, it was something that was totally, it was nonsense and one of my colleagues,, we were both Black, we were called up into a meeting, our professor who is European, of European descent and uhm, basically it was a clash between departments when we got there our Prof is more concerned about maintaining relationships between the departments, more concerned about that than actually defending the regs' [registrars] so if I was one of

> those uh "*lit*"[25] people (laughing) I could have lost it but I can't because, one, as a psychiatrist you are actually suppose to have things together like you can't throw your toys, you know what I mean, worse, you can't throw your toys in front of your…
>
> Nokulunga: …White superior.
>
> Sanda: You know what I mean!

6.6. Support and mentorship

Participants in the study referred to mentorship as a means of bridging the gap between them as trainees and their trainers. Most of the registrars reported that once a good mentorship relationship was established it was quite valuable:

> There's people who've travelled this road before. So they know what challenges are ahead, they know how to overcome those challenges. They can be like your…your champion with the other powers that be, you know, they can manoeuvre the politics for you, well it's supposed to be confidential, so you're supposed to tell them things. If you've going through a difficult time or personal things or even work-related things and they can, you know, take it through the necessary channels and fight for you, be your advocate and so forth, *ja* (yes).

Some departments have formalised mentorship programmes while others place responsibility on the students to identify potential mentors. Participants highlighted that the benefit of them being allocated mentors meant they did not have to approach consultants themselves, as this at times can be intimidating. However, they also raised an issue of fit, which is an important

[25] Slang word for intoxicated that is used in this instance to describe being disinhibited.

element to a workable mentorship relationship. Sanda reported not having a good relationship with her mentor and found that she needed to reach out to others for assistance:

> So what I found is, yeah, I've kept the same mentor ever since, but we don't actually have much of a relationship. I've had to actually identify like other people, you know, that I speak to more than I speak to my mentor. Purely because I think I've had episodes where I've gone to my mentor with something and I just find that nothing happens, nothing changes.

It also appeared that the registrars were not clear about how the mentorship process could take place, and they did not seem optimistic about the possibility of effective mentoring. Tumelo expressed that it was the responsibility of the consultants to respond to the interests of the trainees:

> That's what I expected and that's how I want things to be in the future. If people declare an interest, you must support them from the beginning and just give information.

However, as in many other interpersonal dynamics, there are many challenges that create barriers in mentorship access. One of them is the perceived difference in support for Black registrars due to limited consultants from their own ethnic backgrounds who could potentially be mentors. Nonhlanhla felt that the few Black consultants that are there are not doing enough to support Black registrars specifically. She reported, *"There is one [Black consultant] who I think is very neutral with everybody, but um yeah, which I found a bit disappointing*". She further explained that the disappointment was also due to her feeling as though the consultants were trying to further their own careers without upsetting anyone instead of forwarding any political agendas:

> I don't know, I think everybody is there on their own personal capacity and not necessarily to forward any agendas, and so yes it's nice, but they also seem like the typical or sound like the typical token Black people that are always described.

6.7 Conclusion

Despite transformation efforts that have seen an increased number of students enrolling at medical school, the everyday experiences of training, according to the participants, are still not ideal for Black students. Furthermore, from their point of view, there seem to be a number of challenges that need to be addressed with regards to postgraduate training in medicine. The next chapter will unpack and discuss some of the themes that emerged from the interview data.

CHAPTER SEVEN: DISCUSSION

7.1 Introduction

The data reflect what the registrars chose to talk about; given the open-ended conversational style the interviews took. As a result, a lot of what they spoke about was undergraduate experiences and there were less detailed accounts about their current training. There may be a number of things that could account for what they chose to speak about. It seemed to me that the participants were able to speak more candidly about the institution, the programme and the culture of medicine during undergraduate training than about current experiences. When I interviewed them, I felt as though there was a distance that they allowed themselves – the power of retrospect if you will – where they could identify more openly what they perceived to be examples of racism or race trouble in undergraduate training rather than more recently. Many expressed not knowing whether things they experienced currently were overt or covert incidents of racism, perhaps because they could not create that distance as they are currently in that training environment. There is also the issue that, at postgraduate level, they have much more personal contact with trainers and colleagues – they are no longer part of a large class, but a member of a small clinical team who have to be able to work together. The issue of not focusing on race currently is evidenced by Sanda's account:

> I don't think maybe people are doing it on purpose, ja, you know I just think it's how it is and uhm, ja (yes), Stellenbosch! (laughs) it's how it is!

This illustrates Durrheim et al.'s (2011) concept of race trouble, where individuals may be left with a troubling sense of discomfort when wondering whether an experience is indeed discriminatory along racial lines or not. At the same time, though, through what I read as a coded comment – "Stellenbosch!…it's how it is", I experienced Sanda as appealing to me

implicitly as an insider familiar with Stellenbosch – there was, I think, an assumption or a hope that I would read implicit racial issues in the same way that Sanda did. I have little doubt that my own positionality as a Black health professional who trained at Stellenbosch University affected how participants spoke about their own experiences. These and other themes will be discussed in this concluding chapter.

7.2 Race trouble and politics of inclusion

The advent of democracy indeed called for redress and transformation in higher education. However, troubling race issues continue to be concerning within HEIs (S. Swartz et al., 2018). As the data suggest, it is difficult to be Black while pursuing one's studies due, in part, to the legacy of our apartheid history (Maseti, 2018). Registrars reported multiple ways in which race trouble can occur. This includes issues relating to access – financial constraints, a lack of representation, and feelings of being isolated due to language. All these factors in combination add to a sense of being out of place and the experience of "not being accepted as legitimate students" (S. Swartz, 2018 et al., p. 37). This is evidenced by one of the registrars referring to herself and her classmates who were in the extended programme as the "BEE" students. While Black Economic Empowerment (BEE) is meant to be one of the ways in which apartheid policies are redressed (Alexander, 2013), occupying these positions almost seems like a double-edged sword where the implicit message is, "under normal circumstances you would not be here". "BEE" has come to be a catchphrase in South Africa for many discursive tropes, some of them highly pejorative (Dimitris Kitis, Milani, & Levon, 2018). In a discourse analysis of how the emerging Black middle class is constructed discursively in South Africa, for example, Dimitris Kitis et al. (2018, p. 165) quote the following from South Africa's biggest selling Sunday newspaper, the *Sunday Times*, as long ago as 2009:

> BEE has become the opium of the Black middle classes, and it is now time for rehabilitation.
>
> (*Sunday Times*, 8 March 2009)

In analysing this quotation, the authors (Dimitris Kitis et al., 2018) make the following trenchant point:

> In (the extract above), BEE is compared to the *opium* of the 'black middle class', echoing Karl Marx's famous quote ('religion is the opium of the people'). Ramifications of the metaphor can be understood conventionally, that is, the 'black middle class' is addicted to the drug of BEE. But it can also be viewed as a pun against the socialist origins of both the quote and affirmative action policies like BEE, which the author implies have turned into a 'religion'. Nevertheless, drug addiction is a special kind of dependency that still retains its significance of moral decrepitude and corruption.

I cannot be sure of what the registrar meant exactly when she referred to herself and others as "BEE students" but I can vouch for the fact that the trope of "BEE" is at times in contemporary South African discourse taken to refer to corruption. The use of BEE links to the concept of "tenderpreneurs", a coin termed by a Black South African government minister (Dimitris Kitis et al., 2018). In contemporary South Africa slang, tenderpreneurs are Black people who benefit (unfairly, it is often implied) from government policies to give preference to Black and disabled South Africans to receive tenders from government to complete lucrative government-related work contracts. In all of this discussion, especially as there have indeed been tenders which have been awarded corruptly, and work which has not been completed properly, the terms "BEE" and "tenderpreneurs" are used by some as shorthand to refer to people who benefit corruptly from redress policies. The term "BEE"

here and its discursive ramifications, of course, fits squarely with the contemporary backlash against affirmative action in higher education in contexts in the global North, where discourses of "fairness" are invoked (Carter, Lippard, & Baird, 2019; Morgenroth & Ryan, 2018).

One of the registrars spoke about feeling alienated due to some clinical notes and conversations during ward rounds being in Afrikaans: *"um sorry guys in case you've missed me, I'm Black".* Maseti (2018) speaks about race as a space of constant negotiation. These spaces include daily social interactions that shape one's experience, and if the experience has its ties in our deeply racial, segregationist past, what does it mean for the Black student? The context may implicitly assume White as the norm, which may not be intentional but has serious implications in terms of its exclusionary effects on the Black person. This may be some of the reasons why some, like Maseti (2018), argue that the university is not always "Black student friendly" (Maseti, 2018, p. 346). But what does "in case you've missed me" imply? The issue here seems to be not one of unfriendliness but of unintentional erasure (Cooper, 2018) – the student is describing an experience of being unseen, being overlooked, being invisible.

Further evidence of this exclusion could be seen in Mandla's account where he speaks about asking lecturers to clarify things in English, but they subsequently revert to Afrikaans:

> It was tough to adapt. You had to learn and sort of become independent because you had to rely on yourself, but also got irritating because we did have the right or the freedom to raise your hand say to the lecturer please explain in English but after a while it becomes tedious as well.

This example of race trouble highlights how the institutional culture at SU is formed in a way that privileges those who historically inhabited SU. It is probable that when the lecturer reverted to Afrikaans they were not conscious of how they were taking for granted the politics of space and who belongs in that space. The lecturer(s) may take for granted that that is their space, and the space of those who understand Afrikaans. Therefore, they will not see the need to adapt. Luvalo (2019) argues about this very thing. The tendency to overlook institutional culture when discussing transformation is dangerous, because, as illustrated above, if people from HAIs do not see the need to adapt their ways then it calls to question what transformation means.

7.2.1 Forced servitude – sorry, I mean – dependency

A particular instantiation of more general issues regarding higher education is the nature of medical training and how "Black friendly" this training is. As discussed before, some registrars had to work in clinical settings that were far from where they lived. Mandla reflected on having to rely on a classmate who had a car to get to his practical placement: *"I chose a partner who's got a car – it was a White guy".* Interestingly, when we spoke about this he said, "unlike [you] born-frees[26]" he did not have a car. This statement offended me, as he was making assumptions about what privilege I held as a "born-free" myself, and being implicitly disparaging of me and my assumed privilege, but the fact that he made it does underline the complexity of racial and identity politics in the data and more broadly in South Africa. I do not wish to introduce new data here, but there was something so powerful in his statement and account as it relates to dependency and access. The concept of freedom here (as in "born free") raises an interesting conversation about what is enacted in the exchange of having to get a lift from his White classmate. Part of the issue implicit in this account is having to be grateful for his classmate's kindness, and of course the idea of being dependent

[26] "Born-free" is a term used to describe those who were born in the democratic South Africa, and presumably "enjoy" the benefits of social transformation (Maseti, 2018, p. 62).

on this mercy in order to access parts of his training which may have been difficult for both of them.

Lourens (2018), who is a blind South African academic, writes about the politics of having to depend on others for giving her lifts in their cars in a context where there is poor public transport infrastructure. She discusses the way in which she silences herself and refrains from disagreeing with or upsetting those who are kind enough to offer her lifts, as these constitute for her an "indispensable resource" (p. 568). In her interaction with one person who gave her lifts, she became aware of the subtle politics of her own dependency. She did not want to seem ungrateful for the help, nor did she want to risk that the help might be withdrawn if she expressed disagreement with the views expressed by the person kind enough to offer her lifts, disagreement which she felt strongly. Tellingly, she refers to this as "the politics of shutting up". Lourens' (2018) discussion deals with the phenomenon in the context of disability, but there are similar issues instantiated in relation to those who have fewer resources than others, and in South Africa, as in many other contexts, there is a relationship between not having resources like a car and one's race. Implicit in the registrar's account was the reality of having to keep quiet about parts of his reality (whether or not he felt comfortable about having to get a lift for example), because, as he explained, getting around became easier when the White classmate assisted. This highlights the deeply ingrained roots of oppression (Lourens, 2018). It is a form of race trouble that reproduces a master-slave relationship. It is important to note here that neither the registrar himself claimed, nor am I claiming, that the motives of the White classmate were anything other than helpful and kind. But again, as the discipline of disability studies so clearly shows, kindness and charity, however well-intentioned and necessary for the social good, cannot but reproduce existing power hierarchies. Charity is enacted in situations of inequality – where

all have the same access and resources, charity becomes unnecessary (Riddell & Watson, 2014).

7.2.2 The (broader) "politics of shutting up" (Lourens, 2018)

The "politics of shutting up" (Lourens, 2018) can be applied much more broadly to the data than just to questions of charity. Throughout the data, especially with regards to experiences of registrar training, was the sense of not being able to speak up, even when there were clear incidents of racial discrimination. Sanda, for example, suggested that it would be "futile" to say or do anything about some of her experiences. She went further to explain that *"you can't fall apart every day"* when faced with what seems to be an everyday experience. Lourens (2018) discusses what happens when one has to operate within what she terms an uninhabitable space. She discusses how covert experiences of hostility, feeling unwelcomed and discriminated against lead to a process of being silenced from within. Where woven into one's internal world is a need to remember one's place, it is almost as if it ought to be part of the genetic makeup to be silent, as evidenced by this registrar further saying, *"you don't have it in your DNA to speak up and you basically boil and simmer as time goes by".* Naming subtle discrimination, unintentional exclusion, or dependency is clearly very difficult, and as Lourens (2018) notes, has emotional consequences for participants. The issue here is not just about the futility of mentioning things that are difficult, but also about the fact that to the participants, exclusion was so everyday and usual. Drawing attention to extreme issues of outright racism may be relatively easy; pointing out what is more usual and generally unnoticed is much more difficult. This silencing around quotidian exclusion, of course, links with the literature on microaggressions, which I discussed earlier. It is difficult to point out and name issues, which are there but are invisible to those who perpetrate them, consciously or otherwise. There are at least three levels of difficulty here. First, it is difficult to be the one to name as a problem something which is unseen by others, and especially by those who are

more powerful, because one's perceptions may be invalidated and questioned. Secondly, though, there is the risk that as somebody who disrupts the social order one may be stigmatised and pathologised as somebody who cannot manage the work or the system (*"you can't fall apart every day"*). Third, there is the possibility that even well-meaning people who are consciously committed to redress and transformation may be hurt by being viewed as perpetrating or allowing racism or racist microaggressions. The registrars may not wish to upset or hurt these people, and they may also fear retaliation.

I should like to suggest that there may be something at work here which is common to the experiences of excluded groups, and again, an example from disability studies may be instructive. Writing about her experiences as a child with a visual impairment, French (2004) describes going on a walk with her family and being asked anxiously by her parents if she can see a rainbow. French (2004) cannot see the rainbow, but she says that she can, in order to make those around her, who do not have visual impairment, feel better and less worried about her. Speaking more generally about this issue, French (2004) notes that disabled people and people from other excluded groups have to manage not only their own feelings about being excluded, but also the feelings of those (in French's case, nondisabled people) who are in the dominant group. The registrars who spoke with me told me a similar story – as minorities in the White world of medicine, some of their silence and fitting in may have been part of their taking on the extra load of dealing with the emotions of those whose world and assumptions were excluding them. This may have been partly to do with fear of retaliation, or worry about being seen as mad or insufficiently strong (*"you can't fall apart"),* but it also speaks to the hidden emotional labour which may go hand in hand with being part of an excluded or oppressed group. Jansen (2019) discusses the role of Black domestic workers in South Africa, who are commonly described by employers as "like family" when in fact they are not full family members in a range of ways. They are positioned as not able to speak of

this truth – that they are not family. In a similar way, the registrars are in a world that excludes them, but to speak of how they are not "part of the family" may endanger the implicit agreement amongst those around them to see everyone as unproblematically part of the same group – "like family".

7.3 On Being a (Black) doctor

7.3.1 Is being a doctor at odds with social responsibility?

Wildschut and Mayers (2018) discuss the role of medical and allied professionals in the perpetuation of injustice during apartheid years (see Chapter Two), and suggest that their social role is one of constant conflict in post-apartheid SA as well. One of the things they also highlight is the dual loyalty healthcare workers find themselves holding. The duality of loyalty here is the understanding that a doctor, for example, has a duty to their patients and to ensure just care and access, but also loyalty to their employer, which is in most cases the state (Wildschut & Mayers, 2018). In the context of the participants, duty to their patients could potentially stretch beyond providing care to also include social responsibility (Paul, 2019). One of the things I found interesting was what seemed like a reluctance on the part of participants to engage with student protests or general discussions about transformation and change, partly because it appeared that they saw this role as not in line with being a doctor. Some said that it could be detrimental to their careers if they participated or even engaged in political discussions. There was a sense that being politically engaged did not marry well with medical culture. It appeared that avoiding political engagement was a strategy to perhaps ensure success but most evidently to not get into trouble. Consider Zama's reflection of being asked by her consultant whether she was training to be a doctor or a politician because she wore a t-shirt with Steve Biko's face on it: *"I realised that I can't go to the hospital with 'my change divide' t-shirt, my Steve Biko shirt"*. The feeling that one cannot engage with politics

as a doctor perhaps links to conversations about doctors being superhuman (which I will discuss shortly) and may be true for all doctors. However, the experience may be different or perhaps create more tension for Black doctors who also may have an increased fear of getting into trouble in a world in which their status is not secure. Zama reported that her voicelessness and fear of not conforming to the medical environment (which would potentially have negative consequences for her) made her feel complicit in perpetuating certain injustices:

> You know, I was very complicit allowing…something just didn't feel right, I didn't realise that this is institutionalised racism, I did not realise. I did not have the words to say that.

For some of the participants it may be true that they feel engaging in politics puts them in danger of not succeeding or getting into trouble. Others may genuinely believe that the role of the doctor is an apolitical one; or both positions may be true for some. It is also intriguing that Zama says, "I did not have the words to say that" – it is possible that for some of the registrars, they feel that they do not have a political vocabulary, or a way of articulating political concerns which they view as not in the traditional purview of medicine, an issue I discuss below. However, from the data and from my interaction with the participants, I often gained the impression that the participants may be anxious about causing disruption and becoming visible to scrutiny in an environment where they may not feel a sense of belonging.

7.3.2 Constructions of being a Black doctor

I now want to briefly comment on how being a doctor is discursively constructed within the data. A few scholars (Haslam, Loughnan, Kashima, & Bain, 2008; Ofri, 2013) have written about such constructions. We even see how the medical world is constructed on

television as well, which also shapes how we understand it. The following quote is taken from the popular medical television series Grey's Anatomy:

> The lab coats and badges and scrubs all work together to indicate a person of authority, someone you can trust. When the clothes come off, that's a different story. We're sensitive, lonely, human.

Here Dr. Meredith Grey, the protagonist, reflects on how doctors are often viewed as superhuman and devoid of all feelings whereas in reality they are humans with the full range of emotions. Ofri (2013) discusses that there is a general understanding that emotions are present at every level of medicine, but she argues that these are often grouped with the "all encompassing" (p. 9) experience of stress and fatigue. She further suggests that within this construction of emotion, essentially as a symptom rather than a part of being human, the assumption is that the skilled medical practitioner should be able to adequately deal with these "part of the job" feelings. Ofri (2013) argues that there is a tendency in medicine to disregard the more complex and nuanced emotions that any human, including doctors, can have. One of the registrars spoke to this very thing, saying, *"as a doctor, you are not a human being"*. The assumption here is that doctors cannot be overly involved emotionally with patients, and should maintain a neutral stance. This generalises to a view about politics – in relation to politics this positions doctors as apolitical, as their role is to serve all. Globally, there is very good evidence that political factors, and social inequality in particular, can have strong negative effects on health (Wilkinson & Pickett, 2011, 2019), and South Africa is one of the most unequal societies in the world (Soudien, Reddy, & Woolard, 2019) with a range of associated poor health outcomes (Pillay-van Wyk, Dorrington, & Bradshaw, 2017). So the construction of a doctor as someone who should not be moved by political questions, and questions of poverty and exclusion, may have implications for how much medical personnel, and especially those from formerly excluded groups, may have an effect on population

health. But, as I suggest below, it may also link to constructions of what it means to be a Black person.

7.3.3 A double death: The Zone of Blackness as the Zone of non-being

These conversations about being nonhuman, or, as a doctor, as something other than human, may link in a possibly unexpected way to other ideas about who counts as human. The participants in this study are professionally socialised to not being human, in a sense (as the participant cited above put it, *"as a doctor, you are not a human being"*), in line with common cultural expectations of doctors in many contexts (Ofri, 2013). However, I cannot help but also think about what this might mean for Black doctors in South Africa and similar contexts. The participants in this study live with the historical legacy of being viewed as part of an inferior race. Maldonado-Torres (2016, p. 19) called this the "zone of non-being" where he conceptualises the zone of blackness as the zone of damnation, suggesting that in historically racist contexts, to be Black is to be seen as cursed and damned. But, the form of how this works goes further than this. Black subjectivity is located within the tension between the "desire" to be White (regarded as human) and complete resignation because "the hell of coloniality is that of self-erasure: blackness must disappear or at least be covered-over by whiteness" (2016, p. 14). So the participants as Black people may be being positioned as not human in two ways. First, as doctors they may be positioned as not human, and second, for very different reasons, as Black people they may also be positioned as not human. It is possible that there are two assaults on these participants' sense of themselves with legitimate views and emotions – as doctors they may be positioned as discursively outside or above the realm of human subjectivity, and as Black people they may be positioned as discursively ineligible to be part of the group allowed to experience fully human (i.e., White) subjectivity.

7.3.4 Cleanliness is next to godliness: Symbolic systems of purity[27]

There are other ways in which participants in this study may be understood as having to deal with contradiction and disavowal. If being Black is inferior and is the "zone of non-being" as Maldonado-Torres (2016) puts it, then it is a small step to assume that one cannot be Black and a doctor at the same time. This echoes ideas of what a doctor ought to feel, know, and in this case, look like. After having had conversations with my participants about being a Black doctor, I start to see a potential existential crisis for them – a situation which could have effects of making the registrars feel helpless. The reality of being a Black registrar at these institutions (SU and UCT) may be that one is painfully aware of being out of place or occupying a space that is not theirs.

Another way of discussing this is by looking at Douglas' (1966) ideas of purity where she explores the idea of dirt and "dirt avoidance" (p. 36) in a symbolic way to understand what is considered "pure". Relevant to this study is the idea of dirt as "a by-product of systemic ordering and classification of matter" (Douglas, 1966, p. 36). Consider this quote from one of the registrars: *"I am starting work now at the hospital and they don't like untidy hair".* Implicit in this statement, and indeed in the data in its entirety is the sense that these doctors experience themselves as pollutants in what used to be a "pure" (White) space or social order. Within this order, even the way they looked had to change to something more "clean". Douglas (1966) encouraged us to look beyond hygiene as narrowly understood in our definition of dirt in order to understand its symbolism, but one cannot help but wonder what happens when your very being represents dirt and you must try to mould yourself into a cleaner version of yourself in order to fit into a structure that was not made for you – where your existence is constantly at odds with cleanliness, and of course cleanliness is central to

[27] Douglas, M. (1966) *Purity and Danger: An analysis of the concepts of pollution and taboo.* New York: Routledge and Kegan Paul.

good health. As medical doctors training in hospitals, the registrars must constantly be aware of the need to be clean, so as to avoid infection and other poor health outcomes. This may be a psychological challenge when in some way one's presence in the "White" zone is in itself a form of social pollution. Ideas about cleanliness have links to other ideas of course – as we see in the aphorism "Cleanliness is next to godliness". Ideas of what is deemed clean and appropriate, and by whom, reflect contemporary forms of the colonial enterprise – with the attendant links with coloniality as a continuing implicit ideology.

7.4 The patriarchy of medicine in South Africa

The number of women entering registrar training continues to be relatively lower than men. Ncayiyana (2011) argues that women tend to gravitate toward what is seen as "softer" specialties like pediatrics, while men tend to dominate the "harder" specialties like surgery. As reflected in the data, one of the registrars discussed how difficult it was for her when she chose surgery as a specialty. She spoke about having to verbally defend herself when a male senior wanted to place the blame on her for a surgical error and subsequently assaulted her:

> I think I stopped wearing that white coat thing long time ago but then with my clothes like he was carrying me like I was so scared. I just looked at him and I spoke back I was like I'm not gonna keep quiet like do whatever that you wanna do but I did not kill the patient but I handed him over to you and I don't know what you did.

Perhaps the male colleague was pulling rank based on seniority, but the participant understood it as partly a product of his loathing that she had expressed an interest in surgery. She recalled her thoughts at the time:

> I cried like oh *(sighs)*… So then that was my personal experience as well in surgery, male-to-female, like realising that shucks like I think these people are serious like

> they're serious that surgery is not for females. I was like oh well screw him. Like I like surgery like what are you *gonna* [going to] do?

Ncayiyana (2011) highlights how some in the medical fraternity have anxiety about medicine losing its prestige due to the increase in the number of women. One cannot help but wonder if this were perhaps the case with this particular male doctor, and if he thought that due to the participant's "inexperience" and her gender it would be more plausible that she had made the error that led to the patient dying. So, the assumption is that the ideal doctor, her male counterpart – mechanical and superhuman thus devoid of error – could not have made an error, which is frequently at odds with what women "naturally are". This complicated construction of women in medicine in its relation to sociocultural expectations also intersects with race.

This is of particular importance when considering that Black female registrars in this study predominantly function in a medical space that is historically White and masculine (Thackwell, 2014). Most of the participants in this study are Black women, and therefore it warrants mention. One of the registrars mentioned that she is the only Black woman in her department. She reflects that most times she does not notice that she is, but that at times she has moments of wondering if her experience would be better or if she would feel less isolated if there were more Black women in her department:

> I am the only Black female [in the department] and most days I don't go to work feeling oh my gosh I am the only black female, but I have days where I feel if there were other Black females would it make a difference? Would I feel like a minority?

7.4.1 Gender, mis/non-recognition and citizenship

Another participant spoke about starting her registrar training whilst pregnant. She reported that the consultants were very understanding and helpful, but she also reflected on

the need to keep up with the workload so as to ease her colleagues' concerns about their needing to pick up work she could not do. She reported being looked at as though being simultaneously pregnant and specialising in a medical discipline was a bizarre thing to do. While there has been an increase in women in medicine globally, there still appears to be a lack of mindfulness in terms of how the structures, like the culture of working long hours, serves to marginalise women in medicine (Thackwell, 2014). Thackwell (2014) discusses how working long hours is a norm even if it is above and beyond what is contractually expected of them. This does not allow much of a work/life balance and assumes that the responsibility of maintaining the family falls on the spouse, traditionally the woman. If we look at the intersection of race, culture and gender here, another thing to be considered is the socio-cultural expectation for some women to perform certain duties in the home, which may conflict with what is expected of them at work. Medicine in this regard is still very patriarchal and needs to look at ways of accommodating women.

7.5 Specialist training

7.5.1 Post-1994 realities and transformation in higher education

> *Nabo besiza! Baphethe izibhamu; bathi siyaboyika, bathi sizobaleka – asiyi ndawo! Asiyi ndawo! Sizophumelela! Asiboyiki ke thina, ngoba thina sizophumelela. iNkosi ijongile, amadlozi ayabona. (Amanda Black, 2017)*
>
> *Here they come! They are carrying guns; they think we are afraid, they think we will run away – we are not going anywhere! We are not going anywhere! We will conquer! We are not afraid of them, because we will conquer. The Lord is watching, the ancestors can see*[28].

[28] The word here is used figuratively to describe how ancestors watch over those who are still living with the purposes of guiding them.

The quote above is taken from the song *Phumelela* by Amanda Black, the title of which means to succeed or conquer in both isiZulu and isiXhosa.[29] During a recent performance, the vocal powerhouse, Amanda Black, spoke about how the song was inspired by the Fees Must Fall movement. She explained that when she initially wrote the song it was about the students' struggle, but that it has since evolved in meaning for her and represents the daily struggles experienced by the majority of South Africans: *"When I initially wrote this song it was inspired by the fees must fall movement, and every day it becomes about life – every day situations".* When I heard the song for the first time, I thought wow! Imagine my generation, the so-called born-frees, are singing struggle songs in post-apartheid South Africa. It also made me think of Chikane's (2018) argument about the country that was born in 1994 – a stillborn country that has not really moved forward in terms of progress. This may be a harsh evaluation by Chikane (2018), but it does call up questions about politics and time. If transformation is about changes over time, and we are still making struggle songs that reflect the state of our nation where the youth are intimidated with guns while fighting for their rights, what does that mean about transformation?

7.5.2 "What was I chasing?" Obstacles on the road to specialisation

Zama spoke about having dreamt of going to UCT for a long time, and she used the analogy of standing in a room [of greatness] that she wanted to be a part of. For her, and for many other participants in this study, going to UCT was about accessing excellence. She left Kimberley in pursuit of excellence and took up a medical officer's post after being promised that an opportunity to apply and undergo specialist training. She had already two offers at other universities and had written two of the examinations in partial fulfillment of her MMed, but chose to go for her dream and move to Cape Town and wait for a post. She explained that

[29] isiZulu and isiXhosa are cognate Nguni languages and share a lot of vocabulary. They are generally mutually comparable.

she was met with a lot of obstacles and that she was running out of time. What was striking in her narrative was the idea of a dream deferred (Gevisser, 2007). Chikane (2018) discusses this theme in relation to the realities faced by post-1994 Black South Africans. Chikane (2018) argues that the student protests questioned and called for the urgent change of the status quo. He further argues that it is due to this status quo that "the dreams of millions of South Africans in 1994 were dreams deferred" (p. 3). Chikane (2018) argues that South Africa's youth is starting to see beyond the illusion of the miracle. One could argue that on some level, Zama could have felt that finding herself in this room of greatness was something of a miracle, a dream, that she seemingly fast became disillusioned by, *"what was I chasing?",* as she asked herself. Zama reported asking the consultant that assured her that there would be interviews for a registrars post about the status of things and he suggested that she go into the private sector. This calls up ideas of Black women seldom occupying higher positions in the academy and having less representation in postgraduate medical education.

7.5.3 Where is the miracle?

In solution focused behavioural therapy one of the techniques used is the "miracle question" and one version of this goes as follows (Pichot, 2009, p. 27 as cited in Searight, 2010, p. 1):

> Suppose tonight, while you are asleep, a miracle happens and this problem is solved. You didn't know that the miracle happened because you were asleep. What will be happening the next day and how will you know that the problem is solved?

The response to this question would indicate what would be present in a person's life if the problem were no longer there. The difficulty I face with trying to apply this question to the imagination of a post, post-apartheid South Africa where a miracle has indeed taken place overnight, is that I cannot imagine it. This is in part because I do not know for whom post-

apartheid is post for and how long the actual wait for real freedom, real transformation will take. I struggle to envision what a transformed South Africa can look like.

7.5.4 Chronopolitics: Hurry up, and wait

Part of the difficulty in imagining a transformed South Africa, and more specifically a transformed university space, is the pace at which things are changing. Also striking in Zama's narrative in earlier discussions in the results section was the idea of what we are taught growing up. For most people, but especially for Black people, the message growing up is, "education is the key to a better life". Unfortunately, for many young Black people, this becomes an impossibility after grade 12. So, one has to "hurry up" and finish up high school only to wait for access. In the university space specifically, and thinking back to Zama's story, I question whose time counts but also what it means to be patient.

Specialist training is in many ways is a race amongst the "best" in the field. It is also, now with the Master of Medicine (MMed) being compulsory, about what can be delivered in that short space of time as well (Felt, 2017). Registrars are expected to complete their clinical practical, write their examinations as well as complete a research project within a certain timeframe. Felt (2017) argues that the focus on what can be delivered in a short space of time may work to the detriment of what can be achieved in the long run. That is one example of the academy's time being more important than the students' time. However, also consider what it means to have to be patient in a postgraduate space that does not take into account the implication of having to wait. Zama reflected on her frustration in terms of the barriers to her getting into specialist training; aware that she did not have the luxury of time. She reported that her anxiety, and possible depression, was due to the system not being aware that she did not have time to wait until a registrar post opened up. She did not have time to go into private medicine and wait it out: *"I don't have two more years… I have an expiry period".* The

burden of waiting is often on those who continue to be disadvantaged. It feels to me that the plight of most Black students is needing to hurry and get things in order for them to realise their HE goals but then need to wait for access, recognition and citizenship – so the struggle for freedom continues. And what does it mean to have, as Zama puts it, "an expiry period"? To expire, literally, is to die. I do not think that Zama was consciously talking about dying, but her talk does lead me to recall what I have said earlier about the zone of non-being. Could it be that there is a sense here of waiting to be regarded as human, and that if the waiting takes too long, the consequence is akin to a form of death or of never becoming fully human? This may be putting things strongly, but I think there are elements of this basic struggle in the data.

7.6 Talking about race: Personal reflections

I spent a lot of time looking at literature to try conceptualising, and perhaps understanding the race trouble in post-apartheid South Africa for myself and for the purposes of my research. I found that arriving at definitions and conceptualisations was difficult. I often gravitate toward personal narratives because, for one, they are written in accessible language, and based on the understanding that if it is true for one, there is at least one other person that can relate. In my search for narratives about racialised experiences, I found Eddo-Lodge's (2018) book entitled *Why I am no longer talking to white people about race,* and I found the title intriguing. I initially misread the title as: *Why I am no longer talking about race.* This intrigued me because I thought the book might be one of two things: i) a White person's account on how tired they are of hearing us Black people moan about racial politics so long after apartheid; ii) reflections of someone, much like my participants, who feels that these discussions fall on deaf ears. On closer inspection, and wondering why there was a space between the *talking* and the *about race* I realised the deliberate use of a black and white

cover, where the book is white, the font in black but with the exception of *talking to White people* being in white for it to actually read as *Why I am no longer talking to White people about race*. The brilliance of the cover alone made me buy the book, but I wondered what this account would be about. Was it a story of colour-blindness or frustration towards White people's lack of acknowledgement of the persistent nature of racial issues? I definitely got a sense of resignation, though, which was a clear theme in my research – the resignation of oneself to the hopelessness of the situation.

I read the preface of the book, which I found to be the most useful for me. I found it particularly striking because the author situates how this book came about. She presents a blog she posted in 2014 about why she is no longer talking to White people about race. In this post, her agenda was to express how she felt, unbeknownst to her that the responses would lead her to writing a book about the issue. She writes:

> I'm no longer engaging with white people on the topic of race. Not all white people, just the vast majority who refuse to accept the legitimacy of structural racism and its symptoms. I can no longer engage with the gulf of emotional disconnect that white people display when a person of colour articulates their experience (p. ix)

Eddo-Lodge (2018) encapsulated the general feeling I sit with when it comes to talking about race. As I was writing this dissertation I was working in a predominantly White private medical setting, and in this context I am reluctant to talk about my research because when I did I was often met with what I experience as disapproving eyes. Most importantly, Eddo-Lodges's (2018) experiences throughout the book capture what I think my participants must be feeling that leads them to err on the side of not saying anything about what they experience as difficult racial dynamics or experiences of outright racism. The fact that the

registrars rather find ways of persevering in their training environment because the alternative is that their career is at risk is unacceptable.

As I read Eddo-Lodge's (2018) book, I was reminded of when I presented my article for the SAJHE (Chapter Five) at the University of Kwa-Zulu Natal's seminar on the hidden curriculum of medical education in 2017. After I anxiously delivered my auto-ethnographic account, questions were invited. My co-supervisor asked a rhetorical question: "So, where do we take our Black child for medical training?", implying that there is no right place for Black people to learn to become health professionals in South Africa. He asked this after we had had multiple conversations about the nature of medical and allied health discipline training, and the challenges faced there.

Then a White member of faculty raised a question. He asked: *"But isn't Masters training difficult for all the students?"* This served to completely devalue and trivialise my experience, not because Masters training is not difficult for everyone, but because the specificity of Black experience was not seen or acknowledge by a White person. In this regard, the intervention by the faculty member reminds me of the debates about "Black lives matter" versus "All lives matter". As Atkins (2019) notes, the "Black lives matter" movement in the USA came about to highlight widespread neglect of the value of Black people's lives. The "All lives matter" backlash, largely on the part of conservative Whites, Atkins (2019) suggests, arose from a misreading of the "Black lives matter" movement as one trying to create a special (and overvalued) place for Black experience rather than as a movement designed to redress historic and ongoing disadvantage and exclusion.

But back to the meeting in 2017. In response to the comment from the faculty member, my Black co-supervisor rolled his eyes, and my White supervisor, with horror in his face, responded, saying that it is difficult for all but we do not enter the situation on an equal footing. Whether we like it or not, this is the reality. But, for the purposes of this discussion,

let me come back to this. For me, as emotional and exposing as it was to present my auto-ethnographic paper, it felt like there was that emotional disconnect that Eddo-Lodge (2018) describes. I was telling a story of how difficult Masters training was for me as a Black student and I was met with *"Masters is difficult for all"*. No-one has ever doubted that White lives matter in the systematic way that there have been doubts about the worth and value of Black lives Similarly, no-one has ever doubted the competence of White people as a group, but we find our students reporting feeling that they *need* to work extra hard to defy racial stereotypes and most importantly to get by. As Eddo-Lodge (2018, p. xi) says:

> I can no longer have this conversation, because we're often coming at it from completely different places. I can't have a conversation with them [White people] about the details of a problem if they don't even recognise that the problem exists. Worst still is the White person who might be willing to entertain the possibility of said racism, but who thinks we enter this conversation as equals. We don't.

The participants in this study were painfully aware of how different their experience was. They spoke about Black tax and the need to think about their social responsibility in relation to their identities as doctors contrasted with what they believed was the experience of their White counterparts. The structures in HEIs like UCT and SU often influence the way in which registrars experience their training environment and how that environment can render them voiceless.

7.7 Some solutions?

7.7.1 Decolonising the Black psyche

The need to decolonise the Black psyche also speaks to the rejection of what colonisation and more recently, apartheid, defined the Black person to be. It is the rejection of *"the old assumption on which White domination was based because they diminished the*

value of the person if he was not White" (Ngubane, 2015, p. 26). Ngubane (2015) argued that due to South Africa's segregationist legacy, Black people in South Africa have lived needing to apologise for who they are and not embracing their personhood.

The feeling of defeat or the participants resigning themselves to things potentially never changing or, if they do, that it would not happen any time soon was striking. Some of them reflected on being taught not to "disrupt the peace" and follow instructions and get out – the blind, sheepish position that Biko (1978) was energetically against. He argued that *"the most potent weapon in the hand of the oppressor is the mind of the oppressed"* (Biko, 1978, p. 69). As a clinical psychologist, I agree, more than anything, that we as Black people need to gain more confidence – that pride and determination (Biko, 1978), especially when operating in spaces where we tend to be the minority. Biko (1978) also suggested that the freedom that the Black man seeks comes from within them rather than it being something to be acquired externally. This is not to say that issues of institutional racism and covert ways in which racism is perpetuated in post-apartheid South Africa are not to be addressed, but rather a suggestion that there is some responsibility to be taken by us to free ourselves from the inferiority complex that sometimes stands in the way of us achieving greatness. We need to continue having these conversations about the mental state of Black South Africans. We need to decolonise the mind so that African thought can have its place in the academy rather than it being in reaction to something. Biko (1978) suggested that it is necessary for the process of Black evolution to be shown in order to understand Black subjectivity today. He also alluded to this being possible through re-establishing *Ubuntu* or connectedness:

> We must relate the past and present and demonstrate an historical evolution of the modern African. We reject the attempts by the powers that be to project an arrested

> image of our culture…we must seek to restore to the Black people a sense of the great stress we used to lay on the value of human relationships.

Many of the registrars spoke about not daring to speak up or choosing to be invisible in clinical spaces. I also reflected on instances where I feared being discovered, as this would reveal the fraud I believed myself to be. There seems to be a tendency to shy away from fully inhabiting all aspects of the self in certain spaces as a survival instinct, and we can see from the earlier discussions why this is. There seems to be a tendency to not rock the boat, only speaking when spoken to, and at times the need to outsource validation from our White counterparts in order for us to start feeling some sort of pride. We need to start taking ourselves seriously, and take ownership of who we are as Black people.

7.7.2 Support systems and mentorship

Mentorship has been regarded as an important component to medical training as it has been seen to promote and develop professionalism among medical trainees (Bagwandeen & Singaram, 2018; Thackwell, Chiliza, & Swartz, 2017). Bickel and Rosenthal (2011, p. 1229) provide us with a broad definition of what mentorship is: *"a scaffold for sharing expertise in the service of lifelong learning that could otherwise only be attained through experience"*. The medical world is very competitive, and data show that it is quite overwhelming, especially at postgraduate level. Mentorship, therefore, forms an integral part of the success of trainees during their training as well as in their careers (Bagwandeen & Singaram, 2018; Bickel & Rosenthal, 2011). During the focus group, one of the registrars reflected on the value of mentorship:

> There are really some good consultants that are looking out for juniors and they are fairly doing so, because my second exam experience was quite different, it was quite different. Um, now in retrospect, I realise that it's important to have good leadership and it's important to have good mentorship.

7.7.3 The hidden curriculum

In a field where diagnostics, research and practices are constantly changing, trainees need support and guidance in addition to the formal curriculum (Alpert, 2009; Grossman, 2016). The mentorship process can help students' access to what is known as the *hidden curriculum* of medical education. This refers to the norms of medical culture, interpersonal skills and values that may not necessarily be included in the formal curriculum (Kentli, 2009; Thackwell, 2014). It is the socialisation aspect of education that helps trainees navigate a complex socio-political environment inherent in higher education. Kentli (2009) argues that it is for this reason that the hidden curriculum is important for critical pedagogy. Participants in this study reported that a lot of the pressures that come with medical specialist training could be alleviated through mentorship relationships. A mentorship relationship includes a number of intricate interpersonal dynamics including issues of power or hierarchy, the expertise of the mentor and the interests of the mentee (Thackwell et al., 2017). Participants in the study referred to mentorship as a means of bridging the gap between them as trainees and their examiners. Most of the registrars reported that once a good mentorship was established that it was quite valuable:

> There's people who've travelled this road before. So they know what challenges are ahead, they know how to overcome those challenges. They can be like your…your champion with the other powers that be, you know, they can manoeuvre the politics for you, well it's supposed to be confidential, so you're supposed to tell them things. If you're going through a difficult time or personal things or even work-related things and they can, you know, take it through the necessary channels and fight for you, be your advocate and so forth, ya.

The above excerpt from the focus group highlights the roles that a mentor can play in a trainee's journey through medicine. It also assumes a mutually beneficial relationship where all parties' interests are served and there are good intentions (Bickel & Rosenthal, 2011). Some departments have formalised mentorship programmes while others place responsibility on the students to identify potential mentors. Participants highlighted the benefit of being allocated to a mentor and not having to identify one themselves, as this at times can be intimidating. However, they also raised an issue of fit, which is an important element to a workable mentorship relationship. One of the participants reported not having a good relationship with their mentor and found that they needed to reach out to others for assistance:

> So what I found is, yeah, I've kept the same mentor ever since, but we don't actually have much of a relationship. I've had to actually identify like other people, you know, that I speak to more than I speak to my mentor. Purely because I think I've had episodes where I've gone to my mentor with something and I just find that nothing happens, nothing changes.

Being assigned to a mentor early can ensure that a student can access resources sooner, but as highlighted above rapport is very important. It also appeared that the registrars were not clear about how the mentorship process could take place, and they did not seem optimistic about the possibility of effective mentoring. One of the participants expressed that it was the responsibility of the consultants to respond to the interests of the trainees:

> So that's what I expected and that's how I want things to be in the future. If people declare an interest, you must support them from the beginning and just give information.

However, as in many other interpersonal dynamics, there are many challenges that create barriers in mentorship access. One of them is that underrepresented minorities often express feelings of isolation with limited mentors from their own ethnic backgrounds. While efforts have been made to include diversity among medical students, in South Africa this is more evident in undergraduate training than in postgraduate studies (London et al., 2009). Both Stellenbosch and University of Cape Town registrars highlighted the lack of Black consultants at the training hospitals. They also identified this as a barrier to acquiring a mentor, especially if the responsibility is placed on them to approach a mentor. Bickel and Rosenthal (2009) raise this as a great concern because even the well-meaning White consultant may lack the nuanced understanding of things that might plague some Black trainees, for example "Black tax" (p. 1230). In most cases, mentees look for someone they can relate to and a lack of diversity in postgraduate medical education may discourage trainees from approaching consultants (Thackwell et al., 2017). The themes of affinity and identification seemed to relate to the extent to which registrars felt they could identify a mentor where formal mentorship structures were not established.

Thackwell et al. (2017) discuss factors contributing to the slow progression of transformation efforts at South African medical schools. They suggest that the lack of open conversation on the historical structures of racism and their legacy within HE and medicine serves to ultimately sustain and recreate contemporary ways in which race issues occur in the medical space. Silence, in this regard, becomes one of the culprits in the way of effective supportive structures being established. Interestingly, the participants in this study seem to place all the responsibility of facilitating transformation efforts on Black consultants. Registrars suggested that one way to help transform medical education would be through having more Black consultants at academic hospitals. This would increase the likelihood of the establishment of mentorship relationships. Implied here is the idea that people tend to

gravitate toward and relate better to people with similar characteristics. It was also interesting, however, that the registrars were somewhat suspicious of the few Black consultants that are there. They reflected on their expectation of the Black consultants to mobilise change, and held them somewhat responsible for things not moving as quickly as they could:

> P2: What I'm saying is the level of distrust comes as the fact that as a consultant, how have you let, like all these things, continue going on? In this department, haven't you noticed that this and this and this is going on for the Black registrars?
>
> P1: Why is it that as a [Black] consultant, you get along with these White consultants and this status quo actually continues to go on in your presence? Everyone has aspirations. I mean, people want to be heads of department, people want to be…so maybe even the Black consultants are also keeping their heads down in order to get like some kind of career progression. To a certain extent also as a Black registrar you feel, is this person being genuine in their wanting to mentor me or is it just Black guilt? Like I feel like I need to reach out to this person because they are Black?

7.7.4 A cautionary note: the hybridity of Black academic identities and the burden of expectation

At the time when the data were collected for this study, Professor Bongani Mayosi was serving as the Dean of the FHS at the University of Cape Town. Prof Mayosi was the first Black Dean in that faculty. His name came up a lot during the interview process where he was identified as the beacon of hope to mobilise change. The introduction of new data here is important for this particular discussion on transformation. When asked what they felt are the ways in which medical education can start transforming, Nonhlanhla reported the following:

> So what I hear, um I don't know Prof Mayosi, so I just hear from other people, um that they're trying to get as much Black academics into senior positions as much as possible but also not just because you're Black but they are actually equipping the people…you know, like he's basically mentoring people from the younger stages and ensuring that networks are open, not just in South Africa but making sure that they're relevant um on a global scale which I think is a good idea.

For some of the UCT registrars included in this study and for many Black students, Professor Mayosi was going to facilitate real change. News broke in July 2018 of the Dean's completed suicide. He, reportedly, had been suffering from depression for two years (News24, 2018). This news shocked the medical fraternity by storm with many reflecting on his selflessness, level of approachability and leadership. In a time where social media plays a huge role in reporting on current news, it was no surprise that there was an overwhelming Twitter response to the Professor's death. Some strongly blamed UCT for Mayosi's death. We can never know why the Professor made the decision to end his life, but like many, we can speculate and wonder about what it must have been like to be in his position as a Black academic in leadership, an example of a form of dual loyalty. Therefore, the brief mention of Professor Mayosi and his suicide here serves to shine a light of what a burden it can be to hold the responsibility of embodying the enterprise of transformation. In an article for the *Daily Maverick*, a doctor from the surgery department at UCT, Lydia Cairncross (2018) reflected on Professor Mayosi's death:

> … the responsibility of being the beacon and role model, and therefore never stumbling, never failing, never showing weakness. The responsibility for supporting individually and collectively, socially and academically, the young Black students and

> staff who desperately need a light before them to guide them onwards. This is a privilege yes, but also a massive responsibility.

She later further added what she could imagine to be a tension between needing to, on the one hand be a leader within the university structure and not encourage the *"unacceptable and reprehensible"* (Nyamnjoh, 2015, p. 48) behaviour of the student protestors, and on the other hand be a symbol of hope for students and facilitate change. There are not enough data for me to form too much of an opinion in this regard, further research would be indicated (which I will discuss later in the concluding chapter). However, I remember the feeling I had after learning of Prof Mayosi's death and thinking if it was a cosmic way of answering the question of the re-imagination of higher education and medicine that Ratele (2015) posed. For me, it goes back to the argument that we need to acknowledge the legacy of apartheid and its structures and understand that there are such structures that still persist that make the experience of higher education and medical education exclusionary for Black and other minority students. This needs to be addressed not only by representativity in terms of race, but also by ensuring that certain exclusionary traditions are understood then subsequently dismantled to make way for new institutional practices.

CHAPTER EIGHT: REFLEXIVITY, CONCLUDING THOUGHTS, LIMITATIONS & RECOMMENDATIONS

8.1 Reflexivity and Bias

In a recent talk on women and rage, Canham[30] (2019) mentioned that anger and rage are important feelings, especially when engaging with issues relating to race. He mentioned that allowing ourselves to feel rage in response to something we experience as unacceptable is a form of loving ourselves, and a sense of some hope that things can be different. The reality is that when I engaged in these conversations with the registrars in the study, I was aware of how difficult it would be for me to be objective and just tell stories about Black students' lives from an outsider perspective when I am a Black student myself, and in the healing profession. I deliberately use the word conversation, as that is what I was engaging in, a co-construction of meaning. Critical reflexivity, one that moves beyond just stating my investment in the research, moves beyond positioning the researcher as the "knower" and emphasises equal power between the researcher and the researched (Shih, 2019, p. 231). When you set up the research journey that way, bias cannot be completely eliminated and perhaps should not be. I understand that the outcome of the research would likely look very different, and perhaps less emotional, had it been done by someone completely different. I do not claim to have had no feelings or identification going into this research process, and I am aware that the conversational style influenced the kind of data I collected. However, conceptualisations of bias have their foundations in positivistic epistemologies (Roulston & Shelton, 2015). Roulston and Shelton (2015) encourage us to re-evaluate how we understand bias, and understand that while it may limit what can be discovered, it can "also motivate and illuminate inquiry" (p. 336).

[30] An Associate Professor at the University of Witwatersrand.

I also remember walking away from each interview exhausted, not only because it was hard work but also because it felt like I was a container[31] for a lot of emotional distress that the registrars were carrying. It meant that as the researcher I ended up occupying a number of roles: a Black student, a researcher and a clinical psychologist. Emotionally evocative work is not problematic, and Dickson-Swift (2019) argues that emotional challenges during the research process are becoming more difficult to ignore. Dickson-Swift (2019, p. 2158) suggests that everyone involved in the research process should reflect on their emotions rather than viewing emotions "as risks to be avoided". It is for this reason that there has been a commitment to stating and reflecting on my bias throughout the process.

In claiming this subjectivity, and arguing for its importance, however, I do need to acknowledge clearly that the data I have collected, and my understanding of the data, cannot be considered as the whole truth. As I mentioned at the outset of this dissertation, together with the Harambee team, I chose as a first qualitative study for the project to focus very closely on registrars' experiences. I did not look at what trainers of registrars experience, and I would imagine that there could be different interpretations of the training experience from trainers' points of view. I also did not look at the experiences of White, Coloured, Indian, or supernumerary registrars, nor did I speak with registrars in other provinces, where racial dynamics may be different from the Western Cape Province. I cannot and do not claim that my methods and reflections are able to extract issues which are specifically and exclusively "Black issues" – this attempt at disaggregation would go against the theoretical orientation I have discussed earlier. All accounts and all analyses are in their nature partial, and I acknowledge that I have collected partial information and tell a partial story. But it is also a story which I believe deserves being told and explored in its own right, not least because of

[31] Borrowing from Wilfred Bion's psychological theory of containment

the imbalances of knowledge between the North and the South, and between White and Black. In the fields of health sciences and health education, we have quite a lot of data on how more powerful people understand the health and the experiences of the less powerful. We know far less from the perspective of the less powerful. Within this mix, the participants with whom I have worked have a rather complex positioning – they are Black, with all that implies given global and South African history, and, indeed, given the fact of ongoing issues of coloniality in the world, as I discussed earlier. They are also, given their professional status as medical practitioners, in a powerful and esteemed position in other ways (cf. Chikane, 2018). We know remarkably little about what this feels like and how it is experienced, and I hope this dissertation begins to address the gap in knowledge. But I am not claiming that this dissertation provides the whole truth, or that every issue discussed and addressed is by definition exclusive to Black registrars. Of course there may be overlaps and similarities – for example, I have found the work of Lourens (2018), who is a White disabled academic, and not a medical doctor, helpful to my understanding of the experiences of Black medical doctors. But in keeping with a decolonial approach, what I do argue for, and I hope I have done this issue justice, is the importance of careful attention to narratives which may have been excluded in the past. Paradoxically perhaps, there is more research recording the voices and experiences of Black South Africans who more clearly inhabit spaces of poverty and abjection than do my participants (for some excellent book-length studies, see, for example Henderson, 2011; Ramphele, 1993; Steinberg, 2011; A. Swartz, 2017; Thornton, 2017). There are of course important texts which look at Black South African, and African, experience more broadly, including work focusing on middle class experiences (see for example, Comaroff & Comarof, 2009; Southall, 2016; Van Wyk & Posel, 2019), but my study contributes to a relatively small body of research exploring the experiences of emerging Black professionals from their own perspectives (Canham & Williams, 2017; le Sueur &

Tapela, 2018; Muller, 2018). My study is partial, and incomplete, but, I would argue, part of a broader project of work redressing imbalances in knowledge.

8.2 Conclusion

Some South Africans question why we discuss race and racism in post-apartheid South Africa. The reason is that race – whether the minority in this country want to acknowledge it or not – continues to shape the everyday experience of many South Africans (Alexander, 2013). In a society where coloniality persists, the lives of the majority continue to be disadvantaged (Maldonado-Torres, 2016). Student protests highlighted this reality. Chikane (2018) suggests that student protests resurrected what was otherwise an unconscious country. They definitely provided a much-needed backdrop for conversations about deeper transformation to happen. From the registrars' accounts, it is evident that race trouble continues to influence how they experience their training environment in the Western Cape. Eight years ago Serote (2011) had similar findings, and more recently Thackwell (2014) did as well. Black trainees'experiences of medical training (mostly on postgraduate level) have not changed because, as I have argued in this dissertation, the institutional cultures have not changed (Luvalo, 2019; Ratele, 2015, 2018).

Literature and the data show that there is a need for the reconceptualisation of what transformation in HE means (IRTC, 2019; Ratele, 2019; Pattman & Carolissen, 2019). I do believe that representation is important. In my own reflections and from what the registrars said, representation of racial, gender and disability in higher positions and in postgraduate training in higher education is important. It allows for students of those designated groups to feel represented and that they can relate to their trainers. It also allows for increased opportunity for mentorship – with the argument that it would likely be easier for students to seek out help from those they find affinity with. However, as Ratele (2015, 2018) amongst

others, has argued, transformation by numbers, and by assimilation is not enough. Especially when HEIs have not fundamentally transformed and struggle to rid themselves of their colonialist and racist legacies. Evidence has shown that there are incidents of racism at UCT (IRTC, 2019) and the promotion of White supremacy through language at SU (van der Waal & du Toit, 2019). So, it appears that the answer to the secondary question of this study, *what are the obstacles to transformation in higher education?* is that there is a lack of deep thought when it comes to the practice of transformation. The policies are there and have ensured the increase of representation within medical education and HE at large, but have failed to acknowledge and address the lived experiences of students. We need to think about how participation and citizenship can be promoted. It is evident from the recent student protests that the university space, especially at historically advantaged institutions, is not a welcoming space for Black students (Maseti, 2018; Pattman & Carolissen, 2018; Shabalala, 2018). It is also evident from the registrars' accounts that registrar training is intense and that there is a culture of not regarding doctor's emotional wellbeing. This too warrants attention. Cairncross (2018) suggested that it is important for the academy to not only engage in issues of transformation on a deeper level, but also to not reinforce the unhealthy work habits of long hours to the detriment of self-care.

8.3 Limitations

This study included a small sample of registrars from across specialties; therefore it does not provide the full range of experiences of specialist training. It also does not, although it alludes to it, give a deeper understanding of varying degrees of blackness and how this might influence the experience of training. There are two things I would like to mention in this regard which may suggest the need for future research. After I presented a workshop on qualitative methods and making mention of my current study at the meeting at UKZN in

2017, one of the Indian registrars questioned my exclusion of Coloured and Indians in the study and, furthermore, in the definition of Black. I had excluded them, and this also limits the study and also highlights the risk of essentialising the Black experience. Another example of this is, and the second thing I want to highlight, the exclusion of supernumerary doctors in the study. Supernumerary doctors are also excluded from this study, and from what some of the participants have mentioned, they are Black and may too experience the training environment as unwelcoming. Both these areas also need further research.

8.4 The journey forward

I am aware of the performative pressure to make recommendations for medical education in the future and for transformation in higher education in general. However, I would like to caution against hastliy jumping to solutions instead of perhaps taking time to have careful conversations about the landscape of higher education. In other words, as I have shown elsewhere, developed policies that attempt to redress social inequalities already exist, and as I have argued elsewhere the implementation of such policies tends to fall short. It is for this reason that I have chosen to not make statements about how this body of work might influence policy-makers at this stage.

The research project is under the auspices of the Harambee organisation, and together with Harambee conversations can be started with the trainers regarding the continued humiliating experiences of registrars. With the help of Harambee, a meeting could be arranged with the association of deans of medicine where such conversations can start. The idea of such a meeting would not be confrontational in nature but rather an urge for a slowing down of the processes and taking a step back from the great policies that are there and really interrogating what is happening for students. Perhaps another aim of such a meeting would be

to create a platform where there is an exchange between students and management, where registrars feel empowered to express the reality of their experience.

At the end of last year, after having had a number of discussions about my career going forward with my mentor, I decided to interview for a lecturer position at the University of Johannesburg. I was always reluctant about pursuing a career in academia because I could not imagine how I would perform. I had no teaching experience and still regarded myself as a student. I did not feel prepared, and (at the risk of selling myself short) I was not convinced that I could evolve and become an academic. The Dean was particularly interested about when my PhD would be complete, and highlighted that he could see that I already had one sole authored publication (things that I am learning are of top priority in the academy), but wondered if I am wanting to grow within the academy and go for promotion (in other words, publish more in order to qualify for promotion). He also mentioned that I was offered an interview in 2017, and that I did not take that opportunity. He wondered what changed and if I was a clinician who lectures from time to time or if I would be actively pursuing this journey through higher education. My response was "well, I did not do a PhD for it to collect dust on a shelf". Well, I got the job and I am now finding my feet as a young academic. In response to his question, perhaps less sarcastically now, the plan is to work on publications that will continue and contribute to the conversation on transformation in higher education.

I also plan on growing in the department as well; I think there is a potential for me to feel at home there. Growing in the department and occupying more senior positions is also important so that other young Black students can feel represented and imagine themselves in that space too. Perhaps Maseti (2018) and others (Luvalo, 2019; Ratele, 2015, 2018) who talk about how the historical culture and traditions of HEIs impeding on transformation, and the

extent to which I could potentially feel at “home”, raise an alarming point. However, my story has been different in that I was able to identify mentors, and despite some challenges I have faced within higher education, I can truly say that I am exactly where I ought to be and will energetically work towards my growth. I plan to put to action the ideas of Steve Biko in my own life, as I pump life back into myself as a young Black woman within higher education. Conversations in the social sciences and in psychology specifically also are focusing on the decolonisation agenda and my feeling is that that will still be the case for a very long time.

My research going forward will focus on my journey transitioning from being a clinician, predominantly, to an academic. It will still have similar themes to my current work, but I think I am moving more towards discussions on what is regarded as knowledge and an academic in contemporary South Africa, as well as the politics of space and time within the academy.

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Appendix A

Interview guide for interviews with the medical specialist trainees/registrars

- What motivated you to become a doctor? Tell me about your journey till today.
- Where did you do your undergraduate training, and what was your experience. Were there any challenges?
- How do you experience being a doctor?
- What motivated you to undergo specialist training?
- Describe the transition from your undergraduate training to being a registrar
- What expectations did you have at the beginning of your training?
- What was your experience as a first year registrar?
- What major adjustments did you face?
- With time, did you your experience change, and in what way?
- What are your current concerns and experiences with regards to training?
- Who are your trainers? To what extent are you able to identify with your trainers?
- How many black registrars are currently in your group?
- What is the racial and/or gender dynamic?
- Do you experience the training as equitable?
- Can you give me an example of a bad experience and a good experience?
- How do you feel about the process of transformation?
- Do you have any suggestions regarding issues of transformation?

Appendix B

The experiences of black medical specialists in training at two universities in the Western Cape		
Theme	**Subtheme/s**	**Description/relevant clusters**
1. Complexities faced on the road to becoming a doctor	Childhood experiences leading up to medical school	Lack of finances during childhood
		Received quality education in school
		No awareness of racial issues growing up
		Racial demographics growing up: Being "the only black" as a norm
		Some racial experiences in school
	Various social factors that lead to pursuing medicine as a career	Teacher's influence assisted in choosing medicine
		Chose to study medicine because of its popularity in the community
		Choosing medicine as a career because of early exposure to the field
		Medical background in the family influencing career choice
		Choosing medicine as a career because of liking it
		Choosing career as a doctor because of opportunities that follow
		No initial interest in studying medicine
	Adjusting to pursuing a career in medicine	No sense of career direction during undergraduate training
		Undergraduate training program was engaging
		Difficulties in adjusting to a greater academic pace in university
		A sense of not fitting into/faking it in the academic culture
		Adjusting to different cultures in university
		Adjusting to living away from home
2. Language use as an obstacle and an asset		Adjusting to English and/or Afrikaans as a medium of instruction during undergrad
		Afrikaans language use in clinical work resulting in exclusion of blacks
		Learning Afrikaans in order to survive
		Learning multiple languages makes you more effective
3. Finances and the influence on transformation		Financial struggles in undergraduate training
		Lack of finance as a barrier transformation
4. Training institution/location and the influence on quality of training		The attractive element of academic excellence in a university
		Sense of comradeship towards undergrad university
		Academic support at the university
		So you come from a "good" university
		Efficiency of Western Cape medical system
5. The meaning and expectations	Reality of what it means to be a doctor	Realisation of "being a doctor"
		Culture of helping those in need

ascribed to a doctor		Medicine is considered "glamorous" yet it is not
	Social pressures of being a doctor	The pressures of the status of being a doctor
		Conforming to expected physical appearance of a doctor
	Socio-cultural considerations of being a doctor	The confusion of being a senior to your elders in the profession
		The "scientific" culture of medicine vs. a need to consider social factors
		A need to be more relatable to patients
		The difficulty of medical field practitioners in gaining an understanding of traditional practices
		Ethical implications of a traditional perspective alongside a medical perspective
6. The reality of racial and gender dynamics	Racial dynamics are a given	Naivety around racial dynamics
		Racial dynamics are a reality
		Covert nature of racial dynamics
	Factors that may result in development of racial dynamics	Racial issues may develop due to socialization
		University systems may perpetuate racial discrimination (extended program & evaluation systems)
	Racial dynamics may occur on multiple levels of relationships	Racial dynamics with patients
		Dynamics amongst non-white races
	Various reactions to racial dynamics	Various emotions are elicited by racial dynamics
		Putting your "head in the sand" in order to survive racial prejudice
	Gender dynamics are a given	Gender demographics at registrar level vary
		The inevitability of gender issues at registrar level
7. The realities of practicing as a medical professional		Clinical work was a positive experience
		Intensive practical nature of clinical work
		Conflict experienced in clinical work due to hierarchy in medical profession
		Community service being likened to social work – lack of resources
		More independence experienced in community service
		Gaining more confidence as a medical

		officer before registrarship
8. The complexities on the road to specialization	Various reasons leading up to specialization	Specialisation path was not clear from the beginning
		The need to broaden knowledge through specialist training
		Choosing to specialise in order to have a voice in the healthcare system
	Adjustment into specialization program	Transitioning to reg. program was positive experience
		Work pressure in registrar program
		Accessibility of consultants depends on the department
		Difficulty in balancing work with family during registrarship
	Few black professionals in specialization arena	Demographics in reg. program – few black registrars
		Supernumerary registrar dynamic
		Lack of transparency regarding registrar positions
		Blacks and/or females do not belong in certain specialisations
	Lack of faith in the black registrar	"Confidence" of white registrars
		Showing respect/shyness from the black registrar towards superiors
		Being scrutinised as a black registrar (the imposter syndrome)
9. The difficulty in accessing appropriate mentorship		Mentorship as a means to alleviate pressure in reg. program
		Where are the black consultants?
		The difficulty in finding a mentor you can identify with
		The black token doctor
		Black consultants are not there to forward transformation agendas
		If you cannot network – you miss out
10. The pressing need for effective transformation		Transformation relates to equal access
		Transformation is a tough but necessary process
		Students are "fired up" about transformation
		Ambivalence regarding appropriate application of transformation
11. A need for a strong presence of black professionals in medicine		Unwillingness of blacks to apply for reg. programs in Western Cape
		School education has resulted in limited black registrar candidates
		Hiring more Black medical professionals could aid transformation
		A need for a high calibre black persona in medicine
		Black people need to support each other
12. Striking a balance between professional independence and effective mentorship		A need for more mentorship/supervision in reg. program
		Mentorship can open access to resources
		Uncertainty regarding application of mentorship process
		The importance of struggling through research
		A need for reg. research support