

“We waited for our turn, which sometimes never came”: Registrars negotiating systemic racism in Western Cape medical schools

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### Statement

I, the undersigned, hereby declare that the work contained in this thesis is my own original work, and that I have not previously in its entirety or in part submitted it to any university for a degree.

Signed.....

Date.....

### **Abstract**

In order for the transformation objectives of racial and gender diversity to be adequately reflected in the South African medical profession, it is crucial to understand how Black medical registrars experience the training environment. This qualitative study presents the experience of ten Black African medical specialists who completed their registrar training in the Western Cape in the past five years. Using both thematic and discourse analysis the study aimed to identify and describe the interpersonal, structural and institutional factors that may impede or promote Black advancement during registrar training. Participant experiences were contextualised in relation to discourses around the medical profession as a site of cultural reproduction that has been historically constructed as the exclusive domain of the White male. The analysis unearths experiences of systemic racism where the organisational culture of training institutions is experienced as alienating and unwelcoming to Black professionals. The findings raise the need for a more thorough evaluation of how transformation efforts are being received in specialist medical education.

*Key Words: Black doctors, Transformation in Higher Education, Systemic Racism, Medical training.*

## Opsomming

Met die oog op die realisering van die transformasiedoelwitte rakende ras- en geslagsdiversiteit in die Suid-Afrikaanse mediese professie, is dit deurslaggewend om te verstaan hoe Swart mediese spesialis studente die opleidingsomgewing ervaar. Hierdie kwalitatiewe studie gee die ervaring weer van tien Swart Suid-Afrikaanse mediese spesialiste wat die afgelope vyf jaar hulle opleiding in die Wes-Kaap voltooi het. Deur gebruik te maak van beide tematiese- en diskoersanalise, poog die studie daarin om die interpersoonlike, strukturele en institusionele faktore wat Swart bevordering tydens professionele opleiding kan belemmer of bevorder, te identifiseer en te beskryf. Deelnemers se ervarings is gekontekstualiseer in verhouding tot die diskoerse rondom die mediese professie as terrein van kulturele voortsetting van wat histories as eksklusiewe domein van Wit mans gegeld het. Die studie ontbloot ervarings van sistemiese rassisme, waarin Swart professionele beroepspersone vervreem en onwelkom voel in die organisasiekultuur van opleidingsinstansies. Die bevindinge beklemtoon die behoefte aan 'n meer diepgaande evaluasie van hoe transformasie-pogings ontvang word in mediese spesialis opleiding.

Sleutelwoorde: *Swart dokters, transformasie in tersiêre opleiding, sistemiese rassisme, mediese opleiding.*

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**“We waited for our turn, which sometimes never came”: Registrars negotiating systemic racism in Western Cape medical schools.**

**Chapter One: Introduction and Motivation for Study.**

**1.1. Introduction**

A strong human resource base that includes racial and gender diversity among medical doctors and specialists has been identified as crucial if the demands of South Africa’s health care needs are to be met (Breier & Wildschut, 2006; Khan, Thomas, & Naidoo, 2013; Ntuli & Day, 2003). In 2001, The Ministry of Education indicated that, in addition to being clinically competent, doctors should also be “socially responsible and conscious of their role in contributing to the national development effort and social transformation” (2001, p. 5). A racially diverse medical workforce will be most able to fulfil this mandate by representing a wider range of backgrounds and languages, and thereby enhancing cultural competence in the treatment of patients (Hipolito, Malik, Carpenter-Song, & Whitley, 2011; Smedley, Butler, & Bristow, 2004). Therefore, the retention and development of Black<sup>1</sup> and/or female doctors is an important objective in today’s training environment (Kington, Tisnado, & Carlisle, 2001).

While it is clear that steps have been taken to improve racial diversity in undergraduate medical training since the end of Apartheid<sup>2</sup>, it is not clear if this increase is translating into racial diversity amongst specialists. Whilst specialist medical training is acknowledged as a lengthy and arduous process for all registrars (specialist medical trainees), reports that that Black registrars experience the training environment as even more challenging or even unwelcoming than do their White counterparts

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<sup>1</sup> The word “Black” is used to connote all those race groups that were disenfranchised by Apartheid and is thus inclusive of Black African, Coloured and Indian groups.

<sup>2</sup> A policy or system of segregation and discrimination on grounds of race that was implemented in South Africa during the period between 1948 and 1994.

(London, Kalula, & Xaba, 2009), are of concern. Due to the paucity of research around the experience of Black registrars in South Africa, it is unclear how attrition and throughput rates compare in relation to White registrars. Structural, institutional and cultural obstacles have been shown to influence attrition rates amongst female registrars (Wildschut, 2011). Based on indications in the literature that suggest the experience of registrar training may be qualitatively different for Black trainees (London et al., 2009), it is likely that a similar set of obstacles could translate into increased attrition among Black trainees. This small qualitative study aimed to explore the training experiences of a group of Black African specialists who have completed registrar training in the Western Cape within the past five years, in hopes that a larger study that looks at throughput and attrition rates among Black registrars could be warranted in the future.

## **1.2. Key Terminology**

### **1.2.1. Race in post Apartheid South Africa.**

Race problematically remains as a primary social category, whereby people identify themselves in relation to others (Leibowitz, 2012, Posel, 2001). The dilemma that researchers in the social sciences face, is that we have little choice but to use these inherited racial categories (despite their being scientifically discredited), because they have gained an experiential reality for all those who have been defined by them (Durrheim, Mtose & Brown, 2011). In this study, race is understood as a sociopolitical construct that has been historically used to organise systems of inequality in favour of White interests (Malat, Clark-Hitt, Burgess, Friedemann-Sanchez, & Van Ryn, 2010). Racial subjectivity, or the experience of oneself as 'raced' is created through the interaction between the self and 'the other' (Hook, 2012) in a process that is mediated through discourse. As such, race exists both as an embodied subjectivity, as well as a historically sanctioned ideology of White superiority that has

wrongfully justified the distribution of power along racial lines. Drawing on this, racism is defined in this study as:

An ideology through which the domination or marginalization of certain racialised groups by another racialised group or groups is enacted and legitimated. It is a set of ideas and discursive and material practices aimed at (re)producing and justifying systematic inequalities between racialised groups (Duncan, Van Niekerk, De la Rey, & Seedat, 2001, p. 2).

All of the participants in this study are Black Africans, who are South African citizens.

However, for ease of explanation in this paper, the word “Black” is used to connote all those race groups that were systematically disadvantaged by Apartheid and is thus inclusive of Black African, Coloured and Indian groups. While not all Black people were previously disadvantaged during Apartheid, the prevailing environment of racialization can be viewed to have at least some effect on the quality of life of Black South Africans. Since democracy, the power balance has shifted towards a majority-led government, and much has been achieved in terms of transformation; such as Black economic empowerment strategies that have resulted in a growing Black middle class (Durrheim et al., 2011). Yet race remains entrenched as a strong determinant in terms of increasing a Black person’s likelihood of experiencing social, economic and educational inequality such as poverty, inadequate education, increased chance of exposure to trauma and violence, and being at the receiving end of a dysfunctional public health system (Charasse-Pouélé & Fournier, 2006). As Burgard notes, race plays a significant role in “determining life chances and health outcomes” (2004, p.1128) amongst South Africans.

### **1.2.2. Diversity**

The goal of reflecting diversity in higher education requires the acknowledgement that different people often have diverse values, cultural beliefs, racial, ethnic and gender backgrounds, sexual orientations, (dis)abilities and life experiences (Carr, 2000; Goduka, 1996). Diversity is viewed as beneficial to the development of educational excellence through the sharing of viewpoints and perspectives. One of the ways that diversity has been promoted in South African medical education is through policies that recruit a wider range of undergraduate students that more closely reflect the demographic profile of the country at large (Khan et al., 2013).

### **1.2.3. Transformation**

Khan et al., (2013, p.75) define transformation as, “intentional and planned changes aimed at addressing historical disadvantages”. Thus transformation policies at formerly White institutions of higher education in South Africa have been charged with the task of bringing universities in line with the social and political developments within the country since Apartheid. Transformation efforts are focused on building an institutional culture at the universities that is inclusive of diversity and respectful of alternative viewpoints, in order to advance “interracial, inter-ethnic, multicultural and intercultural understanding, tolerance and cooperation” (Stellenbosch University Strategic Framework, 2000, p. 15). However as some studies (Dixon & Durrheim, 2003; Swartz et al., 2008; Walker, 2005) have demonstrated, desegregation and transformation towards an institutional culture that favours diversity is often more complex than well-intentioned, transformation policies allow for (Leibowitz, 2012).

#### **1.2.4. Registrar training**

Registrars (known as residents in some parts of Europe and the United States) are doctors who have completed undergraduate training and are embarking on medical specialisation in a chosen field. Typically this involves four to six years of further training within a clinical environment at a university hospital. Registrars are apprentice specialists who further their learning through a combination of practical experience and formal lectures, under the supervision of senior staff, called consultants<sup>3</sup>. Prior to qualification, registrars must pass independent examinations through the College of Medicine of South Africa (CMSA). In order to be eligible for these examinations, certain rotations must have been completed to ensure that the necessary clinical and/or surgical experience has been gained. The two universities with medical schools in the Western Cape are the University of Cape Town (UCT), where training is completed at Groote Schuur Hospital and associated facilities, and Stellenbosch University (SU) which is affiliated with Tygerberg Hospital and associated facilities. All the participants in this study completed their registrarships through one of these institutions.

#### **1.3. Motivation for present study**

There is currently very little research focusing on the training experiences of Black medical registrars in South Africa specifically. Despite the fact that university registration rates show a dramatic increase in the number of Black medical students registering for postgraduate study (Breier & Wildschut, 2006), it is unclear whether there is a similar increase in Black registrars who complete their training and register with the Health Professions Council of South Africa (HPCSA), in order to enter specialist practice. It has been identified that disaggregated data examining attrition rates among Black doctors is needed to determine whether increased registrations and graduations are translating

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<sup>3</sup> the designation given to a medical specialist in a public hospital (Breier & Wildschut, 2006).

into increased racial equity among qualified South African medical professionals (Wildschut, 2011). This is an empirical question that requires statistical data beyond the focus of this study; the current small study reported on this thesis forms a first stage of a broader project which will investigate completion and attrition rates amongst this group in more depth, along with Black registrars' experiences of their training. As a first step in this bigger study, colleagues and I on the broader research team argued that the views of registrars who had been successful in completing training could provide interesting information in itself, but also data which could inform the broader study.

#### **1.4. The aims and objectives of this study**

Understanding the potential obstacles that registrars encounter is crucial if the objectives of racial and gender diversity are to be realised and reflected amongst South Africa's medical personnel. Based on admission numbers it would seem that suitable provision for formerly disadvantaged groups has been made within medical education, yet a lack of diversity in senior and specialised tiers of the profession could indicate structural barriers to advancement.

I chose critical discourse analysis as an additional analytical lens, whereby the experiences that participants reported could be viewed not only as individual experiences, but in relation to discourses around the medical profession as a site of cultural reproduction (Nicholas, 1999). This research therefore aims to identify and explore the experiences of Black registrars in order to identify structures, practices, attitudes and ideologies that may promote or impede the advancement of Black specialists into the medical profession.

The objectives of this study are as follows:

- To identify how Black registrars experience the training environment in the Western Cape.

- To explore cultural, structural and institutional factors that may impede or promote Black advancement in this context.

### **1.5. Outline of this thesis**

Chapter Two establishes a brief history of race in medical training in South Africa, leading up to the current training environment. Chapter Three is a discussion centred on some of the current issues that surround diversity in medical training, including affirmative action, feminisation of the medical profession and lack of equity in senior tiers of medical departments. In Chapter Four, I review the literature in this area, from both local and international studies. Thereafter a detailed description of the research methods employed in this study follows in Chapter Five. Subsequently I will present the findings of the participant interviews in the form of a discourse analysis and discussion in the concluding chapter of this thesis.

## **Chapter Two: Medical training in South Africa: The impact of Apartheid.**

### **2.1. Introduction**

It is important to view the current health system in light of South Africa's political history. Tracing the roots for South Africa's current health care challenges; Coovadia, Jewkes, Barron, Sanders, and McIntyre (2009) put forward that a history of colonialism and, more recently, Apartheid, have resulted in substantial healthcare gaps. They go on to note that the former policies of racial division and discrimination underpin many of the structural inequalities that are present in both access to care, and the training of medical professionals.

Disruptions in the social, cultural and organisational fabric of society as a result of Apartheid have had far reaching health implications for Black South Africans in particular. During Apartheid,



health resources were allocated along racial and geographical grounds and while White, urban areas were serviced by well-equipped hospitals, in predominantly Black, rural areas access to medical services was poor, and civic development neglected. Black women, elderly people and children were generally confined to these rural Bantustans<sup>4</sup>, while Black men were forced to leave their families to work in the mining industry as migrant workers (Coovadia et al., 2009). This facilitated a breakdown of agrarian culture and family structures, the repercussions of which we continue to see reflected in the myriad of economic, educational, psychosocial and physical health problems plaguing Black communities (Seekings, 2008). Soudien puts forward that race categorisation is still a pervasive social phenomenon in South Africa and that the reasons for this are complex and often unclear:

Whether it is by design, conspiracy, presumption, or even sheer naïveté, racial assumption circulates inside of, is beneath, on top of and around what people have to say and how they behave to such a degree that there is little that is not covered over and determined by it (2010, p. 225).

## **2.2. Medical training under Apartheid.**

The history of South Africa's medical schools is characterised by racial division and the country's eight medical schools were established to cater for the training of doctors in racially segregated facilities. The University of Cape Town (UCT), The University of the Witwatersrand (WITS), University of the Free State (UFS), University of Pretoria (UP) and Stellenbosch University (SU) were White institutions, whereas MEDUNSA, Kwa-Zulu Natal (KZN) and UNITRA (now Walter Sisulu University WSU) were exclusively for Black African, Coloured, and Indian students.

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<sup>4</sup> A so-called "homeland" area, set aside during the period of Apartheid for Black African people to live in.

Black medical students experienced inferior educational experiences for two main reasons. First, institutions offered substandard educational opportunities and facilities where needs such as accommodation, transport, recreational spaces and institutional support were neglected (Tobias, 1980; Perez & London, 2004). Second, with factors such as lawfully racist policies, widespread poverty and a deficient Bantu education system, simply entering into medical training and passing was much more challenging for Black students (Noble, 2004). By ignoring White privilege as a precipitating factor for success in tertiary education, the state was able to justify the systematic, ideological construction of the Black race as inferior and worthy of discrimination, using these compromised students' poor performance as evidence of Black inferiority. In light of these challenges it is perhaps not surprising that in 1985, 83% of all doctors and 94% of specialists were White (Perez & London, 2004). Due to stricter admissions policies for Black candidates, very few Black medical students were allowed to study at historically White universities during Apartheid. Those who did had restricted access to training opportunities, and were under no circumstances able to treat or even be in the same room as White patients, even post mortem (Faculty of Health Sciences (FHS), 2002; Perez & London, 2004).

Because training hospitals were racially divided, Black registrars often received training in hospitals that were grossly underfunded, under-equipped and overcrowded. Noble (2004) suggests that the situation at these substandard medical facilities influenced Black registrars to become tolerant of racist and unethical practices during training, out of necessity. In order to get through training they had to make do with work conditions and a level of service that would have been deemed unacceptable in White hospitals. Thus the mistreatment of Black patients, students and staff was normalised under Apartheid (Perez & London, 2004), and this could be viewed as a factor that has lingering repercussions for today's Black healthcare users and providers.

### **2.3. The current training environment**

The burden of disease in sub-Saharan Africa is a staggering 27% of the world share. This coincides with a serious shortage of medical health professionals with around 18 physicians for every 100 000 people (Chen et al., 2012). Many of South Africa's population do not have access to basic services; not all have adequate healthcare and sanitation. In order to address some of these inequalities, government strategy has centred around a focus on primary health care, and increasing living standards through the provision of clinics, water, sanitation and electricity (Chopra et al., 2009). However, many new and inherited problems have complicated the progress of this vision. Poor service delivery, overstretched resources in public hospitals, underserviced rural areas, mass emigration of healthcare professionals, and the HIV and AIDS pandemic are some of the problems that have contributed to the current challenges in health care provision (Coovadia, et al., 2009; Mayosi, Lawn, van Niekerk, Bradshaw, Karim, & Coovadia, 2012; Tankwanchi, Ozden, & Vermund, 2013).

The burden of four colliding epidemics (Coovadia et al., 2009) including HIV and AIDS, tuberculosis, chronic conditions and high incidences of mental health disorders has placed considerable strain on health resources in South Africa. High rates of interpersonal violence, childhood malnutrition, and poor maternal and neonatal health all contribute to the load (Mayosi et al., 2012). In order to redress some of the inequalities in health care provision, medical education has shifted from specialised, hospital-based care to more generalised community based, primary healthcare aimed at disease prevention (Chopra et al., 2009; Kent & De Villiers, 2007). Yet it is difficult to attract doctors to work in rural areas where these services are most needed. The tendency for qualified doctors to emigrate or move to urban areas after training is one of the main reasons that rural healthcare is still underserviced in South Africa (Chen et al, 2012; Mullan, 2005).

A move toward community-based, primary health care has necessitated a shift towards the production of “generalist” practitioners over specialists in South African medical schools (Kent & De Villiers, 2007). A wide range of additional skills such as planning, advocacy, programme implementation, management, and evaluation are necessary in a primary healthcare-focused strategy (Sanders, Chopra, Lehmann, & Heywood, 2001). However, while private hospitals are well equipped and staffed, the public hospitals that serve the majority of South Africa’s population are still largely under resourced. This makes for an uncertain and demoralising workplace for medical health professionals (Kent & De Villiers, 2007; Organisation for Economic Co-operation and Development, 2004), who in turn may be motivated to immigrate or join the private sector. Strategies such as compulsory community service at the end of a medical degree have been shown to increase the retention of health workers in rural posts (Chen et al., 2012), particularly if the doctors originate from a rural community (De Vries & Reid, 2003; McMillan & Barrie, 2012).

The roll-out of a national health insurance (NHI) system is proposed as a viable way to address these challenges, and will be phased in over the next decade. It is hoped that the new system will help to address the inequality that has characterised the public/private; rural/urban divide. Whether or not there are sufficient doctors and specialists to share the workload will be a crucial consideration (see Matsoso & Frayatt, 2013).

### **Chapter Three: Diversity in Medical Training in the Western Cape.**

#### **3.1. Introduction**

In order to improve health care services for the majority of South Africa’s population, it is important that diversity is reflected among medical personnel for a number of reasons. There is evidence to suggest that race concordant doctor/patient interactions may benefit patients due to better

communication and improved understanding by doctors of social and cultural circumstances that may impact on treatment (Cooper et al., 1999; Jansen, 2009; Swartz & Drennan, 2000). Increased trust and patient involvement may result in more accurate diagnoses, as well as influencing adherence to treatment plans (Dy & Nelson, 2011; Merwin, Stern, & Wilson, 2008; Rheede, 2003). Furthermore, students who have trained in a multicultural environment report feeling more confident with patients from different cultural groups (Saha, Guiton, Wimmers, & Wilkerson, 2008). In a similar way, doctors with physical or psychosocial disabilities would be able to provide an enhanced clinical understanding and facilitate more open communication when interacting with patients (Chambers, MacDonald, Mercer, 2002; Cook, Griffin, Hayden, Hinson & Raven, 2012; Kinross, 2013). However people with disabilities are underrepresented in the medical profession (General Medical Council, 2008), and experiences of discrimination and hostility have been reported (Moloney, Hayward, Chambers, 2000). The need to provide reasonable accommodation and support for doctors, and students with disabilities in medical training programs, has also been identified as a key objective (World Health Organisation, 2001).

While race and gender diversity has increased dramatically in undergraduate admissions and graduations since 1994, some recent research at South African medical schools suggests that Black and/or female medical graduates are less likely to proceed to postgraduate level, and to complete their specialist training (Karim, 2004; London et al., 2009; Wildschut, 2011), thereby undermining efforts by universities to create diversity within specialist and training tiers of the medical workforce to some extent. In 2004, the percentage of total enrolment across the eight medical universities, using race as a distinguishing variable, showed an increase in Black and coloured student enrolment with 41.0% and 6.9% of the total enrolments respectively; as well as a decrease in the number of Indian and White students with their enrolments at 17.8 % and 34.3%. Breier and Wildschut (2008) reported that while

numbers of Black, Coloured and Indian undergraduates made up the majority at enrolment in this survey, a greater proportion of White students graduated. The Apartheid legacy of poor education for the majority of Black learners could be contributing to poorer performance at tertiary level (Bezuidenhout, Cilliers, Van Heusden, Wasserman, & Burch, 2011) and this is an issue that I will cover in some detail later in this thesis.

In addition, the institutional culture of the two formerly White medical institutions in the Western Cape could be viewed as contributing towards training experiences that are qualitatively different for Black and White students. As Steyn and Van Zyl (2001) note, *Whiteness* continues to stand at the unacknowledged core of the institutional culture at formerly white universities, and this could be a factor that hinders black advancement in these contexts. Higgins (2007, p.107) defines institutional culture in higher education (HE) as follows:

[T]he dimension of social and pedagogic communication as it operates both formally and informally, in both teaching and more generally in student life on South African university campuses. In particular, it has come to refer specifically to the forms of cultural and intellectual capital that come together in much critical thinking as whiteness: the unconscious bias in educational communication towards a norm derived from white privilege.

### **3.2. Affirmative action in selection policies**

A growing debate surrounds the future of affirmative action in South Africa (see Bitzner, 2010) with many theorists objecting to the use of racial categories at all (even if just for administrative purposes). Erasmus (2010, p. 247) asks:

Do we need apartheid race categories for the purposes of redress? Can we devise indicators that capture what lives behind these categories to ensure redress while undermining both apartheid's common sense use of race and its objective to fix these categories permanently?

South Africa has the rather unique situation of an affirmative action policy that favours the Black majority, rather than an ethnic or racial minority as is the case in some countries. University admissions policies have been geared to address the injustices of the past with the aim of counteracting structural barriers to advancement for formerly disadvantaged race groups and women. Affirmative action, however, is often met with resistance (Delany, 2004; Durrheim, 2003; Resendez, 2002). The selection of students in accordance with what are viewed as racial quotas can be perceived negatively by other groups who are in competition for placements in registrar programs. Negative attitudes towards affirmative action can lead to the stigmatisation of recipients, when their competence is questioned. This negative appraisal is perhaps the most important factor that undermines the opportunities that affirmative action sets out to provide. According to Kravitz et al. (1996), people tend to judge affirmative action more positively when they believe that precedence is being given due to so called "universal contributions" such as merit or qualification. Attributes particular to the individual, such as race, ethnicity and gender are not viewed as good performance indicators. Furthermore due to the historically racialised distribution of wealth in South Africa, those who are eligible to benefit from affirmative action and those who are not, can be seen either to be doing so on behalf of their forefathers, or as a burden for the sins of their forefathers respectively, which can further polarise attitudes between groups, thus sustaining division (Mahone, Humber, Gault, & Mokhobo 1998; Wale & Foster, 2007).

The perception that recruitment using affirmative action works solely by means of a quota system rather than by selecting qualified and talented Black applicants where possible, has been shown

to influence White employees' perceptions around affirmative action (Unzueta, Lowery, & Knowles, 2008). White males, who once dominated the workforce, may feel threatened at the prospect of being disenfranchised in such situations, however in arguments that construct the White male as the recipient of reverse racism, there is a hidden assumption that the playing field is already level, and that women and members of formerly disadvantaged groups already have the same opportunities as White men (Clayton, 1996). The privilege of "Whiteness" and discourses of male superiority are rendered invisible in such arguments and this is testament to the power and pervasiveness of these ideologies. Unzueta et al. (2008) contend that arguments that use affirmative action as the reason for White applicants' failure to secure placement in a programme may serve as a psychological defence of the self esteem of Whites who have (since the end of Apartheid) been displaced from the centre of the job market.

The admission of Black undergraduates who, as a result of inferior education, may be less academically prepared, in some ways serves to strengthen discourses of White entitlement while further alienating Black students. Science, and particularly medicine are regarded in the public imagination as representative of the highest academic and even moral standards. A perceived drop in standards, where "anything goes" leads to negative attitudes toward transformation efforts among some Whites (Equality Impact Assessment, 2011). To complicate matters, consultants and registrars are dually employed by both the university and the Department of Health, which is a governmental organisation. The recruitment procedures of these two very different institutions may vary with regards to affirmative action and thus the freedom of academic departments may be constrained when hospital administration becomes involved in selection processes that would usually be defined by university policy.



The term *pre-labour discrimination* (see Porte & X-nanterre, 2003) describes the situation where the favouring of Black applicants in selection processes may not adequately suffice as a means of bringing about social equality and may only end up benefitting a few. Systems of historical disadvantage such as lack of access to assets and financial credit, uneducated parents, dispossession of land and violence and instability in community life can complicate educational experiences for trainees who come from disadvantaged backgrounds (Hall, 2012). These factors may be overlooked when, as a result, recipients of affirmative action fail or drop out of a programme, with the situation being interpreted as evidence of their original unsuitability for inclusion (Resendez, 2002). In an effort to control for poor academic preparation by schools, changes have been implemented in the acceptance criteria for undergraduate medical training, that include an evaluation of so called non-cognitive attributes such as leadership, evidence of community engagement, determination, and realistic self appraisal (Delany, 2004).

### **3.3. Global “feminisation” of the medical profession.**

While the focus of this research is on race, it is important to note that the history of women in medicine in many ways runs parallel to the history of Black doctors, as the medical profession has historically been the preserve of the White male. Since many of the Black doctors in this study are also women, there are intersecting issues surrounding female specialists in training, as Black women may carry a double burden (Wildschut, 2011). In a study of undergraduate throughput data, which disaggregated race and gender, Breier and Wildschut (2008) note this intersection, and found that in comparison with other groups, women of colour formed a lower proportion of graduates than they did of admissions.

While the South African medical profession is still predominantly male, there is a steady increase in female medical graduates, and in 2005 females accounted for 56% of MB ChB graduations (Department of Education (DoE), 2005). This is in line with a global shift toward the feminisation of medicine. It has been theorised that women are well suited to today's healthcare objectives because they are engendered to (more comfortably) practise a client-centred approach, and are more likely to work in public health, primary healthcare and in poorer communities (Breier & Wildschut, 2008). However, these self same "feminine" traits can sometimes be undermined by societal expectations for women to be the primary home maker. The meeting of these expectations result in time constraints that leave little time for women's engagement with the power structures of the profession, such as governing committees and research bodies.

The trend towards feminisation has necessitated changes in work schedules, with increased provision for part-time work in hospitals, with female registrars in the Western Cape being eligible to apply to do so in a few departments. However, more flexible working hours are often viewed as inferior when compared to the full tenure required of specialist physicians, characteristic of the previous tradition (Wildschut & Gouws, 2013). As a result, female medical professionals may be undervalued and marginalised if they do not align with the culture of "all hours work" (Ozbilgin, Tsouroufli, & Smith, 2011, p.1588). This socially constructed conception of the *heroic doctor* requires that hospital doctors work in excess of what is contractually required of them, a priority that is based on the assumption that domestic and childcare duties can be accommodated by a spouse. As Wildschut and Gouws (2013) caution; if professional discourses that subtly discriminate against women continue to influence workplace policy, the influx of women into medicine will be ample, but lacking the structural power to transform the organisational culture of training institutions and hospitals. Therefore, it is required that those charged with the task of bringing about transformation pay attention

to the ways in which gender is constructed in the workplace in order to develop processes that provide support and opportunities for female professionals. The failure to do so could cause a serious dearth of suitably qualified medical personnel, if the many women entering the profession do not find the employment environment viable for them to continue practising in-hospital (Breier & Wildschut, 2006).

### **3.4. Lack of equity among senior faculty**

The process of diversification in university faculties in the Western Cape has been considerably slower than student diversification, particularly in the senior tiers of academic departments (Mabokela, 2000). Difficulty in recruiting qualified and experienced personnel is cited as one of the main obstacles to filling training positions with suitable Black candidates (London et al., 2009). There is competition between universities to attract Black academics, with efforts to improve the retention of these employees having been identified as a pressing concern (Equality Impact Assessment, 2011). The “brain drain” away from academic medicine towards the private sector can also account for some of this difficulty (Karim, 2004). Furthermore, if registrar experiences are unfavourable for Black trainees, it is unlikely that they will elect to stay on as consultants and may decide to move on after they have specialised, particularly if they believe that have been excluded from career development opportunities such as research and leadership roles within the department. A few studies conducted in United States medical schools found that Black faculty members were less likely to be promoted to senior rank than White faculty (Fang, Moi, & Colburn, 2000; Palepu, et al., 1999). Radithalo (2007) explains that Black staff may face subtle or overt racism in the form of a lack of administrative assistance and support and negative or even racist attitudes from staff and students. Without the proper support, retention of these valuable human resources becomes a problem, once again diminishing Black advancement into senior tiers of academic departments.

In the next chapter I will review the literature available in this area, which has tended to be survey data that focuses on the structural, institutional and cultural barriers faced by women and (to a lesser extent) racial groups that were previously disadvantaged in South Africa. In order to contextualise the picture at an ideological level, emphasis will be given to analyses around power, status and privilege in the medical profession, and how discourses around “the good doctor” (Whitehead, 2010) have historically defined the profession as the preserve of the White male.

## **Chapter Four: Studies of race, gender and registrar training**

### **4.1. Introduction**

As I discussed in the previous chapter considerable effort has been made by universities to increase the intake of students from formerly disenfranchised groups into medical programmes; yet medical training in South Africa has been identified as being fraught with racial and gender inequalities (Khan, et al., 2013; London, et al., 2009; Wildschut, 2011). Because the training experiences of Black registrars in South Africa is an under-researched area, this study aims to expand on these findings through a qualitative study that focuses on individual training experiences in the Western Cape.

Diversity in postgraduate medical training has been identified as a strategy to address problems experienced in healthcare settings for ethnic minority groups in the USA, where evaluations of resident racial and gender demographics have been conducted in Orthopaedic Surgery, (Day, Lage, & Ahn, 2010) Radiation Oncology, (Chapman, Hwang, & Deville, 2013; Winkfield & Gabeau, 2013) Pediatrics, (Frintner, Mendoza, Dreyer, Cull, & Laraque, 2013) Surgery, (Ly & Chun, 2013) and Internal Medicine (Park, et al., 2006). The following issues have been identified as key factors that contribute to a training environment that can be viewed as more challenging for Black residents:

## 4.2. Race in medical training

There is strong evidence to suggest that racial disparities influence the training experiences of medical interns globally (Buckley, Sanders, Shih, Kallar, Hampton, 2000; Carr, Szalacha, Barnett, Caswell, & Inui, 2003; Fang, Moy, Colburn, & Hurley, 2000; Odom, Morgan Roberts, Johnson, & Cooper, 2007). Definitions of racism are diverse, as Dalal (2002, p. 27) defines: “Racism is anything—thought, feeling or action—that uses the notion of race as an activating or organising principle. Or to put it another way, racism is the manufacture and use of the notion of race”. Building on this definition; racism alters the lived experience of those who are categorised by it (through advantage or disadvantage) in relation to ideologies that have been historically constructed to maintain power structures.

In a study of the experiences of Black residents in specialist training at a United States medical school, Liebschutz et al. (2006), report that Black residents may experience both overt and covert discrimination from both colleagues and patients. Overt instances of racism may take the form of racial slurs and name calling (Coombs & King, 2005). In some instances patients may request a White physician after first being assigned to a Black resident. Black residents also report being mistaken for a non-physician such as a cleaner, or a medical professional of lower rank, particularly when female (Liebschutz et al., 2006).

Covert discrimination may take the form of seemingly inconsistent expectations and unfair treatment by senior and consultant staff, difficulty advancing in the department, a disregard for their seniority when it comes to making clinical decisions, and social isolation such as being excluded from social events, where networking takes place (Liebschutz et al., 2006; Pololi, Cooper, & Carr, 2010). A survey of student experiences at Stellenbosch University medical campus (Equality Impact

Assessment, 2011) highlights that there are hidden rules and agendas regarding White entitlement that have an impact on where people sit, eat and talk in the social sphere (Dixon, Tredoux, Durrheim, Finchlescu, & Clack, 2008). These informal segregation practices form a barrier that may impede diversity-promoting policies.

The term *race fatigue* has been used to describe a sense of dissatisfaction with being the token Black face in a White-dominated workplace (Harley, 2007). This study found that representing the “colour factor” can often lead Black faculty members to feel over-extended, scrutinised and undervalued. Black residents in a study of minority training experiences reported their need to constantly prove themselves, or work doubly hard in order to validate their place in the programme, and to ward off what they experience as the critical gaze of their White colleagues (Liebschutz et al., 2006). This psychological state of hyper-surveillance (Purwar, 2004) may lead to increased stress due to feelings that one’s profession hangs in a tenuous balance between being accepted or discredited (Radithalo, 2007). These residents’ use of coping strategies such as keeping a low profile at work and not challenging the status quo (Equality Impact Assessment, 2011), may only serve to perpetuate this system of White dominance.

Despite the best efforts of transformation bodies to implement an institutional culture that is inclusive and welcoming of Black students, there is evidence that long-established ideologies of White supremacy may subtly undermine these objectives (London et al., 2009; Pololi, Cooper & Carr, 2010; Walker, 2005). Radithalo (2007) explains that institutions such as universities are adept at maintaining the status quo and may systemically resist transformation in order to uphold the autonomy of academic rule, an ideology that can be seen to mask and protect the interests of the privileged elite. In such an environment, Black students and staff are welcome on the condition that they assimilate into the prevailing culture of the institution, and attempts to transform or draw question to systems may be met

with resistance (Duncan, 2005). It thus becomes evident that the culture of the institution may serve to resist change, and may negate efforts to transform it if not acknowledged and tackled directly. Jansen (1998) argues that formerly white institutions of higher education have tended to take a rather limited view, that focuses transformation goals at changing the racial demographics of students and staff, rather than focussing on the “substance of pedagogy, curriculum and assessment” (p.107).

### **4.3. Studies of female specialists**

While the diversification and feminisation trend that has characterised undergraduate medical training has yet to be fully realised in post-graduate admissions, there is evidence that gender and racial diversity is increasingly reflected in admissions to registrar programs. Breier and Wildschut (2008) report increases in registrar enrolments at UCT among all formerly disadvantaged groups between 1999 and 2006. They also note a 37% decline in the proportion of White males enrolled during this period. In a survey of trainee specialists at UCT, London et al. (2009) reported that proportions of Black registrars had risen from 26% in 1999, to 46% in 2006. Increases were also observed among Black African registrars whose proportion rose from 10% to around 19% between 1999 and 2003. The proportion of women registrars rose from 27% to 44% during the same period.

However despite the positive increase in admission numbers, it is clear that access alone does not guarantee that Black and/or female registrars will progress through the system to register and practise as specialists, and there are some indications that suggest that registrar attrition rates may be high among these groups (Breier & Wildschut, 2006; Wildschut, 2011). London et al. (2009) suggest that a lack of satisfaction with the training environment can result in a “revolving door” like situation, where it is difficult to attract and retain doctors from formerly disenfranchised groups, and as a result, structural inequality is reproduced further, as more White men specialise and progress on to senior

positions. Because accurate throughput rates are difficult to establish, as individual training time periods differ dramatically, detailed cohort studies are needed to get a more comprehensive view of this problem (Breier & Wildschut, 2006).

In a cohort study focussing on female registrars at UCT, Wildschut (2011) confirms that female doctors experience barriers that can impede their advancement. While graduation rates amongst females at undergraduate level are increasing and female performance is of a high standard (Hay & Jama, 2004), it is clear that many qualified female doctors are choosing not to enter specialist training. Female registrars often face significant challenges if they have children as they attempt to balance childcare duties with a demanding professional schedule (Heiligers & Hingstmana, 2000), and may take longer to attain tenure (Valain, 2000). Registrar training is difficult and trainees are expected to work long hours under very demanding conditions. Conflicts between work and family life are difficult to resolve in a professional culture that constructs a “good doctor” as one who will work night and day to solve a clinical problem; thus women may be viewed as less dedicated than their male colleagues and may be discriminated against in the workplace by both staff and patients (Health Systems Trust, 1998). They may have less time to demonstrate their dedication and develop their professional identities (Hamstra, Woodrow & Mangrulkar, 2007), because working long hours may not be an option due to child care responsibilities. As a strategy to manage this conflict between their public and private life, female specialists may choose specialisations that require fewer hours and avoid the more prestigious specialisations such as surgery for example (Krige, 2004; Walker, 2005). It is clear that these choices result in sustained structural inequalities where men retain and reproduce positions of power, leaving women on the periphery.



#### 4.4. The culture of medicine

Medical students undergo an acculturation process whereby they must learn to adopt the discourses of the profession and the training institution through a process of absorption and assimilation (Gordon, Markham, Lipworth, Kerridge, & Little, 2012). Socially constructed ideas of what a doctor should look like, and how they should speak and conduct themselves transmit a powerful message that is imbued with a particular cultural orientation. For example wearing a white coat has been shown to create an image of hygiene, authority and efficiency to patients (Rehman, Nietert, Cope, & Kilpatrick, 2005), yet this symbol is also illustrative of a certain hierarchical power dynamic between doctor and patient. It has been argued that historically, the structural and professional culture of medicine developed around a particularly powerful construction of White masculinity (Kilminster, Downes, Gough, Murdoch-Eaton, & Roberts, 2007; Whitehead, 2011), and that elements of this ideology shape the experience of Black and/or female trainees who are viewed as “other” to the ideal conception of a physician. Walker (2003, p. 113) elaborates:

Specialisation was seen as a largely male preserve, a culture imbued with distinct norms and values. It is seen to involve total commitment and single-minded immersion into the discipline; characteristics which are traditionally attributed to men. Such an understanding of specialisation does not make space for men or women with responsibilities, obligations and needs outside of medicine.

This construction of masculinity can be viewed as originating from a culture of western individualism where the professional male is free to work unencumbered by conflicting social and cultural pressures. This viewpoint also renders the privilege of the White male invisible and in so doing, ignores a range of experiences that complicate the training process for formerly disenfranchised groups. For example,

specialist internship may be qualitatively different for some Black registrars, who may be among the first generation to be at university and as a result may have fewer role models. They may also have extended family networks that may rely on them financially due to their professional status within the family (Odom et al., 2007; Pololi et al., 2010). In addition, (as discussed above) Black doctors may experience race-related stigma from colleagues and patients alike. These factors may make it more difficult to perform at an optimal level in a demanding clinical environment.

Boutin-Foster, Jordan, Foster, and Konopasek (2008) highlight that the first step in learning cultural competence is to accept and acknowledge one's own cultural orientation. Cultural competence training for doctors has gained momentum in medical curricula in the United States as a means to improve patient experiences (Ly & Chun, 2013; Park et al., 2006). Students may, however, be resistant to considering the influence of culture on medicine and consider the concept of culture as coming from a "soft social science" or something that should be kept out of medicine, which may be viewed as a hard-science empirically-based practice (Boutin-Foster et al., 2008). In a similar way, racial transformation efforts in medicine may be viewed as a "Black" problem rather than something the whole department should be included in. There may also be impatience on the part of people who see themselves as part of a democratic non-racial society with a focus on the legacies of past injustices. In this regard, a key challenge in a so-called 'post-conflict' society like South Africa lies in balancing the need to take due account of past injustices while at the same time promoting a shared future (Swartz et al., 2009). For white South Africans this may include willingness to engage with Whiteness as a culture in itself, that has been constructed over history with its own discourses, assumptions and value systems. Reluctance to talk openly about race during training programs in tertiary education, has been noted by as problematic because it allows "colour blind" discourses to prevail by ignoring the imprint

of South Africa's racial past on the current social and economic environment, factors which will impact the level of care that health workers can offer their patients (Swartz et al., 2009).

#### **4.5. The legacy of unequal education**

In South Africa, the legacy that Apartheid has left on the education system continues to perpetuate unequal opportunities for the majority of Black learners, and may leave some students inadequately prepared to cope with tertiary training. Hall (2012) explains that South Africa's unequal education system has resulted in institutional *poverty traps*, where under resourced schools provide education that isn't sufficient to bring about social and economic mobility. Bezuidenhout et al. (2011) found that some registrars got through undergraduate medical courses without being equipped with certain assumed skills such as computer literacy and presentation skills, which became crucial to success at postgraduate level. Not being in possession of these skills, which are considered essential prerequisites to specialist training (Oberprieler, Masters, & Gibbs, 2005), can form indirect barriers of exclusion if not addressed in academic bridging programmes earlier, during undergraduate study (Lehmann & Sanders, 1999; Tan 2011).

Medical specialisation most often takes place in a competitive and hierarchical learning environment, where registrars must either "sink or swim". In a study of registrar leaning experiences in the Stellenbosch University pathology department, Bezuidenhout et al. (2011) identified that students who are engaged with the learning process are more likely to view the consulting staff members as humble and approachable whereas students who are alienated by the learning process might view the same teacher as disparaging and distant. In a survey at UCT, London et al. (2009) identified that Black registrars were more likely to describe the institution as unwelcoming than White students. It is clear that feeling alienated or unwelcome in such an environment would be a hindrance to professional

advancement as only those who are viewed as most confident, engaged and committed are given opportunities to gain experience and build competence (Macleod, 2011; Levy & Merchant, 2002). Bezuidenhout et al. (2011) describe an effective learning environment as one where all learners feel safe and comfortable to express themselves without risk of humiliation. Ideally, students should feel integrated and supported by the system rather than at odds with it, and this is noted as being a significant predictor of success (Defour & Hirsh, 1990).

According to Torres-Harding, Andrade and Diaz (2012): “Racial *microaggressions*, refer to the racial indignities, slights, mistreatment, or offenses that people of colour may face on a recurrent or consistent basis” (p. 153). These may be intentional or unintentional incidents that may take a verbal, behavioural or environmental form, in a way that communicates hostility or negativity towards those who are racially “other” to the dominant group (Sue, Capodilupo, & Holder, 2007). These factors can be seen to affect whether trainees experience the learning environment as hospitable or unwelcoming.

#### **4.6. Role-models and mentorship.**

There is a considerable research base identifying role models and mentorship as being essential to the professional development of medical students (Ajjawi & Higgs, 2008; Baernstein, Amies Oelschlager, Chang, & Wenrich, 2009; Elzubeir & Rizk, 2001; McLean, 2004). According to Bezuidenhout et al. (2011) registrars learn in accordance with the apprentice model, thus their training is situated within the workplace under the guidance of consulting senior staff. With the predominance of White males in senior training positions in the Western Cape (London et al., 2009), it is likely that registrars from formerly disenfranchised groups may find it difficult to identify wholly with their teachers, and may therefore struggle to engage with a process of professional acculturation specific to their needs. In a survey of preferred role models at the University of KwaZulu-Natal College of Health

Sciences, McLean (2004) found that many students more readily identified with a role model who had struggled yet still succeeded, particularly if they came from a similar background or school. Similarly, female students are more likely to identify a woman who has succeeded in her scientific career as a role model (Lockwood, 2006). Patronage and networking are crucial aspects of building a career in academia or research and the dearth of Black consultants in the Western Cape may affect the access Black trainees have to networks in which they feel accepted and fully welcome.

#### **4.7. Medical specialty of preference.**

There is a tendency for certain medical specialties to attract applicants along racial lines. Black African students at UCT between 1999 and 2004 tended towards obstetrics and gynaecology, while White students opted for anaesthetics. Indian students were found to favour medicine and Coloured students chose paediatrics, psychiatry and medicine more frequently (Breier & Wildschut, 2006). Similarly, gender plays a role in specialty selection, with medicine, surgery and anaesthetics being male-dominated, and paediatrics, psychiatry and obstetrics and gynaecology being the specialties that attracted the most females (Breier & Wildschut, 2006). It is important to note that the number of posts available in each specialty will have some bearing on these choices.

#### **4.8. Transformation in higher education**

In order to promote a more just and equitable society, Walker argues that universities have an important role to play in the promotion of democracy by instilling graduates with the sort of “cultural capital, values and knowledge” (2002, p.43) necessary to foster this objective in society. However as Hall (2012) notes the role of the university is often ambiguous, as it is both a gateway to life improving educational opportunities as well as a ranking system that contributes to the exclusion of some. As

demonstrated above, race and gender disparities infiltrate medical training in certain ways, yet other disciplines have noted similar barriers to transformation in higher education (HE).

In a survey of outcomes among humanities graduates (Academy of Science of South Africa (ASSAF), 2011), racial inequalities were noted with regards to knowledge production (in the form of published articles), with only 20% of total output coming from Black scholars. Jansen (2003) puts forward that While intellectuals still dominate the powerful, global knowledge networks, and in doing so, sustain White authority in a range of academic fields. In a collaborative study of occupational therapy, psychology, education and social work students, across two universities, facilitators found that students were reluctant to talk about issues surrounding race and the lasting repercussions of Apartheid and some believed that “looking back” would hamper efforts to move forward as young professionals in a new democracy (Nicholls & Rohleder, 2010). Other studies have shown race disparities to influence training experiences of clinical psychologists (Kleintjies & Swartz, 1996; Traube & Swartz, 2013). These findings point to a need for a critical awareness of how race issues may adversely affect the provision of healthcare and complicate workplace experiences. As trainees may lack the skills to negotiate these issues, it was advised that some engagement with race dynamics should be part of the training of health-care professionals (Swartz et al., 2009).

#### **4.9. Conclusion**

Based on the findings of these studies it is clear that while considerable effort is devoted to raising the intake of female and/or Black students into medical training, these efforts are in vain if they do not translate into a diverse workforce of doctors and specialists who are both satisfied in their jobs, and willing to tackle South Africa’s Healthcare challenges. As Perez and London (2004) contend,

health training institutions need to continue to strive for the creation of learning environments that are receptive to diversity and nurturing of Black professionals.

## **Chapter Five: Method and Data Collection**

### **5.1. Research design**

This study employs qualitative research methods. Qualitative research methods allow the researcher to investigate attitudes, feelings and beliefs around a particular topic and provide rich, narrative data in order to gain insight into participant experience. While the qualitative paradigm is the most relevant method in this instance, as I aimed to collect rich, experiential data and gain an initial understanding of some of the training experiences that these participants face, it is my hope to later extend the project to include a quantitative analysis of throughput data from all eight medical universities, as well as an analysis of Colleges of Medicine (CMSA) exam data, in order to elaborate on these initial findings.

From the outset of this study, I was cognisant to the fact that a straight forward thematic analysis of interview data that focused on common experience would not be sufficient to uncover the tensions at play in the South African medical training context. As a young democracy, South Africa is an ideologically complex space. While on some level Apartheid policies have been replaced to promote diversity and encourage Black economic empowerment, unequal education and poverty remain a reality for most Black South Africans (Charasse-Pouélé & Fournier, 2006). These factors work together to make tertiary education a qualitatively different experience for many Black students (London et al., 2009). Similarly, medical education has historically been a White, male dominated field and this may exert some influence on the organisational culture of certain disciplines. Therefore, I

understood that my approach to analysis would have to take into account the influence of discourses around the medical profession and racial tensions that exist in South African society.

The term *race trouble* has been used to redefine the problem of racism in contemporary South African society and can be used as a methodology to explain how issues around race are enacted between subjects (Durrheim et al., 2011). The authors define race trouble as “a social psychological condition that emerges when the history of racism infiltrates the present to unsettle social order, arouse conflict of perspectives and create situations that are individually and collectively troubling” (Durrheim et al., 2011, p. 27). A key strength of this approach is that, faced with drastic shifts in South African class structures, the boundaries between elite groups and those living in poverty are no longer strictly defined along race lines, thus the boundaries between “us” and “them” and “racist” and “non-racist” have become blurred. Redefining racism as “race trouble” acknowledges that race is a social phenomenon that affects all people on a complex continuum that varies from context to context. Drawing from this methodology, the focus of this study was on describing these phenomena, critically unpacking them in relation to discourse, situating them within context, and relating them to specific practices.

## **5.2. Critical discourse analysis**

Michel Foucault (1972) promulgated the notion of discourse as a system of knowledge or representation that legitimates relations of power. Discourse is thus a set of rules and practices that forms the objects of which it speaks, thereby reproducing and maintaining power dynamics. Discourse analysis refers to a group of theoretical approaches and methods of analysis focused on the ideological, rhetorical and productive nature of language (Wodak & Meyer, 2009). Discourse analysis emphasizes the ways in which versions of the world, of society, events and inner psychological worlds are



produced and reproduced through language use (Potter, 1997). Critical discourse analysis posits that discourse is a manifestation of social action. Thus, as defined by Link (1983, p. 60), discourse can be viewed as an “institutionalized way of talking that regulates and reinforces action and thereby exerts power”.

In accordance with the principles of critical discourse analysis, in this study, attention was paid to (a) the ways in which participants positioned themselves and their narratives within discourses around the medical profession and (b), in relation to ideologies that reproduce power disparities such as race and gender. The “common-sense” view of racial categorizations is misleading as it constructs race as representative of actual physiological or cultural differences between groups (Posel, 2001). In reaction to this, as Buttny (2003) notes, there is a growing body of work that instead, views racial categories as discursive practices that construct the racial “other” in ways that are negative and stereotypical. Through the analysis of discourse we are able to inspect talk and thus study how discourses of race and gender are constructed and contested in social interactions (Rapley, 2001). According to Wetherell and Potter, racist discourse performs the role of “establishing, reinforcing and sustaining oppressive power relations between those who are defined as racially and ethnically different” (1992, p. 70)

Breier and Wildschut (2006) raise the point that analyses of the discourses around the professional milieu of medicine are crucial if we want to determine what being a medical professional means in South African society. The way people talk about and represent the professional identities of medical professionals creates and maintains the culture surrounding that profession. Discourses around science and medicine have been seen to reproduce inequality by prizing certain professional identities over others (Macleod, 2011), and the medical profession has been historically constructed in accordance with the values of a powerful male elite, while being unaccommodating to the

needs/positions of so-called “minority groups” such as people of colour and women (Wildschut & Gouws, 2013). The assumption of critical discourse analysis is that evidence of these power relationships that connote hierarchies of privilege, will be reflected in the speech patterns of research participants. It is important to note that discourses are not static, and dominant power relationships can be challenged and resisted (Bleakley, 2013; Carabine, 2001).

### **5.3. The origins of this study**

I got involved in this project when I was approached by Professor Leslie Swartz, who had been contacted by members of a group called Harambee. Harambee is a non-profit organization consisting of Black medical professionals; with branches in the Western Cape and Gauteng. This group was formed in an effort to offer support to black medical professionals who were interested in engaging in research after qualifying as doctors and specialists. Dr. Bonga Chiliza (himself a member of the Harambee organisation and a consultant at Tygerberg Hospital), agreed to co-supervise the project. This small study was to be a pilot project that would lead to much larger investigation surrounding throughput rates of Black medical specialists, country wide. The study was identified as a need by Harambee, who hoped to improve outcomes for Black specialist trainees in South Africa.

### **5.4. Participant selection**

I attracted 10 participants to the study using purposeful selection techniques. The parameters of selection were set to include qualified, Black African medical specialists, of either gender, who have completed their registrar training in the Western Cape within the last five years. My motivation for identifying this subset is because they represent those who have managed to gain their specialist qualification despite the potential obstacles. It was my assumption that if this, high status, professional cohort had experienced discrimination or other social and institutional barriers, then these could be

seen as particularly challenging for other, less successful candidates. Thus I have purposefully excluded cases that experienced extreme difficulty with the training and who did not qualify, in order to make tentative conclusions around this issue. I identified the first participants with the assistance of the Harambee Organisation, whose facilitators assisted me in gaining access to participants that met the criteria detailed above. Thereafter I recruited participants using the snowball method.

My recruitment process was conducted as follows: A representative of Harambee first contacted each participant by telephone to request permission for me to email a letter of invitation and information pack to them. These documents included an outline of the aims and objectives of the study as well as a copy of the informed consent document. If the potential participant replied to this email, I proceeded to set up an interview time, based on their availability. After the interview, each participant was asked to assist by putting me in contact with suitable colleagues in their networks, to extend my participant base, using the snowball method. The rate of response to the email was 20%. The participant group consisted of four females and eight males, their ages ranged from 33-42 with a mean age of 35. Eight of the participants studied at UCT and two at the University of Stellenbosch. All but one of the specialists I interviewed were currently employed in state hospitals, which included Tygerberg, Groote Schuur, Lenteguur, Somerset and Valkenberg. One participant was living and practicing overseas.

## **5.5. Data Collection**

Data collection took the form of in-depth interviews where mainly open ended questions were used. I consulted with my supervisor Prof. Leslie Swartz and my co supervisor Dr Bonga Chiliza in order to formulate the questions and probe topics. Dr. Chiliza was able to provide an insider perspective and orientate me as to the structure of registrar training. I conducted a pilot interview to

test my interview guide and thereafter made some omissions and additions, based on the responses that I received in this interview. The interview guide (Appendix A) helped as it aided the flow of the interview. However, because my analysis is discursive in nature, I approached each interview as a discussion where participants could articulate the issues as they understood them, in their own words. I continued to conduct interviews until such time as I believed theoretical saturation had been reached.

The interviews were conducted from June- September 2013. Participants were asked to identify a convenient place and time to be interviewed, whether at their home or office. A participant information sheet (Appendix B) was completed for each participant at the start of each session to collect demographic data. One participant was working overseas, so we conducted the interview via Skype. The interviews were audio recorded and later transcribed for analysis by a professional transcriber.

## **5.6. Data analysis**

The primary objective of this study is to gain insight into the reported experiences of Black African specialists regarding their specialist training. Since this is an under- researched area, I wanted to engage with how the participant experienced the training process and better understand and situate some of the main issues that these participants identified as helpful or problematic.

Thematic analysis is “a method for identifying, analysing and reporting patterns (themes) within the data” (Braun & Clarke, 2006, p. 79). The first step in this approach entailed a thorough reading and rereading of the text, after which I coded the data with an eye for identifying common experiential themes within the text. Experiences that counteract or disrupt these trends were also noted. Using a word processor, I selected textual fragments that I believed most accurately described the experiences

shared by the participants. Using these texts, I constructed a representation of the themes and tensions that emerged from the data.

Because phrases or manners of speaking that conceal or disguise power imbalances are of particular relevance to this research, my analysis was taken a step further. Guided by the principles of critical discourse analysis I considered the post-Apartheid context and power relationships within the discourse of medicine as a whole, in order to further contextualise the experiential data. I have borrowed from the tools of critical discourse analysis outlined by Wodak and Meyer (2009) to assist me in developing an analytical lens whereby the initial thematic analysis of participant experiences were expanded to include the influence of ideology. In this study, this was achieved by paying particular attention to the language used and identifying recurrent “commonplaces” (or frequently used arguments) and preferred identity positions, which the participant may have appeal to. These discourse “strands” were then grouped together to form planes of discourse that are viewed as having a productive impact on how agents experience the world (Potter, 2004). In addition, borrowing from Durrheim et al., (2011, p. 94) I asked the following questions during analysis:

- How is the language organised?
- Why am I understanding this as I do, what is it about the text that leads me to these conclusions?
- How does the speaker want to be heard?
- Is something being argued through the text?
- Who is the audience?
- How is the speaker constructing the objects/subjects of which he or she speaks and in which ways?

- How does this refer back to the self identity that they have constructed?

Using these critical questions was a fruitful way of making sense of what is being communicated through the discursive slant of the text, and provided a point of departure to contextualise each thematic code.

### **5.7. The role of the researcher**

I am cognizant of the fact that interview texts do not necessarily grant access to lived experience and, as Silverman (2004) points out, what the subject tells us is shaped by our prior understandings of the world. Therefore, an analysis of this kind must be reflexive and include an acknowledgement of my own taken-for-granted assumptions and expectations (Wetherell & Potter, 1992).

I am a 33 year old White female doing my masters degree in psychology, by thesis. I have had a long standing interest in post-coloniality, race and identity as research subjects and felt that the project offered an interesting take on these issues because it focussed on the race experiences of some of South Africa's most highly skilled citizens. If this elite experienced systemic racism as the literature suggested it did, surely that would cast an illuminating perspective on the relationship between racism and hegemonic discourse. I was warned that specialist doctors would have little time to be interviewed and I would struggle to find participants, and in some respects this was true. However, I did find that those who were interested in the project went to great lengths to accommodate me in their busy schedules.

During the interview phase, I was aware of the potential effects of the inegalitarian power dynamics that can present themselves between researcher and participant. As a result, I was conscious

of creating a warm and unthreatening rapport with each participant, whilst being cognisant of both of our body language. As medical specialists, these participants occupied a high social standing and I was conscious of this power disparity. As a White student who had little knowledge of the context of medical education, and very little experience of the kind of discrimination that was revealed in the interviews, I hoped that they would trust me with their stories. However, because I am of a similar age to most of the participants I believe that this closed the gap to some degree and I felt comfortable to probe and challenge them during the discussions.

After transcription was complete, I had read the texts in detail and I found that the interview data was particularly rich as most participants had really engaged with the inquiry. The language used was clear and well articulated which made the texts easier to code. In many instances I found that the textual quotations spoke for themselves and revealed the dynamics of race trouble more clearly than I expected. On a more personal level, during the interviews I felt the weight of the injustice of the situations as they were described to me, and I would feel angry for a while after each interview. Later during the analysis phase I was able to gain more perspective on how these racial encounters played out through discourse which proved helpful in processing them for myself.

Because experiences of race trouble are by definition nuanced and unpredictable it was difficult to untangle what could be considered “racist behaviour” or decide which experiences were tainted by racially motivated assumptions and attitudes. Thus, my interpretation is presented tentatively in accordance with the meaning that seemed to be expressed during the participants when presenting recollections of their registrar years

## **5.8. Ethical considerations**

This research dealt with personal and sensitive content, so it did pose a medium risk for participants. In order to mitigate or reduce the risk the following steps to ensure ethical research practices were observed: Each potential participant was informed of the overall focus and objectives of the study, which were included in a letter of invitation (Appendix C) that was distributed via email. Participants were informed that participation in the study is completely voluntary and should they wish to withdraw at any time, they could do so without risk of negative consequence. Similarly a participant could refuse to answer any question at their discretion.

At the interview, each participant was asked to sign an informed consent form (Appendix D) detailing that all interview information would be kept confidential. The transcriber was also asked to sign a confidentiality oath (Appendix E). Participants were assigned a pseudonym and thereafter only be identified as such in the research report. This method of protecting confidentiality was favoured over a numerical code as it allows the reader to acknowledge the narratives as highly personal. Details linking the participants to a field of specialty, the hospital they trained at, and any other identifiable designation were considered carefully in order to protect identity.

Participants were informed that there is no direct benefit to participation in this study; however their views and experience may make a valuable contribution to this area of enquiry. All data is stored on a password protected personal computer and all paperwork in a locked drawer in my office. After five years, the data will be destroyed. The reports generated out of this research will be available to the academic community and a copy will be available at the Stellenbosch University library.

After an internal review by the Departmental Ethics Screening Committee (DESC) of the Psychology department, a research proposal was submitted to the Stellenbosch University Research



Ethics Committee (REC) for full ethical review. Permission to commence with data collection was granted on the 5<sup>th</sup> of June 2013 (Appendix F).

## **Chapter Six: Data Analysis and Discussion**

### **6.1. Introduction**

While it is customary to separate the data analysis chapter from the discussion of research findings, when using critical discourse analysis as a methodology, this separation becomes less defined because describing data and explaining, and situating it, are crucially interlinked. Therefore I have structured these analyses in four parts that incorporate an exploration of a thematic codes identified in the interview texts, alongside a discussion of the implications of the thematic data in relation to discursive patterns and power relationships. The first theme explores experiences of everyday racism among colleagues working at training hospitals followed by analysis of more personal experiences of systemic racism in the form of the internalization of racism and race fatigue. The third section centres on the theme of structural and institutional practises that are viewed to make Black career progression more difficult during registrar training. The final section focuses around discourses of White masculinity that have historically defined the medical profession and the identities that are privileged there.

#### **6.2.1. Theme 1: “I’m here on merit, and tell me where that merit isn’t in me”: Experiences of everyday racism during registrar training.**

All the participants in this study reported experiencing some form of race trouble in the hospitals where they worked during their registrar training. The perpetrators of what was interpreted as

racist behaviour ranged from fellow doctors, to nurses, allied staff, patients and family members. Some thought that experiences of racism simply went with the territory, while others saw it as a reason to leave the Western Cape and work elsewhere. While there were a few reports of overtly racist behaviour, more common was a subtle form of racism that over time cumulatively contributed to a feeling that the working environment was unwelcoming towards Black doctors.

According to discourse theory, we use language to position ourselves in racial terms, and in relation to others. Thus, our experience of occupying a racial body is contingent on the discourses that have come to be constructed around being “Black” or “White” over the course of history (Wodak, 2008). These constructions are used to justify certain beliefs and may be drawn on to reproduce inequality (Wetherell & Potter, 1992). Durrheim et al., (2011) explain that when analysing racial discourse, the focus of analysis lies in the contextual use and social function of the discourse, rather than its accuracy or truth. Thus it is important to state that the purpose of this analysis is not to support or refute claims of racism in Western Cape training hospitals, but rather to document experiences of race trouble which can be read as a text that provides clues as to how these experiences occur and what could underpin them. Thus rather than trying to prove or disprove racist assumptions and stereotypes, the role of the researcher is to identify *how* these discourses may be doing the work of race, and why in a post-Apartheid state these discourses prevail.

While cases of direct verbal slurs were reported in this study, most participants explained that there tended to be an overall climate of subtle intolerance that was difficult to pinpoint. Essed’s (2008) theory of everyday racism is helpful to conceptualise these more subtle and pervasive forms of racism that influence the daily experiences of Black subjects. Racism, while remaining a macro-level social and political ideology, also exists as a means of social order and is produced and created most pervasively through the everyday (re)production of a complex array of discourses, practises, acts and

attitudes. Therefore, racist acts may be very subtle, but due to their frequency and variety, they take a cumulative toll on Black subjects. Essed highlights the problematic distinction between individual racism and institutional racism and argues that racism is by definition “an expression or activation of group power” (2008, p.179). She agrees with Brant (1986), who puts forward the concept *systemic racism* which refers to day-to-day interactions, where destructive micro-inequities have a cumulative effect in creating and maintaining a racist system. Therefore macro social structures can be seen to be produced through the interactions of people, and that routines and repetitions of certain everyday racist practises and attitudes, contribute to the creation and maintenance of institutional racism.

The following extracts illustrate that some registrars felt that while at first they seemed to be welcome in their respective specialist departments, these feelings were unstable and changed as time went on.

Koliwe: Nothing that was glaringly obvious, but very much...a friend of mine would call it “Cape Town Hospital<sup>5</sup>-itis”...and we were always aware that as much as you don't have somebody actually telling you to your face that “I don't really consider you to be equivalent to the rest of the people”, but there are just undertones that make you feel that actually, I'm not necessarily accepted as being equal to everyone.

Koliwe likens her experiences at the hospital to feeling like she had “Cape Town Hospital-itis”, a kind of undesirable affliction that kept people at arm's length. Her description is telling of how she experienced everyday racism, as something intangible but yet undeniably present.

Diliza: I got the feeling the people were very disingenuous, in the sense that to your face they would say something else but tomorrow you would hear a colleague saying that the same

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<sup>5</sup> The specific name of this hospital has been changed to “Cape Town Hospital” to protect anonymity.

person says different things about you, and that was disheartening and you would meet people who would smile at you in the corridors but you would later get to hear that they don't really want you to be part of the institution.

Diliza's experience describes a similar scenario where over time he came to feel that the friendliness that he experienced at face value was undermined by what he perceived as the actions of his colleagues behind his back. Racist speech is often carefully constructed so as to protect the speaker from being viewed as prejudiced, thus overtly racist statements are avoided and more subtle criticisms are made often attached to an anecdotal justification, in an effort to give the prejudiced statement credibility (Van Dijk, 1992; Wetherell & Potter, 1992). Both the above excerpts describe experiences where, as registrars, these doctors felt like they didn't quite belong or, had the perception that others viewed them as not entirely good enough to be training as specialists.

When trying to determine why experiences of race trouble (such as the ones detailed above) happen in today's democratic society it is useful to look to the history of racial relations in Southern Africa. It is possible that these experiences still carry some of the ideological baggage of colonialism that constructed the White race as superior, and therefore justified in their enslavement of indigenous people in Africa and elsewhere through colonial expansion. Black workers provided cheap exploitable labour, which allowed White settlers to gain an economic foothold on the continent. Colonial discourses of race were used as apparatuses of power (Bhabha, 1994), whereby they constructed Black Africans as simple minded and uneducable. These ideas formed the justification for Bantu education, which in turn provided deficient education thereby continuing a cycle of racial subjugation during Apartheid (Durrheim et al., 2011). It is probable that these discourses (in more covert forms) could still be doing the work of maintaining racist stereotypes that cast mistrust on Black subjects who have joined such a skilled and elite workforce. The subtle signs of mistrust and (to use Diliza's word)

disingenuousness lead these Black professionals to feel somewhat like trespassers, in this historically White territory.

Some of the participants felt that there is a perception that *all* Black doctors have been selected for training because of affirmative action and therefore are perceived to be less qualified or not as capable as their White counterparts. Many had had conversations with White registrars and other students who said that they believed that there was no point in even bothering to apply for certain posts because Black applicants would be given unfair advantage. It is probable that these attitudes are the direct reaction to the reality that selection bodies may indeed favour qualified Black students in such situations, and thus White subjects may feel that they are being pushed out or discriminated against in what was formerly a White dominated profession. The symbolic distancing of the White subject from selection process, because there is “no point” can be viewed as a strategy to protect the self esteem by interpreting the situation as evidence of reverse racism (Unzueta et al., 2008). Similarly, refusing to participate denies the Black applicant the satisfaction of engaging with the process as an equal which compromises the goals of Black empowerment to some degree.

In the following extract Koliwe makes use of examples of reported speech in order to contextualise her experience and bring “the White voice” into the description of stigmatization as a Black, female specialist:

There was a lot of grumbling at some points. I remember a time when some White registrars would not get a post, because there had been Black applicants who were meant to be pushed to the front of the queue, so to speak. And there would be a lot of grumbling, in terms of “why it is that these people should be allocated posts sooner than I would get a post, considering that I probably am better than they are”. Not taking into consideration that that person could probably

have gotten that post on merit, and it had probably nothing to do with affirmative action, but they probably were the best candidates on the day for the job. But it would always be taken for granted, that if you are Black and you are coming into the department (and seemingly coming in ahead of many White registrars), you probably got in because you were pushed to the front of the queue by virtue of the colour of your skin.

The word “queue” has been used in a commonplace sense, but the word performs a discursive function in Koliwe’s thinking about how Blacks are constructed as inferior in such circumstances. The idea that a queue is a just means of awarding benefits describes a world where the rules are: first come, first served. It describes a world where those who are best prepared should be granted opportunity first. By Koliwe’s understanding, Black students are constructed by racist discourse as inferior and thus should be at the back of the queue, while White applicants (first to the gates of the “academy” due to the privileges of the past) should be entitled to inclusion. These assumptions could be seen to form part of the repertoire of discourses around affirmative action that tend to ignore the injustice of White privilege.

The fact that beneficiaries of affirmative action are likely to be subject to stigmatization is thought to be an effort to alleviate the dominant group’s discomfort, as they may believe that their status is being threatened by the influx of, in their mind, inferior or discredited individuals, who are viewed as being unfairly granted privilege of access (Kurzban & Leary, 2001). Hegemonic discourses that privilege Whiteness are invisible in these arguments because they assume White comfort, and take White skills levels, and the right to access jobs, as a given. Studies of attitudes around affirmative action have revealed that most Whites in post-Apartheid South Africa tend not to consider themselves privileged (Stevens, 2007; Steyn & Foster, 2008) and this can be viewed as indicative of the normalisation of White privilege to such an extent that it is assumed that the playing field is level and

“colour blind” since the advent of democracy. As Traub and Swartz (2013) put forward, the adoption of a colour blind stance fails to fully recognise South Africa’s sociopolitical history of race and culture, and thus the denial of White privilege, is viewed to be an unconscious strategy to retain such privileges.

In addition, neo-liberal capitalist discourses surrounding work tend to favour a view of agents as radically free individuals, who are able to (with hard work and determination) overcome the sociopolitical constraints that exert influence over their choices and limit access to opportunities (Walker, 2010). In the same way, White privilege may be ignored and instead attributed to individual talent or evidence of dedication. Spurred on by these arguments, those who are critical of affirmative action may withdraw their cooperation, and in so doing, subtly sabotage the development of such co-workers, as the following excerpt illustrates:

Diliza: Institutions still make it difficult for Africans to succeed. They always view us people who have taken so and so’s space, and say: “they will have to survive on their own”, because they got here because of some policy. This is in the minds of our colleagues, we get here because of some quota not because we can succeed and therefore they leave you to drown. Then they say “they are lazy, they are incompetent and they don’t work hard”. And that has to change. As much as we recruit undergraduates we put measures in place to support them, I think that that support has to extend to postgraduate level. And people call it “babysitting” but whether you call it baby sitting or support, it shouldn’t matter at the end of the day. If those that you admit are successful you should be grateful and proud as a teacher.

Racist discourse that constructs the Black race as intrinsically inferior is reflected in Diliza’s view of how he believes some White people perceive Black trainees at the hospital. He explains that

rather than adjusting the institutional culture to be more nurturing of out-group members, an unforgiving “sink or swim” discourse is drawn on. This shifts responsibility for failure onto the out-group member by constructing “them” as lacking in skills or as lazy and incompetent. Diliza’s experience illustrates how institutional efforts to support racial minorities or out-group members may be interpreted as “babysitting” by those who take their privilege for granted. The term belittles the recipients who are again—viewed as incapable— and the recipients of special treatment. Similarly those who are viewed as recipients of the benefits of affirmative action may be doubly stigmatised if they do not thrive in the institution and make a success of their placement there (Resendez, 2002). This “sink or swim” position forms part of a particular discourse of competitive, masculinist professionalism surrounding specialist medicine that I will discuss later in this chapter.

Another perception related to affirmative action that was highlighted in some of the interviews was the belief that somehow, allowing more Black doctors into training meant that standards had to be lowered:

Phindi: I struggle a lot with the impression that when the legislation was changed, and Black people could come and be part of the academic world that they had to drop the standard. There is this impression that the standards have been dropped, there is a view that affirmative action is bad, like “these people are not supposed to be here”. And it kind of goes with this feeling that even if you do well academically, you pass, people are still questioning it. I remember there was a time at Stellenbosch we were having all these talks and one of the consultants came to us and said- “we are not the cream of the crop”, he was talking to all the registrars at the same time and said that “we are not doing so good” and “the department is disappointed, what has happened to the quality”. So



automatically you hear that... and it transfers to you and you think: so does that mean that since I got admitted here the standards dropped?

Again we get a sense from these experiences that Black registrars might be made to feel somehow deficient or somehow responsible for a drop in standards, simply by being there. While in the above excerpt the administration's concern about dropping quality could have been aimed at the entire registrar group at that time, Phindi internalises this criticism and wonders if perhaps these comments are directed at her. This experience reminds her of her racial subjectivity that is associated with a host of racist discursive content, and she wonders if perhaps she is not good enough to be there. A male participant shared a similar experience and felt that these attitudes towards affirmative action undermined his achievements and were unfair, particularly at a registrar level, because he already had his medical degree, and had therefore proven his competency:

I think that near the middle of my time there, I got to know that part of why I was appointed as a registrar was due to the fact that there was pressure to appoint Africans, you know in a White dominated department, and that was quite discouraging because I never wanted to, you know be given something just because I am African, and I never want to be excluded from anything because I am African, but then you know for me applying was just a question of opportunity as a person, so it was disheartening to think that the reason I was chosen was because I was a male African. I think... it also made things make sense to me, like... I'm an unwanted visitor. It's like: "he's Black he can't do much better than we think he can do", and that's that.

This man's description of himself as an "unwanted visitor" again alludes to intrusion or trespassing on the socially constructed White space that is specialist medicine.

Discourse is situated in context and a dialectical relationship exists between race and place (Durrheim et al., 2011). During Apartheid, racial difference was promoted both ideologically and

geographically through the segregation of race groups, who lived in separately defined spaces. In addition, public facilities such as beaches, entrances, schools and hospitals were segregated. Because certain places were reserved for Whites and others for Blacks, the defining constituents of a place impacted upon the discourses that were privileged there. They define who belongs and who doesn't, what kinds of identities are favoured and which are not. This participant's realisation that he was only recruited to provide for diversity, changed his views around his position in the registrar group. He went from being an ordinary specialist in training to being somewhat compromised as an outsider who was only included to further the diversity profile of the institution; in short an "unwanted visitor" rather than a resident.

In the following extract it is evident that familiarity makes it less easy to apply and maintain racial stereotypes, and many of the participants found that over time they came to be accepted within their own departments once they had had time to prove their value:

Kanelo: I mean, my team are fantastic, we had no issues, but like I said you don't only work with only one department, you interact with people from other specialties. And I have found a lot of hostility from some departments, anaesthetics is the worst! And these are educated people so you sort of expect... but nothing is in your face, no one is going to come up to you and say "you can't do this because you are Black".

As a surgeon, Kanelo frequently has to work with other departments whose team members may be unfamiliar to him. He believes that strangers may more readily apply racial stereotypes because they do not know him, thus evidence of his competence has yet to contradict their stereotyped view of his abilities. Unlike a White person of high professional status, his respectability is not a given, but something that needs to be proven.

One of the ways in which subtle racism was made visible was through a perceived lack of respect for the registrar's clinical decisions. In such an instance, a nurse might get a second opinion from a White doctor before carrying out orders, or decisions would be made about a patient without including the assigned doctor:

Phindi: It is always very hard to say what that is due to, but in a lot of instances you will give instructions and then you come back and people have done something else or normally what they would do is they wouldn't follow instructions but phone someone else to confirm that what you instructed is right, and I always felt that that's not appropriate. But it happened anyway and there were a lot of things that happened when you were gone like behind your back, like you come back and you hear people talking like "this and this happened" and then you start realising that oh...that was *your* patient.

Patients may also share prejudiced views towards Black doctors. In the following excerpt a participant explains how even Black patients tend to associate a White face with authority and credibility:

I remember a day where I took the time to speak to a patient in Xhosa, so she understood what was going on with her child and what was going to happen. I arranged the appointment. I pretty much managed her case completely, and then in the end she said, please, don't forget to tell the doctor that you spoke to me! This is after 15 minutes of speaking to her. This is what people are exposed to everyday, so in their minds it has to be that way. So even if you have spoken to someone and explained in her own language, the moment they see a White person...I think they're sitting there and thinking, "now when am I going to see the doctor?" And at times they do ask you to your face, and some people have been extremely rude about it: "No, I didn't come

here to see you. I want to see the doctor”. These are the sort of things that you have to go through.

Instances of overt racism were rare; however they did happen. Reports of being called “a baboon” or being told to “go back to where you came from”, were the kind of overtly racist comments that people had witnessed. However these comments would be said behind the person’s back or directly in Afrikaans because it is perceived to be a language that Black people are less likely to understand, particularly if they are from neighbouring African countries. In the following extract, it is clear that Chana experiences the environment as hostile to his presence and in turn he responds using the signifier “they” which collectively defines these perpetrators of racism as “other” to him.

Chana: People would break off into Afrikaans, which I decided not to relearn, but I was taught at school so I know what people are saying. So if they break off in Afrikaans, it’s just makes the insult that much seem more deliberate, and yet the person is not likely to understand.

Interviewer: So it’s a veiled insult?

Chana: No they are just making clear that they are insulting you. They probably think if they insult you in Afrikaans it will make it slightly worse. But that is what happens. I think people are unhappy that I am here.

It is clear that instances of everyday racism can complicate the specialist training process for Black registrars. Stereotypical attitudes towards Black subjects stemming from Apartheid and colonialism continue to be (re)created through discourse and other everyday practises in some cases. Cumulatively these microinequalities lead Black specialist to experience the training environment as unwelcoming. Misconceptions about affirmative action, that tend to ignore the influence of privileged Whiteness, lead to stigmatization of Black students regardless of whether they were beneficiaries of

these policies or not. In the next section, I will explore the physical and psychological effects of working in the racially charged environment established above.

### **6.2.2. Theme Two: “You don’t want to be labelled as someone with a chip”: Race fatigue, tokenism and the internalization of racism**

Feeling the pressure to prove oneself during registrar training could be viewed as a common experience among all registrars who want to demonstrate their skill to their superiors. However if the work environment is perceived as hostile or intolerant to Black trainees, then it is conceivable that the pressures, and resultant stress, will be far greater. As we have seen in some of the preceding excerpts, racist ideology infiltrates the workplace where registrars have to work against racial stereotypes and discourses of Black failure and incompetence, stemming from Apartheid. These pressures are exerted from the outside in the form of everyday racism; however they can also be internalised, contributing to stress levels and feelings of insecurity in the workplace. Some of the participants, particularly the women who had additional domestic pressure to contend with, explained that they felt that there was a constant need to validate their position that was very tiring, as this female specialist explains:

More than anything, it made me feel exhausted because every day you are trying to prove yourself. You wake up on a daily basis with the mission to show, I qualify to be here, and it's not because I'm Black and I got given this post on a platter. I have experience. I have the necessary qualifications and I can do the job as well, if not better at times, than any other person who would have gotten the job. And I got it on merit, and not by virtue of me having been from a previously disadvantaged background.

One of the main obstacles for Black registrars during training was that there are few Black role models in the higher echelons of academic medicine who could identify with some of the challenges these registrars experienced. According to participant Mawanda, the low number of registrars had a knock on effect and led to a dearth of Black academics, which perpetuated a cycle of a lack of Black mentorship.

Mawanda : It becomes a game of numbers. If you don't have enough trainees that are training from South Africa, who are Black South Africans going through these departments, then you are far less likely to end up with an academic that's been derived from that group, its one Black guy, out of 19 White guys in the unit.

Since qualifying as specialists, some of members of the participant group had become consultants at training hospitals and I asked how they felt about performing a mentorship role for the next generation of Black registrars. While some said that they were gratified to be doing so, one woman articulated that the role was complicated, and she was resentful of the "Black role-model" label. As the following excerpt illustrates, she wished that she could just be acknowledged as simply, a good doctor.

Interviewer: Do you feel like you being there, sets an example for up and coming registrars?

Koliwe: At the moment I take great pleasure in knowing that, and in being that kind of role model for people going through the department and seeing that actually, if she could do it, I can possibly also do it. But I must also admit- that also gets tiring.

Interviewer: Really. Maybe it's not a role that you feel you want to take on?

Koliwe: I don't want to be a role model, to say to people, oh well, look at her, she could do it, so that means you can also do it. But I would like to be somebody that they think, come on, she's so good at what she does, why don't I go ask her what it is that she

thinks about this subject, whatever the case may be. Not to say, well, she's Black, and she can do it. But rather, oh, look at what she has done and what she has achieved, I could probably achieve just as much, how did she go about doing that?

The opportunity to be acknowledged according to the same standards, rather than in relation to Whiteness as a token member of a group or staff, would be real evidence of transformation for this consultant. Like Koliwe, some of the participants expressed fatigue at having to “live up to” being the Black face in the group. This often came with added scrutiny and responsibility to get involved with panels and governing bodies within the department so as to increase the racial profile of these committees, a move that didn't always feel authentic. These findings are consistent with a recent study conducted in the United States where underrepresented minority participants reported increased pressure to fulfil additional responsibilities in addition to their regular work (Dickins, Levinson, Smith, & Humphrey, 2013). This uncertainty is articulated in the following excerpt:

You are always feeling like, well, okay, you want me to sit on the interview panel, is this now as a token thing, a Black face? Or is it because you feel I'm qualified to actually sit on the interview panel? And I don't know if I'll ever know the answer to that, really, but I'm leaning more towards the token side of things.

Mawanda takes a different view:

I might have felt that my appointment as a chief resident... was it because I was Black? You know, from time-to-time you kind of think, I don't want to get pushed into things that I don't want to do, because I happen to be the Black face, and therefore I get put forward to become the face of an organisation. So before I came here, I had to constantly evaluate why am I being placed in this leadership position? So that's always kind of been the thing, but I concluded that it wasn't really the case. You know, people can see whether you are interested.

Interviewer: So you felt that people thought you were the person for the job?

Mawanda: Yes, that's right, that's what I concluded. But I've always had to check myself. So in a sense, (one) I didn't feel that I was disadvantaged because of my race, (and secondly) I didn't think that I was ever advantaged because of my race because... well I fit in with the guys that I work with, and on merit, we sort of get things together.

Mawanda (a surgeon) attributes his success in his department to “fitting in with the guys” and this became evident as a crucial aspect of success within certain departments, and a theme that I elaborate on in more detail later in this chapter. His statement makes explicit his belief that he was neither advantaged nor disadvantaged by race and was awarded the leadership post on merit. However, he was not always certain of the motives of those who elected him leader, and had to check himself so as not to become a token appointment.

While *race trouble* appeared to be a part of everyday reality for these doctors, they felt that it was difficult to isolate and one could never really be sure if what they recognised as racism was merely coincidental. In today's neo-liberal societies, explicit racial subjectification is less common (Hook, 2012), and has, in most contexts, been replaced by what has been termed *modern racism*. This new wave of racism tends to operate on a repressed level where, at face value, subjects would describe themselves as non-racist, yet they may hold certain beliefs (whether consciously or unconsciously) that lead them to behave in subtly racist ways. For example, when a nurse phones a White doctor to verify a Black doctor's orders, she might tell herself that she is just “being on the safe side” and double checking, which may seem justifiable to one who has prejudiced racial attitudes. Since she is making the call behind the doctor's back she can maintain the favoured social identity as a non-racist. By allowing agents to distance themselves from overt racism, these more subtle ways of “doing racism” allow White subjects to feel justified in ignoring their role in perpetuating segregation and oppression



(Durrheim et al., 2011). Thus racism is both tangible, yet hidden in most contexts because it is socially undesirable to be viewed as openly racist. Thus racist speech may be constructed so as to conceal the motives of the speaker, as well as to downplay the influence of race on behaviour.

In this study, some participants felt that they second-guessed themselves because they could not always be sure if what they recognized as maltreatment stemming from racism was real or imagined. The word “paranoid” was used quite frequently to explain this uncertainty and hints at how the internalization of racism may work as a self-depreciating practice where racism becomes “anchored” within the individual (Hook, 2012, p. 27), while simultaneously being exerted from society outside. By acknowledging these subtle instances of racism, Black subjects may be labelled as paranoid or “playing the race card” by those who deny that their attitudes and behaviours are discriminatory. Typically, arguments that use a colour blind discourse will stress that “it is time to move on”, or “Apartheid is over, we are equal”. This discourse allows White people to ignore the inequality that is prevalent in all aspects of South African society and suggests that rising above racial discrimination is a choice. As Bounilla-Silva (as cited in Durrheim et al., 2011, p.76) explains, this colour blind stance “forms an impregnable yet elastic wall” that serves to maintain White privilege, under the guise of transformation.

Thus the obfuscation of racial intent makes it difficult to interpret comments and behaviours. In such circumstances, the speaker is exonerated of responsibility, and feelings of victimization, self doubt and shame are internalized by the Black target. The following excerpts illustrate this internal dilemma, as a result of a racist encounter:

Diliza: I decided to stop talking. You get a sense that maybe I'm not the normal one here. You get a sense that maybe my colleagues are not having the same experiences or they don't want to get in to trouble by raising concerns or whatever.

Kanelo: No one is going to come up to you and say "you can't do this because you are Black", it is in a very subtle kind of way, and if you pick it up and you comment well... It it... you almost need to be paranoid to pick it up in the first place and then you come across as being petty, you know what I mean.

Siya: If I was to sit and talk to a psychiatrist about this believe me, they will think I am mad, and they could easily say, you know what, this guy's got paranoid delusions.

The psychological and physical effects of racism are well-documented (Bennett, Merritt, Edwards, & Sollers, 2004; Carter, 2007; Kaholokula et al., 2012; Pieterse, Carter, & Ray, 2013; Speight, 2007; Williams & Williams-Morris, 2000). The narratives expressed by some of the participants illustrate a view of racial oppression that is psychologically burdensome and it is probable that working in an environment where one has to negotiate race trouble on a daily basis will lead to increased stress levels and even burn-out. If those who believe that they have experienced racism are labelled as petty or paranoid, they may feel that it is better to say nothing and simply view these incidents as something that has to be tolerated, as part of the job. Unfortunately this problematically maintains the view of racism a "Black" problem. Building on this in the next part of this analysis will explore some of the participant experiences that relate to systemic racism in training institutions in the Western Cape.

### **6.2.3. Theme 3: “We waited for our turn, which sometimes never came”: Institutional obstacles to career development.**

As established in the previous sections, reports of feeling that they were treated as inferior and incapable during registrar training were reported by most of the specialists that I interviewed. The experience of these negative attitudes from colleagues and patients added to the already demanding workload and compounded stress levels. Related to these instances of everyday racism, certain structural arrangements within registrar programmes contributed to feelings that Black trainees were not welcome, or perceived as less competent. As I raised earlier; making a distinction between individual and institutional racism is theoretically problematic according to Essed (2008), as it is the contribution of individuals working together within organisational structures that creates and maintains systemic racism, through the daily repetition of small (seemingly insignificant) speech acts, attitudes and behaviours. However, for the sake of clarity in this analysis, I have made a thematic distinction between instances of everyday race trouble between individuals, and structures and practices whereby race discourse may influence registrar programs at an organisational level. However these two themes are interrelated.

It has been theorised that institutional racism occurs and is reproduced because of underlying stereotypes and biases that were imprinted during colonialism (Rangasamy, 2004). Institutions such as universities and training hospitals where historically loci of White power, and due to the fact that there were few female doctors in senior positions, these locales tended to be male dominated. Coupled with this, racial segregation in hospitals and training institutions was the norm during Apartheid. As Rangasamy (2004) goes on to explain, racist or sexist stereotypes are likely to subtly mould the energies and attitudes of successive generations if there is no concerted effort to transform institutions. However as Higgins (2007) raises there is much uncertainty as to how organisational culture can be

altered in favour of diversity, when the very construct of organisational culture is wrapped up in the politics of power and control in institutions of higher education.

Some of the participants in this study felt that the hospitals that they trained at were not favourable environments for career development if you were Black; and if you were also a woman, the problem was compounded. The dearth of racial and gender diversity among senior staff, as well as the perception that the Western Cape was unwelcoming of Black professionals, meant that transformation in training hospitals in the Western Cape, is perceived to be progressing very slowly.

Mavo: Coming into an environment like this, I understood that you have people who are used to one particular culture, and that comes with a culturally dominant way of thinking. So I didn't expect people to appreciate that excellence or good work would come from a different kind of place, that they don't recognise.

In this excerpt, Mavo states that in a hospital what is ideologically valued comes from the tradition of western medicine established in Europe and North America. People may not place value in viewpoints of other cultures, or expect excellence to stem from them. This form of cultural imperialism universalises the experiences and outlook of the dominant group and renders it the norm. Those who are "other" to this conception undergo what Young (1990, p. 59) identifies as a "paradoxical oppression" as they are both marked out as different by stereotypes, and at the same time rendered invisible.

Kanelo: The hospital definitely has problems... I mean if I look at... there isn't a single department that I know, that there wasn't a Black registrar who came, couldn't cope and left. And people said, well look... we are in the Western Cape. It, as a province, is racist. I mean if you think about it what makes up a province? It's cities, and what makes up

cities-- institutions and institution like ‘Cape Town Hospital<sup>6</sup>’ make up Cape Town. So if say the city is racist, then the institutions are too to some extent.

Kanelo makes the point that the cumulative culture of many institutions and the segregated nature of other social spaces such as businesses, neighbourhoods and schools creates and maintains the image of the Western Cape as a “racist” place. A male specialist that I interviewed felt that it would be better for him and his family to move to Johannesburg, because there (in his view), it was more socially acceptable to be Black, educated and successful career-wise. After struggling socially in Cape Town for six years he said that he and his wife (also a doctor) had few friends and had never been invited to socialise with their mostly White colleagues, and felt that there were few social opportunities for Black professionals in Cape Town.

As I touched on previously, a dialectical relationship between racial identity and space influences the discourses that are privileged in a specific context. Durrheim et al., state that “the meanings of places and the kinds of people who belong in them are constructed by reciting racist and stereotypical images” (2011, p. 124). That is to say, certain identity positions are valued in a specific place, and others are devalued. This begs the question of how, in the context of a training hospital, do discourses of racial difference (that have constructed the Black race as primitive and inferior) cohabit with discourses of western medicine which expect excellence, commitment and scientific innovation from their doctors? By this understanding the identity of the “specialist physician” may be difficult to reconcile with the discourse of the “the incompetent person, who has taken someone’s place”.

The historical conception of the “ideal doctor”, as constructed in discourse around the medical profession, is evident in the following statement by Abraham Flexner made in reaction to the fact that Black doctors were being trained at (to his mind) substandard medical colleges in the United States at

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<sup>6</sup> Name of hospital concealed to protect anonymity

the turn of the 20<sup>th</sup> century. Here Flexner asserts that not *everybody* is suitable for medical training and suggests that many Black doctors are inferior because they are not in possession of the innate talents that are necessary for the profession: “Medical education on a modern basis cannot be imparted to everybody; it can be successfully imparted only to persons of good native intelligence, trained to serious application (1925, p. 83)”. The recommendations of this paper, published for the Carnegie Foundation, led to the closing down of seven Black medical colleges, greatly limiting the opportunities of Black medical students for some time thereafter (Strelnick, Lee-rey, & Nivet, 2008). It is clear that his viewpoint draws on the now discredited idea that race is a genetic trait, yet it is important to consider the influence of such discourses on the formulation of taken for granted stereotypes surrounding race and culture that still may be activated today. Thus it is possible that this disjuncture between racist constructions of the inferior “native capacities” of Black subjects and the idealistic conception of the “scientist physician” (Whitehead, 2011), may be doing the work of creating and sustaining an unwelcoming institutional atmosphere for Black doctors. In the same way, women were historically constructed as intellectually inferior and unsuitable for the rigours of a scientific career. While this view would be generally considered as outdated in most contexts, the influence of such discourse still contributes to widespread discrimination, lower salaries and fewer funding opportunities for women in science today (see Bevan & Learmonth, 2011; Sakallı-Uğurlu, 2009; Shen, 2011).

### **6.2.3.1. Institutional practices**

I asked participants to describe practical instances in which they perceived race as a factor impacting on their professional progression. Some registrars felt that they were discriminated against if methods of drawing up schedules for specific rotations were not transparent or seemed inconsistent. Some felt that they did not receive the same senior privileges and clinical opportunities that seemed to be afforded, in these cases, to more junior White registrars. Shifting goal posts and contradictory

standards from one year to the next were said to be attributed to an environment where rules could be bent seemingly in favour of promising (usually White) doctors. Because consultant physicians (who are responsible for the training of specialists) are among a powerful intellectual and sociocultural elite, they hold the power to both make and bend the rules at their professional discretion, and certainly, the freedom to do so is an essential part of their efficacy in making critical decisions in medical practice. However some participants felt that this freedom could be misused to discriminate subtly against Black registrars, if clear departmental guidelines were not in place. Siya recalls the following experience in a surgical department:

For career progression in surgery I strongly felt that everybody else was a supporting act for the Caucasians in the group. For example, in 2007, we got two Nigerians and another White guy in the department. And in his fourth month, this new White guy, he was offered to do a valve replacement procedure. And I remember on that day myself and one of the Nigerian guys said, excuse us, chief, this guy, as far as we are concerned, he just joined us. I mean, we've been here already more than 18 months and we are still awaiting our first valve procedure. And we really expressed our dissatisfaction with that, and he sort of pretended that it was a mistake in terms of allocating and things went ahead. Then suddenly we get told the consultants require somebody to be a "bridge consultant" of some sort, between them and the registrars, this guy is going to be promoted to senior registrar duties, and we didn't really understand what does that mean, and that his duties will include him not being able to do any of those mundane duties in the ward. Basically, he is going to function like a consultant... he doesn't have to come at 6 am like us to see patients in ICU before everybody arrives. He doesn't have to do anything in the ward. He just operates and he gets his days in the lab to do all these procedures, and then in any other time he studies.

He went on to explain:

So then we looked at what month in his training did this start? So he started in his 49<sup>th</sup> month in his training. Ja, so we went on, and then in 2009, in December, I started my 49<sup>th</sup> month. Now obviously, this guy finished 2008, and now I was the senior guy there. And after two months, in my 50<sup>th</sup> month or so, I said, hang on guys, I thought this is the situation when you get to be a bridge, where you have time to study so that you can ace your exams. Where you operate... so that you can become an excellent surgeon. And I remember the answer I got, ja, I'll never forget that, my boss told me that this "culture of post-Apartheid self-entitlement doesn't work in surgery"<sup>7</sup>, surgery is for the mental elite and not the weak", whatever that meant.

Siya's experience was echoed by a few other participants who expressed that the rules seemed to change when they as Black registrars made it to senior rank. While this excerpt only allows us access to one side of the story, the departmental response to his enquiry seems to reflect discourses of elitism and even racism that leave little room for negotiation and transparency. What is implicit in the statement is the experience that White entitlement is so commonplace that it has become invisible, while a Black subject asking for the same opportunities is viewed as self-entitled. Koliwe shares a similar experience:

Initially I thought, ag, well, it was going to be okay and everything was fine, but I think as time went on, one sort of discovered that there were some undertones of not being fully accepted. And sort of being judged, not on the basis of what you can do, but on the basis of the colour of your skin. Basically being thought not to be on par with your colleagues because you are not as...I don't know...qualified perhaps as they might be. And there were times in the rosters where you would find that you would feel a bit hard done by, but you couldn't really put a finger on it and

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<sup>7</sup> Specific specialist department changed to protect anonymity



say but this person is doing this and that person is doing that. And I'm senior to that person, and yet I'm not allowed to be doing that list or that other list, for example. There are lists that are thought to be for people who are passed their primary exams or passed their ICU rotations and things like that, and then there are lists that are for the very junior, junior people. From when we started, we (the Black registrars) would always land up with the list that is for junior people, even though you had completed your two years of being a registrar. And you would find that our Caucasian counterparts would end up with lists that are meant to be...or we'd been told are meant to be for senior people, and yet they aren't necessarily the senior people. And people got to rotate to cardiothoracic and disciplines like that, who had arrived in the department later than what I had done, for example, and yet I wouldn't be allowed to go because...well there were no reasons given.

Reports of unpredictable and unfair promotion within some specialist departments emerged in many of the interviews. Being passed over for career progressing opportunities such as research opportunities, operative experience, and favourable rotations was a common experience for some of this group. Senior registrar privileges, such as time off from ward duties in order to study for examinations were in some instances perceived to be granted only to White registrars, who in some cases are perceived to be fast tracked through the system despite being more junior additions to the department.

One participant reported that in his surgical department the White registrars were always divided across the different rotations so that they by default became the “stars of the show” with the Black students performing a “supporting role” in whatever procedure they performed. This anecdote demonstrates how a seemingly “fair” practice of assigning groups with a racial spread actually echoes and reinforces racial stratification in society, where White people tend to be assigned leadership roles

and Black people tended to do more menial work. What interested me about these descriptions was the use of language of performance, in phrases “supporting role” and “stars of the show” because they highlight the need for a trainee specialist to prove his/her competence and thereby “perform” their professional identities (Butler, 1990) under the scrutiny of their colleagues. Being consistently denied the opportunity to do so is likely to cause feelings of inadequacy and frustration, as marginalization can occur when “the opportunity to exercise capacities in socially defined and recognised ways” is blocked (Young, 1990, p. 54).

While consultants may argue that they are objectively selecting the best person for the job based on the perceived competence of the candidate, it is possible that racial and gender identification may play some part in these decisions, if even on an unconscious level. Drawing on Bourdieu’s theory of *ontological complicity* (1984), Purwar (2004) explains that in groups, or as individuals in a social space, what we view as objective structures and social fields are actually something that we activate with our practices. This is an unconscious and automatic process that Bourdieu calls the *habitus*. The habitus operates as an internal schema of automatic gestures and techniques of the body or ways of doing things. When our habitus matches the field of the social space, the individual experiences ontological complicity in that they “merely need to be what they are, in order to be what they have to be” (Bourdieu, 1990, p.11). Thus if the institutional culture of a hospital has been historically established in accordance with ideologies that favour Whiteness, White agents acting in that environment may be viewed as being in possession of a superior level of mastery or an intrinsic “feel” for the what is expected of them. As Purwar (2004, p.50) puts it, “their dispositions, comportment, gestures, speech and tastes place them ideally to meet the demands of the field in which they manoeuvre themselves—their work”. White male registrars may simply fit the socially constructed mould of what a specialist should “be” or look like with less accommodation. While it may seem

absurd to speak of identifying a specialist by how they look, many of the participants reported incidents where in a ward situation they would literally be overlooked by patients and other staff because they didn't *look* like the person in charge.

Kanelo: Say for instance I am walking with one of my colleagues from orthopaedics, who are generally very tall White males, so suddenly most of the gaze will be directed at him because he is assumed to be in charge. So look, it's a societal thing like I said, White equals a figure of authority and that you can't escape it.

Koliwe: I'm a consultant now in the ICU, and I'm *the* Black consultant in the ICU, the only one, obviously, and registrars from general surgery or other disciplines will come looking for a bed in the intensive care, and they will speak to the registrar who is White and completely ignore me. It is as though I don't exist at all. And it's a matter of: "I'll speak to the person that I think is in charge, and *you* can't possibly be that person". They will even turn around and say to the registrar: "where's the consultant?" And I'm standing right there.

Universities have evolved over time on the basis of certain assumptions, for example the idea that "heterosexual, White men from economically and socially privileged classes, where *naturally* endowed for a university education" (Rangasamy, 2004, p.31). While the race, class and gender spread is far more diverse in today's universities, certain socioeconomic and cultural values may still be retained and as Goodwin (1999) puts forward, may still govern the operational mode and management of universities in line with these social categories. Brozalek and Leibowitz argue that in order to bring about transformation in higher education it is important that practises which are "normalised or considered universal should be exposed for their distinctiveness"(2012, p. 64)

This data reflected that some of the participants had plans to leave their posts in public

hospitals and move elsewhere due to feelings of being worn out due to the daily prevalence of race-related frustrations and obstacles.

Koliwe: At the moment, I think I'm at a place where I'm...I think I was very disappointed, and I feel whatever effort I'm putting in, it's not necessarily appreciated. And I have been beating myself up trying to work as hard as I have been to try and accomplish something, yes, for myself, but also for the university and the institution. And to be completely passed by and not recognised in the fashion that they did, it was absolutely mind-boggling for me.

The preceding excerpt illustrates Koliwe's feelings of disappointment for being passed over for a prestigious research opportunity that stemmed from an initiative that she had set up in her department as a consultant. A White male, two years her junior was put forward for the position unbeknownst to her. She was only made aware of this development once arrangements had been finalised and there was no time to appeal the decision. As a result Koliwe, the only Black consultant in her department, has decided to leave the Western Cape and seek employment elsewhere. She goes on to explain her reasoning:

They could at least have given me the respect to say, would you be interested? This is what's happening, would you be interested? And I could be the one to turn around and say, not this time, thank you, you can send somebody else. But I wasn't even given that chance, on my own project. So I would definitely like to leave because now I'm very much discouraged. I just feel I wasn't given a helping hand when I needed one. So how do they expect the people to specialise when they're not going to help them actually achieve that speciality? And secondly, how do they expect people to want to be academics if they are not going to assist them in becoming those academics?

As in any academic discipline, research, and the publications that are generated from these, are career building opportunities in medicine, and are a prerequisite to entering academic departments. Some of the participants said that they felt discouraged because these opportunities were often given to students who were said to have shown “initiative” or evidence of “commitment”. Some were unsure of how these qualities were allocated and felt that they were overly subjective and could have a race or gender bias, as the following excerpt suggests:

Everything is getting clamped down, and to be a head of department you need to have a PhD. And for you to have a PhD, you need to be around people who are doing PhD sort of work who will be able to supervise you for it, and for you to get a good supervisor he has to think you have the potential. So there again, who is the supervisor? If you look around, who has PhDs in this country? Who are they likely to choose? Is he going to choose a boy from KZN (Kwa-Zulu Natal) and help him get a PhD? Maybe it would be wasted.

In this excerpt the participant is explaining how he perceives the academic workplace to be reliant on social connections, and that black and/or female trainees may not make those connections as readily if an academic department is dominated by White male professors.

#### **6.2.3.2. Difficulties with language.**

Due to the bilingual Afrikaans/English language policy, Black registrars may not view Stellenbosch University as their first choice, due to a tendency for some consultants to deliver ward rounds and lectures in Afrikaans, which may only be a third or fourth language for some Black registrars (Equality Impact Assessment, 2011). Yet, for the most part, being able to speak an African language was viewed as an advantage because many of the patients that were seeking care at state hospitals were not mother tongue English speakers. Speaking an African language was experienced as

“having an edge” over other registrars for some participants, who found that others would seek out their help when communicating with patients. However on an institutional level, language was identified as a difficulty for some. Stellenbosch University’s Afrikaans language policy was experienced as problematic for some registrars at Tygerberg hospital who felt excluded in ward rounds or internal email communications, if no English translation was offered. According to an internal survey of students and staff at Tygerberg hospital (Equality Impact Assessment, 2011), some departments insist on conducting their departmental communication solely in Afrikaans as a matter of principal, a practice that unfortunately serves to exclude some students and staff in a way that could be deemed unprofessional.

Phindi: My major, major problem was with language. The thing that I felt for me was that I was not taken into account of, or respected when people would run a ward round in Afrikaans, being very aware that there are people in the ward round who don’t understand what you are talking about or people teaching and giving us information in Afrikaans when there were some that didn’t understand, and I thought that was unfair because when I applied to do the training one of the first things that I asked was is it in Afrikaans, cause I said I wasn’t going to come if it was. I was assured: No it’s in English, we teach in English. Because, if you run a ward round in isiXhosa for example would it be acceptable? It wouldn’t be. But there are some people who feel that they want to do it in Afrikaans. Having said that it depended who was doing the ward round because some people would ask questions in Afrikaans and then that person would explain it in English to the rest of the group.

### 6.2.3.3. Unfair evaluation.

According to some participants, an area of the specialist training process that requires further research is the Colleges of Medicine of South Africa (CMSA) exams. The CMSA oversees the qualification of all South African medical specialists, and there are a series of written and oral examinations that each registrar would have to pass before qualifying as a medical professional. Attitudes toward these evaluations were divided because the examinations are viewed as only partially objective, as the written examination is followed by an oral examination where knowledge of clinical and surgical procedures is tested by a panel. While some participants rated them as fair, others were critical, saying there seemed to be discrepancies in pass rates along racial lines. A recent study conducted in the United Kingdom (UK) found significant differences in pass rates between Black and other ethnic minorities, and their White counterparts, after factors such as age, sex and an applied knowledge test had been controlled for (Esmail & Roberts, 2013). This study suggests that racial stereotypes may introduce subjective bias into the clinical skills evaluation process. These findings are consistent with other studies of differences in pass rates in postgraduate medical examinations in the UK (Dewhurst, McManus, Mollon, Dacre, & Vale, 2007; Tyrer, Leung, Smalls, & Katona, 2002). In the following extracts Diliza and Siya express their views of the examination process.

Diliza: I got a sense that the reports were written long before when they saw I was coming for a rotation, and you feel voiceless because you can't say anything because you are a trainee and you will be labelled as difficult or not trainable. So you just take whatever is dealt to you – take it as constructive criticism and let it build you. Unfortunately this also extends to your final exams— Colleges of Medicine, where if you are African you are less likely to succeed, and the statistics are there. You will pass your written exams

because nobody knows, but when you present yourself at the White male dominated college you are unlikely to do well.

Siya: The Colleges of Medicine exams, I can tell you now that there are a lot of injustices that are coming out of that. I've never before...I'm not saying I'm clever or anything...I have never written an exam and walked out of it and been absolutely sure that I have passed – and that's not the case. I went for my first exam, walking out of there and thinking I aced it, and when the result comes out I didn't pass. At that time, out of the country, there were seven who wrote: two Caucasians, from Bloemfontein and Pretoria, and the other guys; non-Caucasians from around the country. And only the two Caucasians passed. So then we write the second time round, March 2011, this time there are no Caucasians around the country writing, and nobody passes.

While Siya's interpretation of these events does raise some concern as to the fairness of the CMSA examinations, it is possible that these irregularities are in fact coincidental, and that is certainly the reply that he got when he asked for feedback after failing a second time. However a study that investigates the relationship between race and the results of CMSA examinations would provide strong evidence to support or refute these claims. To my knowledge, no such study has been conducted in South Africa.

#### **6.2.3.4. Leaving the Western Cape.**

There is evidence that the Cape Town municipality remains radically divided along race and class lines when it comes to service delivery and access to schools, transport and healthcare (McDonald & Smith, 2004), and this is similar to the situation in many cities across the country. The socio-geographic segregation imposed during Apartheid has tended to prevail in many neighbourhoods



and as Durrheim et al. (2011) note, these patterns of segregation tend to perpetuate the existence of a racial underclass who, due to poor living conditions and high unemployment, have little hope of attending better schools or finding jobs that will allow for upward mobility.

What is more, the perception that Cape Town is specifically a “racist place” which is hostile to Black professionals (see Surtee & Hall, 2010) have precipitated much debate in the media and theorists reason that this reputation has developed due to a combination of factors, some of which are political. The city’s hostile reputation may be a factor that deters Black doctors from settling in the Western Cape to complete their registrar training. Furthermore, the two medical training hospitals in the Western Cape are attached to historically White universities and this could contribute to the dearth of Black registrars and consultants at both institutions. However some of the participants in this study thought that the problem of racially charged environments in training hospitals was not specific to the Western Cape and is in fact more generalised to the country at large, as a few specialists reported experiencing racism at other institutions both nationally and abroad. Because this study only investigated training experiences in the Western Cape, I cannot infer that these experiences are common to Black registrars elsewhere, however indications from the participants that I interviewed suggest that the problems is not specific to the Western Cape, and thus more investigation is necessary at each of the eight South African training institutions.

The experiences of these doctors suggest that if the organisational culture of training institutions is experienced as alienating to Black professionals, it is clear that simply putting Black faces in the halls does not offer a sustainable solution to the problem of attracting a racially diverse range of medical professionals. And it seems inevitable that retention of these individuals in academic hospitals will only be temporary. The influence of leadership was viewed to play an important part in reworking structures and routines so as to minimise institutional racism which tend to creep in when processes

were unquestioned or constructed as ideologically neutral. In the next section I will explore the privileged masculine discourse that has shaped the culture of medicine, in order to situate formerly disadvantaged groups (such as women) in relation to hegemonic discourses that construct medical specialisation as a male domain.

#### **6.2.4. Theme 4: “Getting on with the guys”: Male centred discourse in the culture of medicine.**

I think in a speciality that’s clearly, just in terms of numbers dominated by males, you will have a preponderance of male ideas and that kind of thing, we are much more likely to play soccer and rugby than we are, to do ballet. (Male surgeon, age 33)

The gendered domains that are delineated by this light-hearted comment by one of the participants hints at the ideologies that have historically constructed the male as heroic and powerful and the female as a fragile object of desire. While during the course of this analysis I have demonstrated that both Black men and women experience instances of race trouble in registrar training, it is clear that Black men may find it easier to align themselves with the male-centred discourse that has historically come to define the identity of the specialist doctor. Thus race and gender intersect to doubly stigmatize the Black female registrar, making their training experience even more challenging.

In her critical analysis of the culture of medicine, Whitehead (2011) asserts that the socially-constructed image of *the good doctor* has been constituted over history in line with discourses that construct the medical profession as a “high calling”. She further notes that this role is discursively constructed as being suited to a man whose character is above reproach. This ideology portrays the

specialist doctor as a kind of “super human” who is part of a social and intellectual elite, as well as a person of unquestionable moral character, who puts no other obligation before his work. As I have explored elsewhere in this paper, women (and other ideologically marginalised groups) may find it difficult to situate themselves within this discourse because they are not granted the same support by society and may have to take on incompatible roles within the family (Wildschut & Gouws, 2013).

When I asked female participants how they coped with gender bias and racism that they experienced at work; a common reaction was to “keep your head down”, ignore it and work harder. This reaction can be viewed to be aligned with one of the ubiquitous idiomatic expressions used to describe registrar training which is: “sink or swim”. For many, simply getting to the end, in order to qualify, was the main goal. What had to be endured in order to get there was viewed as part of a long established hierarchy that was unlikely to change. There seemed to be a need to demonstrate physical and emotional stoicism, and many of the phrases used when describing experiences of adversity tended to belong to discourses of hegemonic masculinity that are favoured in the military and other male-dominated organisations, which value strength, competitiveness, efficiency and emotional detachment, as well as the observance of a strict hierarchical structure. For example:

Mavo: Sometimes if you're being honest with yourself, and say look: nobody is interested in you, and you've got to teach yourself and take it as a warning not to expect anything from anyone. Or, you know, you could interpret it in another way like a warning, this is the system, people are not going to teach you, so you've got to teach yourself and look at other ways of trying to get the knowledge that you need.

Mawanda: It is nature of your field, it is competitive. And the unfortunate thing is... that not everybody is put on the same level. Some people will be given that

mentorship and support and some people won't. So unfortunately it is the culture, if you are part of the boys' club, then we will take care of you; if you're not, then you are on your own and you've got to survive however you survive.

Kholikele: I think there is a certain move to change, but I think South Africa suffers from a problem of dealing with diversity in the workplace. The workplace is changing, so you're not only getting people of colour but you are also getting women, and so the old-boy mentality of doing things has to change. And much of it is very resistant to giving up or sharing power. So it's not changing at the pace of which things are changing on the ground, and that is making the work environment very difficult, and is also making certain parts of medicine unattractive to women and others. So some departments are trying to make a move, but...others not. I think it's still a White male-dominated culture.

The idea of "the boys club" is in reference to informal structures of power that have defined the traditional domain of the socially and financially advantaged White male. Gaining access to these networks by developing successful collegial relationships with senior members is viewed as critical for career development in medicine, and has been associated with residency satisfaction (Sullivan et al., 2012). The metaphorical construction of "the boys club" in this case is representative of the hegemonic dominance of White, heterosexual males in certain professions (of which medicine is one) which maintain access and privilege for its members (Zulu, 2003).

According to the above participant experiences, it is clear that being a registrar is tough and as a result, toughness is rewarded. Discourses that value independence, competition, self-mastery and the "survival of the fittest" are drawn on to justify the success of those who are most in-line with the idealised conception of the scientist physician (Whitehead, 2011). Conversely, being viewed as weak,

or in need of nurturing was interpreted as needing “babysitting”. Related to this, complaining or “breaking rank” was viewed as uncollegiate, and meant that one was bringing one’s private life or “politics” into the workplace. A particular woman explained that colleagues often excluded her, and did not value her input, so she felt that one could easily be marginalised at work if one did not express oneself assertively:

So what you find is that at meetings, possibly, or at ward rounds, or in any sort of situation, to get your point across you have to be a bit louder, or you have to be a bit more aggressive in trying to get your point across. Otherwise, there's just this sort of tendency not to actually pay attention to anything that you might have to say. It takes a certain personality of a woman (especially a Black woman) to actually be a doctor. And most especially in the Western Cape, I have found it absolutely requires you to have a certain, very assertive, very aggressive to a degree...a robust kind of person. You can't be a weakling - you have to be strong - and nobody in their right mind can be strong all the time, but you literally exhaust yourself trying to say, I'm here, I'm just as good, I can do this job as well as the next person.

Aggression and assertiveness are traditionally associated with masculinity, and in this excerpt a female specialist explains that it is necessary to take on these qualities in order to be acknowledged in her career. In contrast, traditional values associated with femininity such as emotionality and collaboration do not fit as easily with discourses around mainstream professionalism. In such cases, the female professional must face the dilemma of being labelled as “too tough” or aggressive because she has taken on “male” characteristics, or alternatively be marginalised because she is not being heard.

Drawing on the work of Walker (1999), Tronto (2010) argues that as long as this image of the autonomous, career driven male remains the standard identity of the ideal professional, then those who are in need of support or care will continue to be marginalised.

Being a mother was viewed as a hindrance to professional development because having children meant that female registrars could not always be as available at the hospital as their male colleagues. According to the following excerpt, having children belongs to the female discourse of the “private life” and the prevailing perception was that there was no room for domestic problems infringing on the professional identity.

Phindi: I mean people will ask: ‘ah how is your child?’ And you are like, ‘oh he is sick’ and they go ‘ohhh okay so um... that patient is coming, and did you see that patient, and that...’ and you realise...okay this is where the boundary is for me.

She goes on to explain:

You don’t want to find yourself in a position where you are a burden to other people and other people have to do work for you and so on. That is not the reputation that you want. I want to have my job done and be reliable, and not be seen as bringing my personal problems to work.

Cassim notes that “masculine ethic” (2004, P. 660) that is prevalent in institutions of higher education stems from the tradition of organising the roles of woman around the home, and the priorities of men around the workplace. These stereotypes are parts of patterns of socialisation that are introduced from childhood, and may influence the culture of institutions as taken for granted ideologies of supposed gender differences.

#### **6.2.4.1. Mentorship relationships.**

The *hidden curriculum* has been described as the unspoken values, skills, norms and conduct that are imparted during the medical training process (Hultman et al., 2012; Wren, 1999). The onus is on each trainee to recognise and internalise these values alongside medical knowledge in order to

operate in the professional context successfully. Mentorship was viewed by these participants as important in order to learn these skills from a senior doctor, through experience. These relationships were also thought to offer a way to keep informed as to career development opportunities in the department and in the field. However there was little consensus on how one could initiate a mentorship relationship. Some departments such as psychiatry offered mentorship programs which participants found helpful, however due to the nature of the discipline of psychiatry, talking and sharing positive and negative experiences with superiors was viewed as acceptable. In other disciplines it was seen as undesirable to be viewed as one who stood out for what were perceived as “the wrong reasons”, and get a reputation as someone who was difficult.

The question arose (in the absence of a structured mentorship program) as to whose responsibility it was to make the first move when it comes to mentorship? Registrars may find it difficult to approach senior staff in order to initiate mentorship opportunities, particularly if the registrar is unfamiliar to the university and the departmental staff. Kanelo had the following answer:

Now the barriers to entry are opening up, but there is no determination to ensure that people who come in, actually complete. And these issues are multiplied because in postgraduate training, mentorship is key; and part of the mentorship is that a mentor must open up to the mentee, and that involves a level of vulnerability. And my feeling is that people...there's the expectation that the mentee must open up, and *then* the mentor will open up.

Interviewer: Okay, so you are saying it's the other way round?

Ja, where it's meant to be the other way round, that the mentor must open up and be vulnerable in the hope that there will be that reciprocal action, but you don't necessarily have to have that action even.

Kanelo makes an interesting point when he speaks about mentorship being a relationship where the mentor (being the more experienced professional or kind of parental figure) needs to reach out to, or make them self available to the student. It is through this demonstration of vulnerability that he believes a relationship of mentorship can form, due to the temporary lapse in the usual hierarchy which makes the senior doctor seem less intimidating and opens up a channel for future discussions. This relationship can be viewed as being especially beneficial to registrars who are in a racial minority within the hospital, as well as to women who may find themselves at odds in a male dominated department and may not feel confident to seek out support. What this understanding of mentorship proposes is a shift towards a more nurturing organisational culture rather than a strictly hierarchical one. Thus, as Hoff, Pohl, and Bartfield, (2004) advocate, the establishment of a supportive and inclusive learning environment should be the primary focus in the training of competent physicians.

### **Chapter Seven: Conclusion**

It is evident from the narratives presented here that experiences of race trouble enter into and complicate training experiences for some in the Western Cape's hospitals. These findings are consistent with studies of resident experiences conducted in other countries (Liebschutz et al., 2006; Ly & Chun, 2013; Odom et al., 2007; Park, et al., 2006; Pololi et al., 2010), and expand upon the findings of similar investigations conducted in South Africa (Khan, et al., 2013; London, et al., 2009; Noble, 2004; Perez & London, 2004; Wildschut, 2011). Training hospitals are viewed as difficult environments for Black specialists to build academic and specialist careers and, based on this perception, it was thought that many Black registrars would qualify and then move on to practice in the private sector.



Race trouble was noted as most often experienced as a generalised undercurrent of feeling unwelcome and unrecognized, and while some instances of overt racial slurs were reported, for the most part experiences of race trouble lurked under the surface, in a way that resulted in a somewhat demoralising workplace for Black registrars. While some participants reported feeling valued and accepted within their own specialist departments, all reported experiencing racism when dealing with colleagues from other departments, as well as patients and their family members. These reports are indicative of societal prejudices that construct Black doctors as somehow deficient or less capable, particularly if they are female. As a result, these registrars experienced a consistent need to prove themselves in the face of this unfounded animosity and mistrust. However, because everyday racism is often experienced as the cumulative effect of a range of concealed and seemingly insignificant incidents, most participants thought that there was little room for recourse, or voicing one's grievances. This was due to the registrars' perception that raising concerns with the department would be pointless because —out of context— subtly racist incidents could easily be denied or dismissed as coincidental. This was supported by the view that complaints would only make matters worse and could result in being stigmatized further and perhaps being prevented from qualifying at all. Registrar programs were accepted as being competitive and physically and psychologically demanding; and there was perceived to be no space for “weaklings” or complainers.

Perceptions around affirmative action were identified as problematic and often stemming from misconceptions around the goals and methods used by institutions to foster Black economic empowerment. Affirmative action has been shown to be interpreted as directly threatening to the status of some Whites (Unzueta et al., 2008) who may not be aware that their Whiteness runs concordant with powerful hegemonic ideologies that afford White people certain taken for granted privileges stemming from a history of White imperialism in Southern Africa.

The instances of race and gender trouble detailed in this study speak to “discursive and embodied routines of practice” (Durrheim et al., 2011, p. 138) whereby, in the post-Apartheid context, certain historically constructed racial identities are being invoked and contested. Using *race trouble* as a theoretical framework to make sense of these encounters, it is evident that since racist attitudes and stereotypes define the experiences of both Blacks and Whites, rather than singling out the racist and the non-racist, it is more helpful to interrogate the mechanisms (discourses, contexts, practices) that enable “race” to be done. For example, the ideologically defined territory of the White male (namely specialist medical practice), which under Apartheid was clearly defined and organised to serve the White elite, has since been intruded upon by that which has been constructed as “other” to the idealised conception of the scientist physician in discourses of Western medicine. The space must now be shared with the Black subject who brings with him/her all the contradictions and complications of South Africa’s racialised past. In the same way, patients who have historically looked to the White male doctor as a symbol of authority may find it difficult to accommodate the new “face” of medicine when presented with a Black woman.

This study is by no means a thorough investigation of each specialist department in order to gauge how well transformation efforts are being implemented and received, and therefore the findings of these interviews must be interpreted cautiously. It should be noted that experiences of systemic racism tended to vary in intensity and frequency from department to department and this was viewed to be dependent on the leadership style and diversity profile of the senior staff. Clear guidelines as to how to avoid bias and to promote a transparent process in the allocation of career building opportunities were viewed as key in order to avoid simply recreating the power dynamics of the past. A structured progression based on seniority was viewed as the most fair method of attributing privileges, such as time off to study and opportunities to gain the experience necessary to sit for the

examinations. Methods of allocating these privileges that rely on subjective evaluation such as identifying individuals who have shown “commitment to the academic spirit” or “initiative” are viewed as biased as they are perceived as likely to favour White registrars who, coming from a background of privilege, may be acculturated into the academic arena more readily and thus perceived as more competent and suitable for promotion. Walker (2006) calls for educators to move beyond “fairness” towards developing capacity, so that every graduate is equipped to make the most of the opportunities that are on offer. Therefore, equality of capacity should be the goal for diverse students; “and not just those whose backgrounds and cultural capital are taken for granted” (Walker 2010, p. 898).

The culture of medicine has been viewed in this study as a means of cultural reproduction that has historically valued certain constructions of heroic masculinity, particularly that of the elite White male who was able to work all hours without competing social and domestic pressures. With race and gender diversity being more frequently represented among medical trainees it is clear that if a culture of non-support (Wildscut & Gouws, 2013) is experienced by those who are “other” to this conception of the ideal doctor, then it is likely that these men and women will struggle to find job satisfaction as medical specialists in public hospitals. Based on the experiences of this small group, it seems plausible to assert that in order for transformation policies to be effective, it is simply not enough to numerically increase racial diversity without acknowledging certain taken-for-granted assumptions that have shaped the culture of the medical profession historically. If the senior tiers of academic medicine are dominated by White males, and if the public image of “ideal-doctor” is a White male, how do Black and/or female doctors cease to be viewed as deficient in some way within the organisational culture of the profession? Without paying heed to the privileged discourses that make up the departmental culture, and interrogating certain taken-for-granted assumptions around what it means to be “a good

doctor”, such practises can be seen to be systemically enforcing compromised outcomes for Black registrars, and thereby unwittingly reinforcing post-Apartheid discourses of “White excellence/“Black failure”, as identified by Robus and Mcleod (2006).

In this study race was identified as a topic that was seldom discussed openly in the professional sphere, as people felt uncomfortable to address it directly. However, in order to ensure equity of outcome for Black registrars, there needs to be a willingness to continue the conversation around experiences of racism and issues of race and transformation in higher education and medical practise, because silence around these issues makes it possible to fall back into old patterns, which serve to sustain and recreate inequality. As Rangasamy(2004), has expressed, it is not enough to put policies in place and then sit back and let transformation take care of itself. Transformation is a systemic process that starts with the individual and follows through to legislature and organisational processes.

### **7.1. Limitations**

The main limitation of this study is that the sample size was too small to produce a generalised view of the training experiences of this group. Because of the low numbers of Black specialists in the Western Cape, participant recruitment was difficult. However despite the limitations of the study it is clear that this under researched area warrants more thorough exploration.

Skills deficits as a result of poor schooling or lack of undergraduate support or preparation were not a feature of the interview texts of these participants when discussing postgraduate training experiences, and this could be viewed as a limitation of the research design. It is possible that because this participant group consisted only of those who had successfully qualified, within a minimum to average period of time (and excluded those who had experienced difficulty meeting the demands of the training program), the data did not seem to reflect these issues. And thus, while I acknowledge that

poor skills development could be a factor that complicates training among formerly disenfranchised groups, the participants that I interviewed did not identify this barrier in their experience. However that is not to say that the discursive assumptions surrounding affirmative action, that construct students from formerly disadvantaged backgrounds as lacking the necessary skills, did not have an effect on training experiences.

Because experiences differed considerably from department to department, there is a need to describe these experiences, and evaluate each department independently in terms of policies and practices surrounding diversity and transformation. Similar investigations at the other eight medical training facilities would provide valuable insight and allow for a national picture of black registrars are experiencing training environments. Quantitative data which evaluates throughput and attrition rates for Black registrars would be a valuable contribution towards understanding and improving training experiences for this group.

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## Appendix A Interview guide

- Describe the first year of your registrar training.
- What was the transition from undergraduate training to being a registrar like?
- Did you feel prepared academically?
- What were the main challenges and high points?
- Did your experiences change as time went on, and in what ways?
- What were your consultants like, did you identify with them?
- How did they treat you?
- How many people of colour were in your group?
- How many were women?
- Did you feel that there was equity in your registrar group?
- Did the race/gender dynamic have any effect on your relationship to the group?
- What is your main motivation for becoming a specialist?
- In your view what contributes to attrition rates among specialists?
- How would you describe the organisation culture of the institution where you studied, who has the power?
- How have societal responsibilities towards family for example had an impact on your career?
- How could your training experience have been improved? What would you change?
- Did you ever consider dropping out?
- What made you continue?
- Who supported you in these times?
- In your opinion, are there enough black specialists?
- What would your recommendations be to retain more black doctors in South Africa?
- Has marriage influenced your experience as a trainee specialist?
- What about children?
- What motivated your choice of specialisation?
- Was it always your first choice?
- Have you experienced any instances of direct racism or gender discrimination?
- Have you experienced covert or indirect racism? Such as uncomfortable workplace atmospheres or being left out?

- Have patients ever been discriminatory towards you? If so why do you think this happens?



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### **Appendix B Participant Demographic Form**

(Note to participants: The following information is collected solely for statistical purposes and this information will not be linked participant identity in any way.)

Name:	
Age:	
Race:	
Gender:	
Year of first post graduate registration:	
Final year of post graduate registration:	
Medical specialisation:	
Training Institution:	

## Appendix C



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Dear prospective participant

Invitation to contribute to MA research project on the experience of registrar training among black medical specialists in the Western Cape

I am a masters student in the department of Psychology at Stellenbosch University, under the supervision of Prof. Leslie Swartz (Stellenbosch) and Dr. Bonga Chiliza (Tygerberg). I am conducting a research project that investigates the experiences of black registrars who have completed their training in the last 5 years in the Western Cape. This is an exploratory project that will form the basis of a country wide study that investigates attrition rates among black registrars in more detail.

This research aims to identify and explore the experiences of black registrars in order to identify structures, practises, attitudes and ideologies that may promote or impede the advancement of black specialists into the medical profession.

The objectives of this study to

- Identify how black registrars experience the training environment in the Western Cape.
- Explore cultural, structural and institutional factors that may impede or promote black advancement in this context.

I would be very grateful if you would agree to contribute to my research by means of a face to face interview at a time and place of your choosing. Participation in this study should take approximately 1.5 hours of your time and interviews will take place between the 1<sup>st</sup> of June and the 30<sup>th</sup> of July 2013.

I attach a copy of the consent form, which you will be asked to sign at the time of the interview. This document also outlines the steps we take to ensure your confidentiality.

My contact details are provided below, if you have any points of concern or need clarity on any aspect of my proposal please do not hesitate to call me.

I hope that together we can present some of the experiences of black medical professionals in a nuanced way, in order to inform and improve training experiences for black doctors in the future.

I look forward to hearing from you.

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**Appendix D**

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**CONSENT TO PARTICIPATE IN RESEARCH**

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THE EXPERIENCE OF REGISTRAR TRAINING AMONG BLACK MEDICAL SPECIALISTS IN THE WESTERN CAPE.

You are asked to participate in a research study conducted by Nicola Thackwell, from the Psychology at Stellenbosch University. Results will be contributed to a research thesis for the requirements of a MA degree. You were selected as a possible participant in this study because you have completed your registrar training within the last 5 years, in the Western Cape, and because you belong to a race group that was formerly disadvantaged under Apartheid.

**1. PURPOSE OF THE STUDY**

This research aims to identify and explore the experiences of black registrars in the clinical training context of the Western Cape. Participants will be asked to share their experiences on a range of topics pertaining to all aspects of being a registrar.

**2. PROCEDURES**

If you volunteer to participate in this study, we would ask you to do the following things:

- Take part in an in-depth interview of approximately 1 hour. This interview can take place at a venue and time of your choosing whether it be at work or home. The interview will be recorded.
- As a follow up, you will be invited to participate in a focus group with other medical professionals involved in the study to discuss some of the issues raised as a group. Participation in the focus groups is voluntary.

### **3. POTENTIAL RISKS AND DISCOMFORTS**

Although there are no significant psychological risks to participation in this study, the in-depth interviews may uncover experiences of a personal nature that could be distressing to some participants. Participants may request to access to psychological consultation through the Stellenbosch University counseling center, should they deem it necessary.

### **4. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY**

There are no direct benefits to participating in this study, However this is an under-researched area, and this data could result in improved opportunities for black professional advancement in specialist medical training, thereby making a contribution towards racial and gender equity in South Africa's medical workforce.

### **5. PAYMENT FOR PARTICIPATION**

There will be no payment for participation.

### **6. CONFIDENTIALITY**

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality



will be maintained by means of a pseudonym and all details linking participants to a field of specialty, the hospital they trained at, and any other identifiable designation will be protected.

Only the researcher will have access to the data, and the person transcribing the interviews will be asked to sign a confidentiality agreement. Data will be stored on a password protected file on the researcher's personal computer. After 5 years all files will be deleted.

The researcher is committed to nullifying any potential complications that may arise as a result of this research, even if it means omitting certain findings from the final report to protect confidentiality. The report generated out of this research will be available to the academic community and a copy that will be available at the Stellenbosch University library. Participants may request that a copy be emailed to them.

## **7. PARTICIPATION AND WITHDRAWAL**

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so.

## **8. IDENTIFICATION OF INVESTIGATORS**

If you have any questions or concerns about the research, please feel free to contact Nicola Thackwell 0844233944 [n.thackwell@gamil.com](mailto:n.thackwell@gamil.com), or email supervisor Prof. Leslie Swartz: [lswartz@sun.ac.za](mailto:lswartz@sun.ac.za) or Dr. Bonga Chiliza: [bonga@sun.ac.za](mailto:bonga@sun.ac.za)

## **9. RIGHTS OF RESEARCH SUBJECTS**

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, contact Ms Maléne Fouché [[mfouche@sun.ac.za](mailto:mfouche@sun.ac.za); 021 808 4622] at the Division for Research Development.

**SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE**

The information above was described to the participant by Nicola Thackwell in [Afrikaans/English/Xhosa/other] and I am in command of this language or it was satisfactorily translated to her. I was given the opportunity to ask questions and these questions were answered to my satisfaction.

I hereby consent voluntarily to participate in this study. I have been given a copy of this form.

\_\_\_\_\_

**Name of Subject/Participant**

\_\_\_\_\_

**Name of Legal Representative (if applicable)**

\_\_\_\_\_

\_\_\_\_\_

**Signature of Subject/Participant or Legal Representative**

**Date**

**SIGNATURE OF INVESTIGATOR**

I declare that I explained the information given in this document to \_\_\_\_\_ [name of the subject/participant] and/or [his/her] representative \_\_\_\_\_ [name of the representative]. [He/she] was encouraged and given ample time to ask me any questions. This conversation was conducted in [Afrikaans/\*English/\*Xhosa/\*Other] and [no translator was used/this conversation was translated into \_\_\_\_\_ by \_\_\_\_\_].

\_\_\_\_\_

\_\_\_\_\_

**Signature of Investigator**

**Date**



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## Appendix E

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### CONFIDENTIALITY AGREEMENT

#### Transcription Services

<p><b>THE EXPERIENCE OF REGISTRAR TRAINING AMONG BLACK MEDICAL SPECIALISTS IN THE WESTERN CAPE</b></p>
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I, \_\_\_\_\_, transcriptionist, agree to maintain full confidentiality in regards to any and all audiotapes and documentation received from Nicola Thackwell related to her masters study on the experience of registrar training among black medical specialists in the Western Cape. Furthermore, I agree:

1. To hold in strictest confidence the identification of any individual that may be inadvertently revealed during the transcription of audio-taped interviews, or in any associated documents.
2. To not make copies of any audiotapes or computerized files of the transcribed interview texts, unless specifically requested to do so by Nicola Thackwell.
3. To store all study-related audiotapes and materials in a safe, secure location as long as they are in my possession.
4. To return all audiotapes and study-related documents to Nicola Thackwell in a complete and timely manner.

5. To delete all electronic files containing study-related documents from my computer hard drive and any backup devices.

I am aware that I can be held legally liable for any breach of this confidentiality agreement, and for any harm incurred by individuals if I disclose identifiable information contained in the audiotapes and/or files to which I will have access.

Transcriber's name (printed) \_\_\_\_\_

Transcriber's signature \_\_\_\_\_

Date \_\_\_\_\_