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MEDICAL STUDENTS' PROFESSIONAL IDENTITY FORMATION DURING A SOCIAL UPHEAVAL: A QUALITATIVE STUDY

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Student number: 8226325

A thesis submitted to the Faculty of Health Sciences,
University of the Witwatersrand, Johannesburg, in fulfilment of the requirements for the degree of Doctor of Philosophy

Johannesburg, 2023

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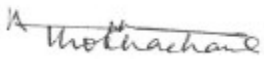
Declaration

I, Mantoa Mokhachane, declare that this thesis is my own work. It is being submitted for the degree of Doctor of Philosophy at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at this or any other University.



…….

M. Mokhachane

Wednesday, 13 March 2024

Dedication

To my father, mother, and brother:

John Mantsi Mokhachane

4 October 1918 – 1964

Ke Mofokeng wa Mantsi, lehopo, e jang ka pele madimo ke ao. Ke motho wa mahlatsi, wa Maloka, motho wa ho nyolosa masasa. Ke re ke bua le Kgiba, Kgiba ha a bue. Kgiba ke selepa Molopo, ha e sale a lepisitse molomo ka la maobane. Nkuru ke Shwetla mora wa Makhabane.

Teta Mampho Claurine Mokhachane

26 June 1926 – 4 January 2007

Ke Motaung wa ha Hlalele, ke Motaung wa nthethe wa morapedi, wa leso la kgomo rapeleha, wa mantswana tsatsi, wa bo pela, wa motho wa mofahatswane, wa motau wa tau rapuleng. Ledinyane la tau mmae o mosweu, ntatae o motsho. Ntja ya motho e momg ha e fetjwe, ha u e fepa e tla loma tsa hao. Motho wa lebese la kgomo le retha le so kene hlufeng ha bo tau. Ha ho marena mangata, Morena ke Hlalele a nnotshi. Hlalele phethu la lekana molala. Ke motho wa moropodi wa moropatsana, motho wa sosana nkgope, motho e ereng ha a tla shwa a pongwe hlooho, a sale a leketla ka mahetlana. Motho wa siso mathula

Freddie Lejoetsamang Mokhachane

14 June 1966 – 10 July 2020

My baby brother, I miss that smile that lit every room you entered. I miss that roaring infectious laugh that made everyone join in. You were a brother, a unionist, a comrade, a teacher, a leader, a father, and a comforter as the situations required. Covid-19 took you too soon.

I pledge to raise funds for your school, the East Rand School of the Arts. Supporting that school is your legacy.

Acknowledgements

- My family, Ntsoaki Mokhachane, for all the support and encouragement and Tebalo Mokhachane, for all the patience and support throughout this journey, not forgetting my nephews Lehlohonolo and Thabo Mphahane for their unwavering support.
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- Thank you to all the co-supervisors,
    - Dr Ann George, who offered a multitude of emotional and academic support, and critiquing my work. For guiding and teaching me skills that were valuable for this journey. For always being there when I did not know which way to turn. For always telling me to choose my priorities when I spread myself too thin.
    - Professor Ayelet Kuper for always reminding me that it cannot just be about the local audience but the international audience, too. For always displaying inclusivity by inviting me to teach your graduate students in Toronto with you, co-author a professionalism book chapter and attend your lab meetings. Thank you for the wealth of knowledge you brought into this PhD journey.
    - Professor Tasha Wyatt for giving me the courage to be disruptive to bring about change, to rattle the cage of the norm to open doors. You taught me that we find the key to human dignity through disruption. Thank you for giving me room to write as authentically ME.
- Professors Mosa Moshabela and Relebohile Moletsane for funding this study through Fit-for-Purpose, a National Research Foundation project.
- Professor Daynia Ballot for her support, allowing me to take a sabbatical leave to author papers and research-fieldwork leave to write the thesis.
- The Faculty of Health Sciences for approving my leave of absence to complete this degree.
- The Unit of Undergraduate Medical Education team for releasing me to find myself.

- The participants who agreed to be part of the study and the valuable contribution they made. They have enabled the articulation of a South African voice in the global discourse of professionalism and professional identity formation in medical education.

Position statement

Through my PhD journey, I have learnt that I should always be looking for a key or keys that open doors to spaces and places of human dignity.

The Oxford Dictionary defines *dignity* as 'The state or quality of being worthy of honour or respect,' a state which was denied for millions of South Africans during apartheid. As South Africans, we all hoped and believed, post-1994, after voting in a new government, that all will change for the better and there will be human dignity for all. However, that hope was not realised.

It seems like I am getting ahead of myself. Let me start from the beginning, the day I was born. I reared my head of kinky African hair on the 31st of May 1961, the day the Afrikaners were celebrating victory against the British. On this day, the Republic of South was born and Mantoa (me), meaning the mother of battle, came into being. This is the name that my father John Mantsi Mokhachane, born in the Eastern Cape, gave to me; to the Africans in the township, it felt and looked as if war was at hand. There were soldiers on foot, on horseback, in police cars and small planes and for my mother, Teta Mampho Claurine Mokhachane, a dual citizen of Lesotho and South Africa, who was heavily pregnant at the time, there was no place to turn. In Sesotho, a saying says, 'Bitso lebe ke seromo', meaning give a child a bad name and curse them for life. My name, Mantoa, meaning 'the mother of battle and a warrior' prefigured my fight for recognition at every turn and in so many places in which I was not expected to be or expected to thrive. Despite these battles, it has shaped my history in a beautiful way rather than laden with curses. It has been a road less travelled, and I am the better for it.

Early in life, I suffered from poliomyelitis, which rendered my left leg semi-paralysed. My father passed away not long after my illness and we became homeless as my mother, a woman, could not hold a title deed (SA Proclamation 293 of 1962, under Regulations for the Administration and Control of Townships in Black Areas in accordance with the Native Administration Act 1927). Our home was locked, and we lived on the pavement (space) for a while with all our belongings. These episodes denied our family's human dignity and we desperately needed a key to regain our human dignity. My eldest brother, at sixteen years of age, became just that, a key to human dignity. He exchanged his aspirations of being a highly educated man to become the head of the household so we could get our home back. He left

school to work, and the house was under his name. We all felt indebted to him for this selfless gesture. From within our own family, modelling of the human dignity key was displayed.

We grew up seeing people from different walks of life living in our home, but to us they were either uncles or aunts; as mom would say: “Everyone is family.” It would be people from within the country and across the borders. They would live with us while looking for employment. Our house was like Park Station (the largest railway station in Africa, like Grand Central in New York or Waterloo in London). There were always more than 20 people living in a four-roomed space. Every room was a bedroom at night. My family values enhanced the importance of being the key to human dignity. Charlotte Maxeke's quotes epitomise what this key is all about:

> This work is not for yourselves, kill that spirit of self and do not live above your people but live with them, and if you can rise, bring someone with you.

When I started school, my mother was apprehensive about my physical disability, not knowing that what seemed like a challenge would be what fuelled me to succeed. What was meant to be a curse became a blessing. I knew that education was the sole thing I needed to survive. It was during this time that two of my siblings became my key to human dignity. They showed me that I could learn to read and write like any other person, which added another ring to this key of human dignity. All these gestures can be summed up as *Ubuntu* (*botho*), the foundation of human dignity.

At the medical school of the University of the Witwatersrand, where I needed ministerial consent to attend (according to a 1959 Act, the education minister had to grant permission for Black people to study in White institutions of learning), I met individuals from diverse backgrounds. Though it was not universal, I still found people of similar backgrounds, not necessarily in the same social class who believed in human dignity. Throughout medical school, we, particularly people of colour or our friends who were ‘White’ on the outside but behaved like those raised in an Ubuntu home, stuck together. I knew little about Charlotte Maxeke then, but we all lived what she said. We made sure that we moved forward together, which added yet another ring to the human dignity key: dignity in medical education. As a small group, we never felt left out. We were in a community that made us feel accepted and gave us a sense of belonging.

I returned to my alma mater, namely, the University of the Witwatersrand medical school, from clinical practice as a neonatologist in a public hospital 27 years after qualifying as a doctor. I found the approach of the contemporary medical students different to what ours had been. There was less of a sense of assisting others, especially where academics were concerned. Each time I encouraged medical students to tell others about interesting patients in the ward, I would get a response like this: "Dr M, it's everyone for themselves and God for us all; they would not tell me if they had interesting cases." I started reflecting on what could have influenced this change in medical education between our time as students and now. As students, we had been united by the struggle against apartheid, our shared sense of standing up against an oppressive system. These students are post-1994 babies, born after the struggle, the 'born-frees'. The medical education fraternity appears to have introduced unhealthy competition into the professional space. While competition may always be prevalent, it may promote unhealthy individualism.

During the #FeesMustFall protests, I was an academic, a coordinator of years three to four of the undergraduate medical programme at the University of the Witwatersrand. When I started, the students (of all races) took it upon themselves to show me the ropes where my colleagues were not willing to do so. When I stepped into this office, some of the staff were not very welcoming because they were disgruntled by the resignation of the previous coordinator, who was a young Black man. They saw this as a race-related issue, but they were still not happy with my replacing him. As a result, I had resistance from some of the staff and colleagues, but students were my allies. I took all this in my stride, and I tried to do everything with love and respect. Through the students' reaction and warm welcome, I learnt to listen and hear their plight. I have learnt to encourage and support them in their good endeavours ever since. I feel indebted to the students and this study was, and is still, very dear to my heart.

In October 2015, #FeesMustFall showed me another beautiful layer from our students I did not think existed: a place and space of standing united and moving forward in unison. They became advocates for human dignity, fighting for their peers facing financial exclusion. They revealed values of Ubuntu that I thought they did not possess as 'born frees.' I learnt so much during this period. The students showed that education, not just pre-University schooling, is a human rights issue. They took me back to my undergraduate years; it was such a relief to see that they have those core Ubuntu-based human dignity values. This gave me hope that it is not the students we need to change but we need to change how we teach, how we assess and how we

socialise them in places and spaces of higher education. We need to bring Ubuntu back into medical education. In my research, I yearn to understand and then create spaces that illuminate and amplify every voice and to respect humans irrespective of race, colour, or creed. Embracing everyone irrespective of their identity or identities is affording them dignity.

The #FeesMustFall protests compelled me to embark on an introspective, reflective and reflexive autoethnographic journey, as I felt more than just a researcher but a co-participant.[1,2] As a researcher in this work, I have immersed my phenomenological autoethnographic stories in the students' stories.

Presentations arising from this study

1. **Mokhachane M**, George A, Wyatt T, Kuper, A, Green-Thompson L. Professional identity formation amidst protest and social upheaval: A Journey in Africa. Annual Congress, 31 August 2022, Association of Medical Education of Europe, Lyon, France.*

2. **Mokhachane M**, George A, Wyatt T, Kuper, A, Green-Thompson L. Professional identity formation amidst protest and social upheaval: A Journey in Africa. Internal medicine Academic Meeting, 11 November 2022, University of Witwatersrand.

3. **Mokhachane M**, George A, Wyatt T, Kuper, A, Green-Thompson L. Professional identity formation amidst protest and social upheaval: A Journey in Africa. South African Association of Health Professions Educationalists (SAAHE) Research Special Interest Group (SIG) Webinar, 30 May 2023, South Africa.

4. Green-Thompson L**, Mokhachane M**, George A, Kuper, A Wyatt T. Professional identity formation: vernacular expressions and global impacts. SAAHE Workshop, June 2023.

5. **Mokhachane M**, Wyatt T, Kuper, A, Green-Thompson L George A. Graduates' Reflections on Professionalism, and Identity: Intersections of Race, Gender, and Activism. Annual Congress, 29 August 2023, Association of Medical Education of Europe, Glasgow, Scotland.

6. **Mokhachane M**. Rethinking professional identity formation and professionalism amidst protest and social upheaval: A South African Journey. Teacher Forum (A CPD accredited session), University of Cape Town. 19 September 2023.

7. **Mokhachane M**. Professional identity: The role of letsema in its formation. 2023 Biennial Research Day, Wits School of Clinical Medicine, 28 September 2023.

8. Ingratta A, Cooke R, Muhango L, Bocchino L, **Mokhachane M**. Ubuntu inspired revival: Fostering positive professionalism at Wits Medical School. 2023 Biennial Research Day, Wits School of Clinical Medicine workshop, 28 September 2023.

9. **Mokhachane M**. Rethinking professional identity formation and professionalism amidst protest and social upheaval: A South African Journey. Education Research Round. Sunnybrook Hub for Applied Research in Education (SHARE), Toronto, Canada, 23 November 2023.

*Best research paper presentation prize – AMEE2022

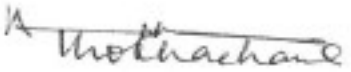
Teaching

Mokhachane M, Kuper, A. Socialisation, Lived Experience and Enculturation. Guest Lecture, 26 January 2023. University of Toronto.

Publications and journal submissions arising from this study

I declare that this work is based on my doctoral work, and I initiated all the papers below. I drafted the initial manuscripts, which the co-authors, who are all my supervisors, worked on. For the published papers, I have sought permission from the publishing journals. For the first and third articles, the SpringureNature Permissions Executive said I do not need a licence to reuse, republish or adapt the material as the article is licensed under the Creative Commons Attribution 4.0 International License, which permits unrestricted use, distribution, modification, and reproduction in any medium, provided I give appropriate acknowledgement to the original authors, including the publication source. I should also provide a link to the Creative Commons licence and indicate if changes were made. For the second article, the publisher said I should acknowledge them as follows: This is an article published by Taylor & Francis in "Teaching and Learning in Medicine" on 19 Jun 2023, available at: doi.org/10.1080/10401334.2023.2224306.

Declaration: Candidate's contribution to article(s) and co-author(s) agreement

Candidate's signature: 

Date: 12.03.2024

Co-author(s) agreement

The co-authors listed below agree to the use of the following articles by the student in this thesis.

Article 1.

Mokhachane, M., George, A., Wyatt, T., Kuper, A., & Green-Thompson, L. (2023). Rethinking professional identity formation amidst protests and social upheaval: A journey in Africa. *Advances in Health Sciences Education 28*, 427–452. doi.org/10.1007/s10459-022-10164-0

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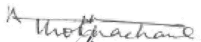
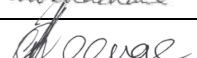
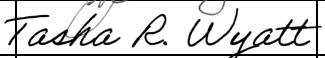
Mokhachane	Mantoa		12/03/24
George	Ann		12/03/2024
Wyatt	Tasha		12/03/2024
Kuper	Ayelet		12/03/2024
Green-Thompson	Lionel		12/03/2024

Article 2.

Mokhachane, M., Wyatt, T., Kuper, A., Green-Thompson, L. and George, A., 2023. Graduates' Reflections on Professionalism and Identity: Intersections of Race, Gender, and Activism. *Teaching and Learning in Medicine*, pp. 1-11. doi.org/10.1080/10401334.2023.2224306

"This is an article published by Taylor & Francis in "Teaching and Learning in Medicine" on 19 Jun 2023, available at: https://doi.org/10.1080/10401334.2023.2224306."

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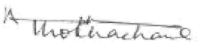
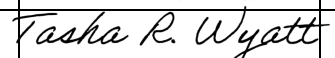
Mokhachane	Mantoa		12/03/2024
Wyatt	Tasha		12/03/2024
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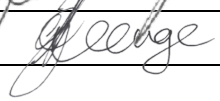
George	Ann		12/03/2024

Article 3.

Mokhachane, M., Green-Thompson, L., George, A., Wyatt, T. and Kuper, A., 2023. Medical students' views on what professionalism means: An Ubuntu perspective. *Advances in Health Sciences Education*, pp. 1-17. doi.org/10.1007/s10459-023-10280-5

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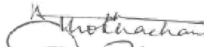
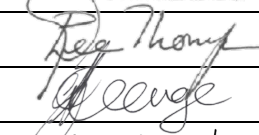
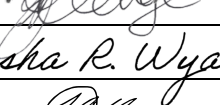
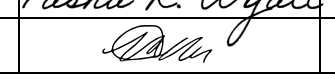
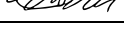
Mokhachane	Mantoa		12/03/2024
Green-Thompson	Lionel		12/03/2024
George	Ann		12/03/2024
Wyatt	Tasha		12/03/2024
Kuper	Ayelet		12/03/2024

Abstract

This phenomenological qualitative study, with an autoethnographic aspect, explored the University of the Witwatersrand's medical students' experiences of professionalism and professional identity formation amidst protests and social upheaval, namely, #FeesMustFall protests. The socio-historical autoethnographic sections emanate from my undergraduate journey in the same medical school 32 years before this study. I interviewed 13 participants. The participants' stories echoed my own story during my undergraduate years in medical training, hence the inclusion of autoethnography. In this study, I question the under-representation of previously marginalised groups in the discourse of professionalism and professional identity formation. I also question the lack of an African influence on professionalism and professional identity formation.

This study was conducted at the University of the Witwatersrand after obtaining Human Research Ethics Committee approval. I used an interpretive qualitative phenomenological enquiry in order to understand the meaning of students' experiences. I also did not want to bracket myself, as my experiences resonated with those of the contemporary students, hence the choice of an interpretive instead of a descriptive phenomenological approach. A purposive sample was drawn from medical students. Thirteen semi-structured interviews were conducted in 2020, during the Covid-19 pandemic. Interviews were conducted with 13 participants, eight final-year medical students and five recent graduates who were in the first- or second-year internship (residency) training. The participants were five women (four Black and one White) and eight men (five Black and three White). An interview guide was used to probe the students' journeys towards becoming doctors, their experiences during the #FeesMustall protests, experiences of professionalism and how #FeesMustFall impacted their professional identity development. Interviews were transcribed verbatim and analysed in MAXQDA 2020. I used an inductive approach, where each transcript was analysed as an individual case for the essence of its meaning and how participants' experiences influenced their being and becoming doctors.

When analysing the data through an African lens, Ubuntu, I used metaphors to allow the reorientation of professional identity formation, what professionalism means to contemporary students and how professionalism is weaponised against those who do not fit the western ideals of a medical professional. Racism was the foundation of many ills in medical education, particularly in the clinical spaces at the hospitals affiliated with the University of the

Witwatersrand. This study highlights the contribution of Ubuntu-based values on professional identity formation and the influence of Ubuntu on the meaning of professionalism to contemporary medical students and recent graduates. It adds an African voice to the global western professional identity theories. This study encourages other researchers to explore their contexts to define professionalism and how professional identity is attained. I recommend reconstructing professionalism using Ubuntu as professionalism in medical education through *letsema*, Ubuntu, advocacy, and the acceptance of the intersectionality with which trainees enter medical education.

Keywords: African influence on professional identity formation; Ubuntu as professionalism; Professionalism; Professional identity formation; Ubuntu; Lebollo; Letsema; Weaponisation.

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Glossary

Apartheid	Apartness. A policy of separate development for the various ethnic groups in South Africa, which privileged White South Africans and excluded Black people, often violently.
Asinamali	We have no money: a term used in protest theatre during the apartheid struggle.
#FeesMustFall	Fees Must Fall
IsiXhosa	South African Nguni Language
IsiZulu	South African Nguni Language
Lebollo	Initiation in the South African Sesotho language
LLB	Bachelor of Laws
Kaffir	An insulting word for a Black African
Letsema	Working together voluntarily to assist others
Luister	Listen (in the South African Afrikaans language)
Moitseki	Means *activist* in Sesotho
Mosadi ke lejwe la moralla	Woman is an igneous rock.
Nyakallo	Means *happiness* in Sesotho
#RhodesMustFall	A student protest movement centred on the removal of a statue of Cecil Rhodes from the campus of the University of Cape Town
Sangoma	Traditional healer
Sesotho	South African Sotho language
#Shackville	Erecting shacks at the University of Cape Town campus protests
Solomon Mahlangu	An activist who was sentenced to death during the apartheid struggle.
Ubuntu	African humanist philosophy promoting collectiveness
Ugqirha	A medical doctor in IsiXhosa
Wits University	The University of the Witwatersrand
Zwonaka	Beautiful in Venda (Nguni language)

Acronyms and abbreviations

AHSE	Advances in Health Sciences Education Journal
ANC	African National Congress
COP	Community of Practice
HREC	Human Research Ethics Committee
LPP	Legitimate Peripheral Participation
RToP	Ring Theory of Personhood
PIF	Professional Identity Formation
SAAHE	South African Association of Health Professions Educationalists
SIG	Special Interest Group
TLM	Teaching and Learning in Medicine Journal
UCT	The University of Cape Town
SA	South Africa

List of Appendices

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Preamble

This thesis uses an integrated format, as recommended in the Faculty of Health Sciences Style Guide and Postgraduate Booklet for a PhD thesis, University of the Witwatersrand.

The integrated narrative thesis has three sections, as outlined in the table below:

Section 1. Setting the scene	**Chapter 1** Background to the study	Introduces the study to the reader, outlining the background of the study, which includes a literature review. Provides the rationale for the study, the problem statement, research aim, research question and the study's objectives. The significance of the research and limitations are included.
	Chapter 2 Methods and Methodology	This chapter advances the argument for a phenomenological approach and immersion in an autoethnographic approach, which adds context to the study. I discuss the philosophical underpinnings of this approach to this study.
Section 2 Telling the stories through articles	**Chapter 3** **Article:** Rethinking professional identity formation amidst protests and social upheaval: a journey in Africa	The article was published in Advances in Health Sciences Education (AHSE) in 2022. I introduced the South African sociohistorical context that led to #FeesMustFall protests using an autoethnographic aspect of my journey towards becoming a medical doctor in a 'White' institutional place and space during apartheid and how I attained my professional identity. I speak about the values of Ubuntu, which medical students (participants) brought into forming their professional identity. This was one of the top 10 (out of 40) research papers presented at the AMEE 2022 Conference in Lyon.
	Chapter 4 **Article:** Graduate reflections on professionalism and identity: intersections of race, gender and activism.	The article was published in Teaching and Learning in Medicine (TLM) in 2023. This paper examined the weaponisation of professionalism in training spaces through an intersectional lens, documented as stories of the five recent graduates (interns or residents) and their experiences of professionalism, particularly how their identities were muted during medical clerkship and internship.
	Chapter 5 **Article:** Medical students' views on what professionalism means: an Ubuntu perspective	This paper consists of two parts. Part 1 documented the students' expressions of what professionalism means to them. The second part compared the Ubuntu perspective of professionalism to the Physicians Charter to add an African voice to the Physicians Charter and the discourse professionalism across cultures.
Section 3 Integrating these narratives for a future-facing perspective	**Chapter 6** Discussion, Conclusions and Recommendations	An integrated narrative of the entire thesis draws the three articles together, discussing the students' experiences in higher education for training. The integration occurred in two stages: findings from the articles. The first part of the integration process involved coding selected sections of each separate article, resulting in ten synthesised themes. These synthesised themes were subsequently grouped into three overarching themes, namely, sociohistorical context; the need to deconstruct professionalism; professionalism reconstructing process and professionalism toward a humanistic culture. I also discuss how I modified the initial conceptual framework based on the findings and developed Ubuntu as professionalism and Ubuntu professional identity formation models. I then discussed limitations, conclusion and recommendations.

CHAPTER 1 Background and context for the study

This chapter reviews the literature on professional identity formation (PIF), which encompasses professionalism, formation and identity. The chapter also provides the political and social background to the #FeesMustFall student protests (social upheaval) in South Africa during 2015/16, followed by the rationale, aim, objectives and limitations of the study. The conceptual framework provides a roadmap of how this study is presented based on its aim and objectives, guiding the research process. In this framework, related concepts grounded in literature were put together to explore the journey and experiences of medical students through their training.[3–5]

1.1 Professional identity formation

Identity is defined as a "sense of sameness and continuity".[6(p191)] One's personal identity formation starts during early adolescence.[6] Identity formation involves phases of exploration and commitment, with an interwoven rhythm of commitment-formation and commitment evaluation.[6,7] During the commitment-formation cycle plausible commitments are weighed against one another, with the individual making choices from viable alternatives. The commitment-evaluation cycle involves settling on a particular identity commitment for a period of time.[6] One's personal identity may be influenced by social identity and upbringing.[2] It is postulated that a person's social context is ingrained in their identity development.[8] Their communities provide a strong foundation in this process.[2,9]

As students negotiate their way through socialising interactions in training spaces, they should be recognised through the process of legitimate peripheral participation (LPP), an important idea in the formulation of communities of practice (CoP). LPP is part of the situated learning process where learners begin to be drawn into the professional environment,[10] leading to the development of personal and professional identities as members of communities of practice.[11(p720).] Personal identity formation precedes PIF, so PIF includes the personal identities that students bring into medical education.

PIF is a complex process. It is integrative in that one internalises core values, moral principles and awareness, which translate into individual values, beliefs, behaviours, and obligations of the profession.[8,12] PIF is located in a dynamic interaction of multiple identities, i.e., individual,

relational, and collective identities, which culminates in a professional identity.[13,14] It is a process through which a trainee eventually displays the habitus of a physician reflected in behaviours, values, and attitudes.[13,15] The physicianship of being a healer and a professional is then displayed through acting, thinking, and feeling as such. This ultimate achievement of being represents the pinnacle of the modified Miller's pyramid 'Is'.[16] Role models, clinical and non-clinical experiences, symbols and rituals, attitude and treatment by patients, peers and healthcare professionals during socialisation impact PIF.[11]

Professional identity is ultimately a confluence of professional and personal selves, hence the importance of understanding personhood.[17,18] The process of professional identity formation aims to integrate the personal identity and the professional identity, but the inflexible culture of medicine is inclined to consume the individual's identity.[19] Medical educators should allow students to reflect on personal identity prior to developing a profession-specific identity.[20] It is also crucial for people from different cultural backgrounds and contexts to contribute to the PIF discourse. Professional identity formation in medicine, discussed below, is acquired through socialisation within the medical community of practice. Holden describes PIF as the intersection of three domains: professionalism, formation, and psychosocial identity development (Figure 1.1).[12] These domains are discussed below.

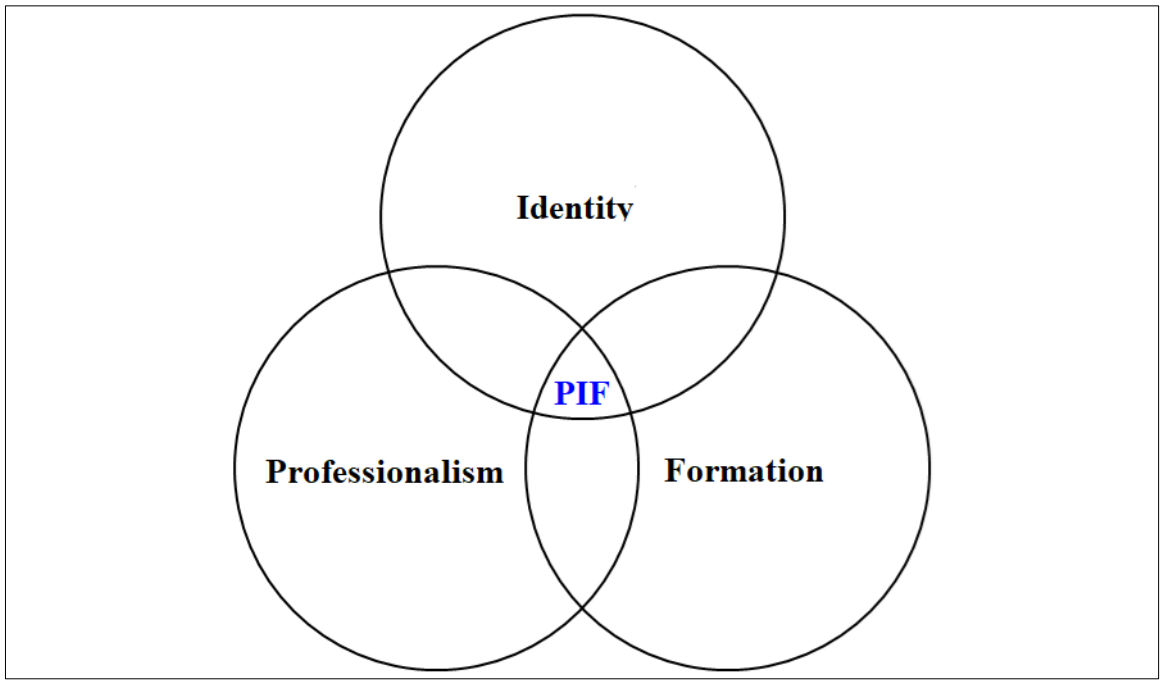

Figure 1.1 Professional identity formation (Holden et al., 2012)

1.1.1 Professionalism

There is no consensus on what professionalism is; traditionally, it has been a western notion with a myriad of definitions, most of which concentrate on attributes instead of clarifying its foundational purpose, a belief system that brings medical professionals together and a reminder of what they have promised society (social contract).[21] Over the years, professionalism has been reduced to lists of principles and elements that may not adequately represent it.[21] Wynia et al. posit that professionalism is a belief system backed by a motivational force leading to clinicians coming together to enhance patients' healthcare.[21] In a Foucauldian manner, professionalism may be defined as a practice of self-government essential in instituting and 'maintaining a profession's (ongoing) legitimacy with numerous constituents, the public society included'.[22,23] Some have classified professionalism as a normative or occupational value that deserves preserving.[22] The literature defines three professionalism frameworks, namely, virtue-based, meaning a physician of character; behaviour-based, a physician who is consistently competent; and identity formation, which focuses on identity development.[24] Some scholars construct professionalism as virtue-based attributes, namely, altruism, honesty, compassion, and respect for others, as well as commitment to social justice.[25]

The content of professionalism and how it is attained is contentious.[26] Some insist that professionalism must be taught and assessed while others question whether virtue can be taught.[27,28] On the contrary, Huang believes that virtue can only be taught through modelling.[29] In pre-clerkship, students saw professionalism as displaying 'good doctor' attributes, such as responsibility and ethics, and self-management and patient-centredness.[30] Unlike the clergy, namely, training of the priest, which models integrity and behaviour from the start, the medical profession relies on modelling by senior clinicians who might sometimes not model this formation appropriately.[29]

1.1.2 Formation

The principle of formation has been borrowed from the seminary training of priests and pertains to the ongoing conversion of the hearts, minds and souls of individuals, enabling them to be effective in serving others.[31] Framing the overarching educational goal as pastoral emphasises that intellectual training needs to be completed by and grounded in perspectives that link ways of thinking to ways of doing and being in the world.[32] In professional education, expertise in deep and frequent reflection is crucial.[33] Seminary students learn through pedagogical

interpretation instead of objectification, drawing from their experiences and the world in which they live.[34] They must have integrity and learn by observing religious leaders.[33] The same could be expected of medical students and their teachers. In the medical profession, one is expected to serve the community, similar to the clergy.[12] However, it is sometimes very challenging for other professionals to behave like the clergy, especially during times such as the Covid-19 pandemic or when faced with extreme staff shortages or resources. For medical professionals' formation to be equated to that of the clergy might be an inappropriate burden on 21st century doctors, who were not trained in a similar manner or a similar setting.[35]

Formation appears to be akin to the development of the ethically framed individual. Ethics is at the core of the social contract or compact thought process and the medical profession.[32] Alignment between institutional values and individual values promotes *formation*.[32] Lewis, addressing the identity formation of Black clergy in Britain, proposed using *Ubuntu* philosophy as an ontological grounding to promote such alignment to the formation process. Ubuntu emphasises relationships in identity and formation.[36] If the way of being as Ubuntu for the South African cohort in this study could be modelled by teachers in training spaces, the alignment that promotes formation could be achieved.[32] Ubuntu embodies respect for human dignity, irrespective of whether it is directed to a younger or older person; it is uplifting, healing, feeding, sharing, and guiding with love and peace.[37] This approach would also work better for professionalism when context and culture are taken into consideration. Earlier in this chapter, I mentioned that 'identity formation is operationalised as professionalism'. Jowsey posits that professionalism is a culture because it has "shared values, beliefs and practices".[38(p996)] For professionalism to thrive, students must be socialised in enriching environments. An essential element of enriching environments is 'interpersonal closeness', implying human interaction.[39]

1.1.3 Social identity theory and identity theory

It is important to consider an individual's social identity and personal identity prior to entry into medical school and how these identities are shaped during the study of medicine. Social identity theory and identity theory view the self as an object that is reflexive and classify and identify self in several ways. When self-categorisation or identification occurs, identity is formed.[40] In social identity theory, one's knowledge that they belong in that social group or category is a consequence of self-categorisation and social comparison, where members of the chosen group category are the in-group while outsiders are classified as the out-group.[8,40] With

identity theory, one categorises ‘self’ as an occupant of a role, for example, wife, husband, medical professional, etc. One then incorporates oneself into that role and self into the meanings of the role, the expectations associated with that role and performance of that role.[40] While identity in identity theory is role-based, for example, mother, father, etc, social identity theory highlights group processes and intergroup relations, where one has a group role in a soccer team, for example.[41] Social identity is “being one with a certain group”; “being like others in the group”; and “seeing things from a group’s perspective”.[40(p227)] There is thus uniformity of perceptions and action among the group members. With identity theory, identity “resides in differences in perceptions and actions that accompany that role”.[40(226)] Person identity is a set of meanings that are tied to and sustain the self as an individual.[40]

Identity is influenced by a multitude of factors. It can be used in a political action, as a specifically collective phenomenon, denoting the sameness of members and can be understood as individual or collective selfhood and more.[42] Identity embodies the multifaceted role of self in society in terms of identity salience or commitment to a role.[43] Identity salience alludes to the prospect that a specific identity could be active across different situations.[44] For example, with identity salience, some roles may be more important than others, where hierarchy might play a role. Regarding commitment, one might also be committed as a mother or a father and that is part of their identity.[41] Both identity and social identity suggest a relatedness between a role and the interaction with society – an idea which is integral to an African Ubuntu philosophy.

1.1.4 What is Ubuntu philosophy

Ubuntu is a philosophy that celebrates community while respecting individuality. It respects everyone, as illustrated in some of the greetings, for example, *sawubona* in isiZulu, one of the four Nguni languages and *dumela* in Sesotho, one of the three Sotho languages. Sawubona translates to ‘I see you’, meaning I recognize you, I respect you, I respect you, and I want to hear from you. Dumela on the other hand translates to 'agree', meaning let us agree that we are here and that I respect and acknowledge you and you also acknowledge and respect me. These greetings are not just done in passing, one needs to pause and engage the person being greeted. Ubuntu has several important principles, including connectedness, not just as human beings but also to the earth we are treading. It celebrates relatedness, considerateness, forgiveness, community, reciprocity, dependability, sharing, trust and social change.[45,46] Ubuntu centres on interpersonal relationships rather than privileging the individual.[45] The importance of

interpersonal relationships is highlighted in the collective fingers theory (included in more detail in Article 3, see Chapter 5), which states that great things arise from working together, as represented by the four fingers of a hand: respect, compassion, solidarity, and dignity. Combining all these principles enhances individuals' and relationships' survival (the fifth finger (the fifth finger) of individuals and relationships.[47] From the Ubuntu stance, experiences as a collective are valued without negating the rights of individuals.

Since Ubuntu embodies the spirit of oneness, identity is formed through relationships and therefore community matters.[36] Ubuntu (a Nguni word) or *botho* (a Sesotho word) speaks to the essence of being human, the dignity of humanity. With Ubuntu, although your humanity as an individual is respected, it is still bound to the humanity of others.[48,49] Desmond Tutu and Steven Bantu Biko believed that Africa's contribution to the world is humanity.[48,50] Ubuntu as humanity is bound in the identities of people in sub-Saharan Africa, in countries such as South Africa, Angola, Mozambique, Namibia, Botswana, Tanzania, Kenya, Malawi, and Congo. In these parts, different names are given to Ubuntu, based on the language of the region.[48] According to Ubuntu, one's identity is not isolated but is intricately dependent on those around you.

In contrast to the African philosophy of Ubuntu, professionalism is a western notion that lacks humanistic warmth and ignores one's background and sociohistorical context. It makes students from backgrounds other than western ones feel unwelcome or excluded. As a result, attaining a professional identity lacks nuances that include other cultural influences.[2] There are calls for treating people equally to be rooted in an ontological standpoint of caring and respect, for example, Ubuntu philosophy.[51] This respectful and inclusive approach might enhance professional identity formation. Bringing humanism into professionalism by linking the heart to the head is being more widely discussed.[52] It has also been acknowledged that Africa, South America and the Middle East are missing in the discussions published in the Academic Medicine Volume I and II on professionalism and that the next volume should include these.[53] For example, current professionalism framing excludes Ubuntu, the spirit of African humanism.

Although I used one form of Ubuntu from management literature in this study, i.e., Mbigi's Collective Finger Theory, there are multiple perspectives on Ubuntu. The post-colonial SA government utilized Ubuntu as a social theory in every aspect of their governance: in health

through *Batho Pele* (people first), education, the legal system, and more.[54,55] Ubuntu was instrumental in the smooth transition from the apartheid to the new the government rule, a transition without war through Truth and Reconciliation, led by the late Bishop Desmond Tutu.[36] Ubuntu plays an important role in social work, marketing, leadership, theology and ethics.[45,56–58] During #FeesMustFall, students, through leadership, advocated for marginalized students not to be excluded from higher education. To these students, education is liberation, and they fought to liberate everyone.[59]

1.1.4.1 Ubuntu and Freireian philosophies of medical education

There appear to be logical connections between Ubuntu and the work of Paulo Freire, both of which may have consequences for lives eked out on the margins. Paulo Freire's philosophy of education became a mantra, birthed through his book, *The Pedagogy of the Oppressed*. This book highlighted the onto-epistemological lives of marginalized people, not just in Latin America but globally.[59,60] Abdi posits that Freire's philosophy has 'trans-spatial and transcultural connections with the humanist Ubuntu'.[59(p2286)] The central transformative tenets of Ubuntu philosophy of respect, dignity, solidarity, compassion, survival and several other values, as discussed in the preceding section, match Freire's tenets of reflective and reflexive transformative thoughts.[47,59] Both philosophies promote humanization in everyday life, ontologies, educating, and learning.[59]

Our current medical education spaces are experienced as oppressive and dehumanizing and need revolutionary measures to change the status quo.[2,9] Freire gave us ways to transform oppression and dehumanization:

> The current movements of rebellion, especially those of youth, while they necessarily reflect the peculiarities of their respective settings, manifests in their essence this preoccupation with people as beings in the world and with the world – preoccupation with what and how they are being. As they place consumer civilization in judgement[;] denounce bureaucracies of all types, demand transformation of the universities [and medical education] (changing the rigid nature of teacher-student relationship and placing that relationship within the context of reality), propose the transformation of reality itself so that universities can be renewed, attack old orders and established institutions in the attempt to affirm human beings as subjects of decision. [A]ll these movements reflect [the] style of our age, which is more anthropological than anthropocentric.[60(p 43)]

'Anthropological,' in Freire's quote, speaks to humanization, the core of Ubuntu philosophy. A philosophy that brings us closer together and promotes respect for everyone, irrespective of their standing in society. Freireian and Ubuntu philosophies are liberating in nature, as they are counter-oppressive and inclusive in striving for humanisation.[59]

The #FeesMustFall students were preoccupied with their peers and workers as 'beings in the world and with the world'.[60(p 43)] They were prepared to fight for the freedom of the oppressed in various ways – students' lack of access to University education and access to employment benefits for the outsourced general workers. During #FeesMustFall, students were determined to transform higher education institutions to accommodate everyone who needs to be in the University space – that is, Ubuntu. In education, Ubuntu is seen in the same manner as the Freirean philosophy, as an onto-epistemological philosophy which has a lifelong impact on humanity, humanization, and liberation.[59] Ubuntu is a lifelong learning process, i.e., education starts very early in childhood, even before schooling, and continues into adulthood to the end of life.[59] The humanizing nature of Ubuntu philosophy renders it an anti-oppressive socio-cultural philosophy, as seen during periods of transition from colonization or apartheid to independence in South Africa and Zimbabwe.[48,59,61] Abdi cautions against the possibility of creating the "problematic historical constructions of Eurocentric epistemic and human advancement".[59 (p2293)]

1.1.4.2 Critique of Ubuntu

Although Ubuntu has a multitude of benefits and virtuousness, one should not ignore concerns other scholars have raised regarding this African philosophy. Swanson cautions against using Ubuntu in governance for ideological purposes that force people to conform and might lead to exclusion.[61] There are claims that Ubuntu is premodern and patriarchal, although Cornell and Van Marke posit that Ubuntu feminism has the potential to stop the exigencies of patriarchy in society.[62] Ubuntu is considered social instead of individualistic and what one person experiences is also experienced by the community. Therefore, "marriage, childbearing and death" are considered a 'communal point'. The downside to this is being seen as offending the ancestors if a woman does not marry or bear children.[56 (p5)]

In response to the South African government infusing principles of Ubuntu in almost every aspect of society, scholars cautioned about the ramifications of potential negative impacts on SA communities and society as a whole.[54,56,63] Nkondo raised concerns that using Ubuntu as a

social theory does not necessarily liberate communities from the dangers of race and ethnicity.[54] He warned against the ethnicization prevalent in some parts of SA, approximating the 'divide and rule' ethos of the apartheid era, asserting that where there is ethnicization, Africa confuses demos (democracy) with ethnos (the ethnic group).[54] There are also claims that Ubuntu has done nothing to improve corporate SA, but was used to justify post-apartheid capitalism.[63] The intense promotion of the Black identity in post-apartheid corporate SA, under the guise of Ubuntu, created a Black middle-class elitist group.[63] This has widened the gap between the rich and poor in SA with the rich getting richer and the poor getting worse.[64]

1.1.5 Theories of professional identity formation

Previously, two distinct ways of acquiring professional identity formation were posited: individually, going through "qualitatively distinct and discontinuous stages", and collectively, where the individual's identity is influenced by the social context.[65(p1186)] Recently, three individualist theories of identity have been commonly used in medical education, namely, "identity status theory, social cognitive approaches and narrative approaches".[8(pS96)] Identity status theory scrutinises how individuals explore future "identities and personal commitment to a course of action towards a specific identity".[8(s96)] The narrative approach relies heavily on the 'inner world of the individual' as representing the foundation of identity.[8(pS96-97)] Lastly, the social cognitive approach frames identity as a cognitive structure.[8] Other theories, both individual and collective, are either based on these three theories or on combinations of these three. Various "frameworks" have also been formulated with the intent of conceptualising the way medical students acquire their professional identity.[12(p14),55,56] Cruess uses a framework where individuals enter training having their existing identities and subsequently acquiring PIF through socialisation.[66] Personhood contributes to professional identity, as discussed below.

The ring theory of personhood (RToP) as part of professional identity suggests that identifying with the profession is shaped by several factors: the innate self, the individual, relational and societal factors.[18,68] The RtoP is displayed as four rings with the innate ring being the inner most one, followed by the individual, relational and societal rings in that order.[18,68] The innate ring is described as being alive, the physical appearance and ties with the Devin. The individual ring talks to one's hobby, occupation, ability to communicate, express feelings and more. The relational ring speaks to relationships with others and the societal ring alludes to race, culture, status, role in society among others.[18] Sarraf-Yazdi in a scoping review used this RToP to address issues around enablers and barriers in PIF, which is discussed later in this chapter and

in chapter 3.[68] PIF thus takes place at an individual psychological and a collective level.[15] Professional identity could be conceptualised as an individual trait, as behaviour or as a socialisation process.[69] Each student has an inherent identity trait that can be identified through behaviour. Although identity is more than just a list of behaviours, as an outward expression of identity, behaviour can be used as a surrogate of professional identity.[69] Identity as a socialisation process assists in anchoring the individual within a particular community and culture, known as a *community of practice* (CoP).[69] In these CoPs, each individual has longitudinal constructive development, as shown by Kegan's theory, which is discussed further in the next paragraph.

Kegan's constructive adult development theory has four lenses relevant to medical education that are employed in meaning-making, namely, instrumental (focusing on rules and rewards), socialised (attending to social norms and expectations), self-authoring (building internal values) and self-transforming (recognising gaps in one's belief value systems, leading to accepting others' value systems).[70] These lenses regulate how one receives and amalgamates multiple influences into establishing their adult identities.[70] Kegan's constructivist developmental model emphasises the importance of social forces in PIF,[11] and may be useful in illuminating how medical students acquire professional identity.[11,65,70–72] The model is based on four lenses. The instrumental lens focuses on rules and rewards. The socialised lens concentrates on social norms and expectations. The self-authoring lens intends to build internal values and lastly the self-transforming lens deals with recognising deficiencies in one's "tightly held values systems".[70(p1299)] When one is facing challenges, more complex lenses are formulated, which catapults them to a level where subsequently formulated lenses afford them an ability to deal with the complexity.[70]

1.1.6 Development of professional identity formation

PIF is influenced and impacted by sociocultural backgrounds, including familial, religious beliefs, gender roles, values and morals.[68,73–75] The process of PIF, which starts from the desire to become a doctor, is influenced by various factors. Sarraf-Yazdi related three of the four rings of RToP to what medical students should be able to intrinsically do, what type of learning environments should be enabling PIF and the barriers of PIF.[68] Sarraf-Yazdi describes enablers and barriers to PIF using RToP lens.

1.1.6.1 Intrinsic enabling factors affecting PIF

Medical students through the societal, relational and individual ring lenses should be able to acknowledge societal expectations concerning their professional role, identity with the medical profession and exhibit professional behaviour; be able to develop relationships with peers, patients and team members; display the desire to gain competence and life-long learning.
She used three out of rings of the RToP, namely societal, relational and individual.[68] Values, particularly positive ones, play a major role in the kind of doctor one becomes and enhances the PIF process. Personal circumstances also contribute to the PIF process by either enhancing it or hampering it.[76]

1.1.6.2 Extrinsic enabling factors affecting PIF

Sarraf-Yazdi sees the learning environments as enablers through the lenses of the different rings. Through the societal lens, she highlights symbolic socialisation, i.e, white coat ceremonies and symbolic access facilitated by clinical immersion.[68,77] Students get opportunities repeatedly to interact with patients.[68] At relational and an individual ring, they receive supportive mentoring system and guided reflections which heightens PIF.[68]

1.1.6.3 Barriers of PIF

Looking at the barriers of PIF the societal ring, students perceptions were experience like the disjuncture between theoretical knowledge and clinical application in practice.[68] Internal tension between personal values and the portrayed medical culture.[2,68] Early clinical exposure is crucial in enhancing PIF; however, some clinical rotations might lead to the opposite.[76] Through the hidden curriculum, students might experience a discordance between what they were taught and what is actually happening in the learning spaces. At relational and individual ring levels, the hierarchical nature of the clinical environment leads to bullying and undesirable role-modelling which hinders students from seeking help.[68,76]

1.1.7 Critique of professional identity formation

Current theories of professionalism and PIF are western notions that ignore context: where people come from, their sociohistorical backgrounds, their culture and how they were socialised prior to entering the medical education arena. Those who were raised in different contextual settings find their socialisation different from the western-based norm.[19,78] These current theories do not reflect how PIF is acquired under stigmatised cultural identities, such

as minoritised groups, religion, and the experiences of women.[79,80] As medical educators, we must strive for inclusivity by celebrating our trainees' backgrounds. Inclusivity means bestowing dignity on the trainees, acknowledging that their experiences, backgrounds, culture, sexual orientation, and their different abilities matter, all of which are lacking in current theories of PIF.

1.2 Socialisation of medical students in the medical profession

1.2.1 Definition

During this process, as mentioned before, medical students acquire knowledge, skills and actions befitting their community, namely, the medical community. It is a process that starts from liminal to full participation in a professional community.[81,82]

1.2.2 Situated learning and communities of practice

Lave and Wenger introduced the importance of situated learning, which is a perfect fit in health professions education and training.[10] Wenger's situated learning theory in combination with its associated components, CoP and LPP, is making frequent appearances in the health professions literature. Wenger-Traynor describes CoP as a social theory with three components: a purpose, a stance and technical terms.[83]. According to Wenger-Traynor, the purpose of CoP is to depict learning as a "socially constituted experience of meaning making".[83(p142)] CoP locates an individual's experience embedded in the social world and varying technical terms have been used, such as *LPP*, *knowledgeability*, *negotiated meaning*, *community* and *practice.*[83]. LPP is a component of situated learning, making learning relational between learners in a social professional context.[84] In showing how PIF is attained within a CoP, Orsmond et al. developed a five-facet model. This model includes five components: being in clinical practice, becoming conscious of clinical practice, mutual engagement in clinical practice, joint enterprise in clinical practice and viewpoints of clinical practice.[84]

Authors such as Bourdieu and others have criticised or improved on Wenger's theory by pointing out areas where they felt there was a lack of clarity or missing important points.[85,86] Some have pointed out that Wenger's theory concentrates on learning-as-participation while ignoring learning-as-acquisition, which Wenger-Traynor (formally Wenger) disagrees with, clarifies and defends in his communication with Farnsworth [83].

> The theory is an attempt to place the negotiation of meaning at the core of human learning, as opposed to merely the acquisition of information and skills. And for human beings, a central drive for the negotiation of meaning is the process of becoming a certain person in a social context – or more usually a multiplicity of social contexts. That is where the concept of identity comes in. And because this is a learning theory, identity is theorised with specific reference to changing ways of participating in a practice.[83(p145)]

In recent times, advocacy towards using Wenger's CoP as a foundational fitting theory of learning in medical education has been growing[87]. LPP is important in training medical students towards becoming professionals. LPP is important because it is 'an analytical viewpoint on learning', which is "a way of understanding learning".[10(p40)] LPP emphasises learning as doing to move learners from a position of peripheral participation to full participation.[88] It affords learners a chance to learn in a position where they are guided and supervised from peripheral participation to full participation.[87] LPP plays an important role in medical education training; however, it might be entwined with issues of marginalisation.[89] In situated learning, there is inherent power and varying degrees of participation.[90] Legitimate peripheral participation (LPP) might have a hierarchical ladder of participation that could be used to marginalise others based on race, gender, social class or (dis)ability.[91] Power and inequity has been shown to be gendered in CoP, with women remaining or being marginalised to peripheral participation while men take centre stage.[90] Power dynamics inherent in gender and social class could interfere with the learning acquired by trainees or learners.[92] This gendered LPP is not just seen in medical education but it can also be seen in political-activist movements such as the #FeesMustFall student movement that will be introduced later in this section.[93(p141)] In this activist CoP (#FeesMustFall), women who were in the centre when protests started found themselves on the periphery, with men taking all the recognition.[90] Having too many learners or trainees in one space, for example, in a hospital ward, might lead to marginalisation of some participants based on the factors already mentioned – gender, race or disability.[94] In CoP and LPP, Lave and Wenger highlight only how being part of a CoP enhances one's identity but silences what the individual brings into the CoP.[92]

The three articles presented in chapters 3, 4 and 5 illustrate further, through the students' stories, how marginalisation might occur.

1.3 #FeesMustFall protests as social upheaval

When the African National Congress (ANC) government came into power in 1994, it promised free education for all, which has not materialised. Although free schooling was provided up to secondary level, this did not apply to institutions of higher education, rendering further learning unattainable for a large proportion of potential students. Institutions of higher education increased tuition fees when the government reduced the subsidies to these institutions. Student protests erupted in 2015 in response to the University of the Witwatersrand planning to increase tuition fees by 10,5%, almost double the prevailing inflation rate. The protest against financial exclusion for students who could not afford fees[93,95,96] became a nationwide phenomenon under the twitter handle #FeesMustFall.[97–100] At the core of what students were fighting for lay the pursuit of social justice. This movement added to other issues that were already simmering at the time, such as the decolonisation of the curriculum and learning spaces. The decolonisation activist movement used the twitter handle #RhodesMustFall.[101,102]

There were several hashtag movements that were appended to all these hashtag protests, such as #Shackville and #RhodesMustFall with 'fallism' being the main slogan that encompassed all these movements. The #RhodesMustFall movement started earlier in March 2015 at the University of Cape Town, when Chumani Maxwele, a student at the University of Cape Town (UCT), tossed faeces at the statue of Cecil John Rhodes in the spirit of undermining previously revered symbols of colonisation.[103,104] To the students it created an image of the fall of colonialism and the whiteness that the Cecil Rhodes statue represents. #Shackville were protests demanding housing for homeless students in UCT.[105] In 2016, the #Shackville movement highlighted the homelessness of students at UCT. The #Shackville movement blocked UCT's main driveway, in front of Jamison Hall, where students erected a corrugated iron shack and a mobile toilet. This was not only a way of bringing the plight of students' homelessness to the fore but to also illustrate that transformation has not materialised in this space since 1994.[104,106] They occupied a space of importance in order to be heard, to be seen and to be acknowledged. #FeesMustFall started on 14 October 2015 at the University of the Witwatersrand, leading to a lockdown and sit-in by students and some staff members.[107]

#FeesMustFall emerged as a rallying call to students countrywide – a call which galvanised them to respond to social injustice.[93,108] #FeesMustFall showed that all racial groups were united in fighting for social justice to support students in financial need. During the

#FeesMustFall protests, the students introduced #OutsourcingMustFall, which dealt with fighting for the universities to stop the outsourcing of labour for general work.[109] It was at times peaceful, while extremely violent at other times, especially when the police started firing rubber bullets and teargas.[109] Overall, it was a call to emancipate those who have been left on the margins of society by a government which promised them a better life. The 'fallism' movements were a way of students, particularly Black students, claiming their positions in the academic space and owning that space.[104]

1.4 Rationale for the study

The medical training journey is characterised by transitions in a spiralling developmental path and each transition may be fraught with tensions of varying descriptions. The more senior one becomes and grows, the deeper the tension, the more robust the reflections become, facilitating the movement from LPP to being embraced as a member of the community of practice (CoP).[10,110] In a setting such as South Africa, with a history of 'divide and rule' based on race and ethnic background, experience in communities of medical students and medical training might be completely different from the norm. This, in the past, led to the formulation of communities of practice within communities of practice based on race. The legitimacy of peripheral participation was also dictated by how one looked like and what their social and cultural capital is. Much has been written about the CoP, LPPs and professional identity formation (PIF) but tensions participants experience while they go through the spiralling transitions are lacking in the literature. It is particularly in circumstances where one's training is disrupted by a social upheaval, emanating from a history of discrimination, where there is a paucity of literature. This study aims to explore the University of the Witwatersrand medical students' experiences of professionalism and how they acquired professional identity formation during protests and social upheaval, namely, #FeesMustFall.

1.5 Problem statement

I was the coordinator of years three and four in the Unit of Undergraduate Medical Education (UUME) medical education programme at the University of the Witwatersrand when the protests started. Several interactions and experiences with students during the 2015-2016 #FeesMust Fall student protests made me aware of undergraduate training issues similar to those I had experienced more than 25 years earlier. The students' anger was palpable. They insisted that their parents had been promised free education for their children when they voted

for the new South African government. The students were quoting [1]Fanon, [2]Biko and [3]Solomon Mahlangu as if they had recently written academic essays about them. They were well-read, highly politicised and willing to protest to avoid the financial exclusion of their peers from the University.

South Africa has a history of segregation under the Apartheid government rule. Social upheaval has characterised the struggles emanating from discrimination against people of colour. The records of atrocities committed by medical professionals continue to surface across the country. During #FeesMustFall, a perception of students' unprofessional behaviour prevailed. However, those who were regarded in protests as being unprofessional might have had an idea of professionalism which is not usually expressed, and which this study seeks to explicate. South Africa is a country that embraces Ubuntu, the spirit of humanness and collectiveness where respect for others is paramount. As a result, professionalism is often seen as a contested terrain in South Africa. This study helps us understand what the possible contestation is and how we may deal with this going forward. Furthermore, a great deal of work has been written about professional identity formation (PIF), but none of the published work highlights how PIF is formed during a social upheaval such as the #FeesMustFall protests.

There is a paucity of data on how professionalism and professional identity formation are acquired in a country such as South Africa, which is rich in a culture that embraces Ubuntu, but also still carrying the dark ramifications of its recent apartheid past. In addition, little is known about how protests such as the 2015-2016 #FeesMustFall influenced professionalism and PIF.[2]

1.6 Research aim, research question and objectives

The aim of this study was to explore the University of the Witwatersrand medical students' experiences of professionalism, PIF, and the impact of #FeesMustFall (social upheaval) on their professional development.

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[1] A physician and psychiatrist (author) who inspired national liberations movements globally, including South Africa

[2] A South African former medical student and founder of the Black Consciousness Movement who died in prison.

[3] A young South African activist who was killed by the South African government.

The research question was, 'What are the University of the Witwatersrand medical students' experiences of professionalism, PIF, and what is the impact of #FeesMustFall on their professional development?'

The objectives of the study were:

1) to explore the lived experiences of students during the #FeesMustFall protests
2) to explore the students' perceptions of professionalism during and after the #FeesMustFall protests of 2015-2016
3) to explore how the participants perceive their professional development from 2015 to date and the influence of #FeesMustFall on their professional development
4) to explore how recent University of the Witwatersrand graduates perceive different dimensions of professionalism in the context of medical education in South Africa and their learning experience at the University of the Witwatersrand

1.7 Significance of this research

This study adds an African voice to the global discourse on professionalism with a focus on the importance of context and culture in attaining a professional identity. It foregrounds an African perspective, using an African interpretative lens to expand the understanding of professionalism and its attendant professional identity formation. Given the social upheaval represented by the student protest, the study provided an opportunity to understand how student activists and leaders understood their role as future medical professionals.

1.8 Setting

This study was conducted at the University of the Witwatersrand Medical School, Johannesburg, South Africa. It was conducted five years after the 2015 #FeesMustFall protests. The interviews were conducted in 2020 with final-year students and recent graduates. This group of participants was exposed to the #FeesMustFall protests in 2015, when they were in classes ranging from their first to fourth year of medical training at the University of the Witwatersrand. Recent graduates were in their first or second year of internship training at either University-affiliated hospitals or peripheral training hospitals.

1.9 Conceptual framework

The proposed structure of the conceptual framework is premised on how the participants were socialised, i.e., prior to University entry and after University entry. Before entering University,

participants were socialised within their respective cultures in the communities. They entered University with their antecedent identities. At the University, they experienced informal and formal socialisation. In their first year, medical students attended classes with students from other degrees at the main University campus, which is on a separate precinct from the medical school. This first year serves as an informal socialisation process into University life.[111] In their second year, they moved to the medical-school campus, where they were taught anatomy and anatomical dissections by scientists, not clinicians. It is only in the third and fourth year that they were taught by both clinicians and scientists, including occasional visits to primary health care settings and hospitals. In the fifth and sixth (final) year of study the medical students were formally socialised into the medical profession as legitimate peripheral participants (LPP) in preparation to become members of the community of practice (CoP).[111–114] After graduation, they work for three years under supervision, two years as interns and one year as a community service doctor, before they can be registered as independent practitioners. See the figure below.[114]

Professional socialisation may then be seen to encompass three distinct phases, viz, pre-clinical preparation (basic science, years 1–3), clinical training (exposure to patients, years 3–6) and postgraduate experience (the experience of the graduate as a new professional). In the group of students during the period of #FeesMustFall, this movement has had the greatest impact in the pre-clinical preparation phase of the students' socialisation. This conceptual framework proposes that an entering student bringing with them an antecedent identity is subject to multiple tensions and transitions in their journey of growing into professional identity, evoking a different sense of professionalism. Through this journey, the antecedent identity is transformed into feeling, acting and thinking like a doctor. See Figure 1.2 below.

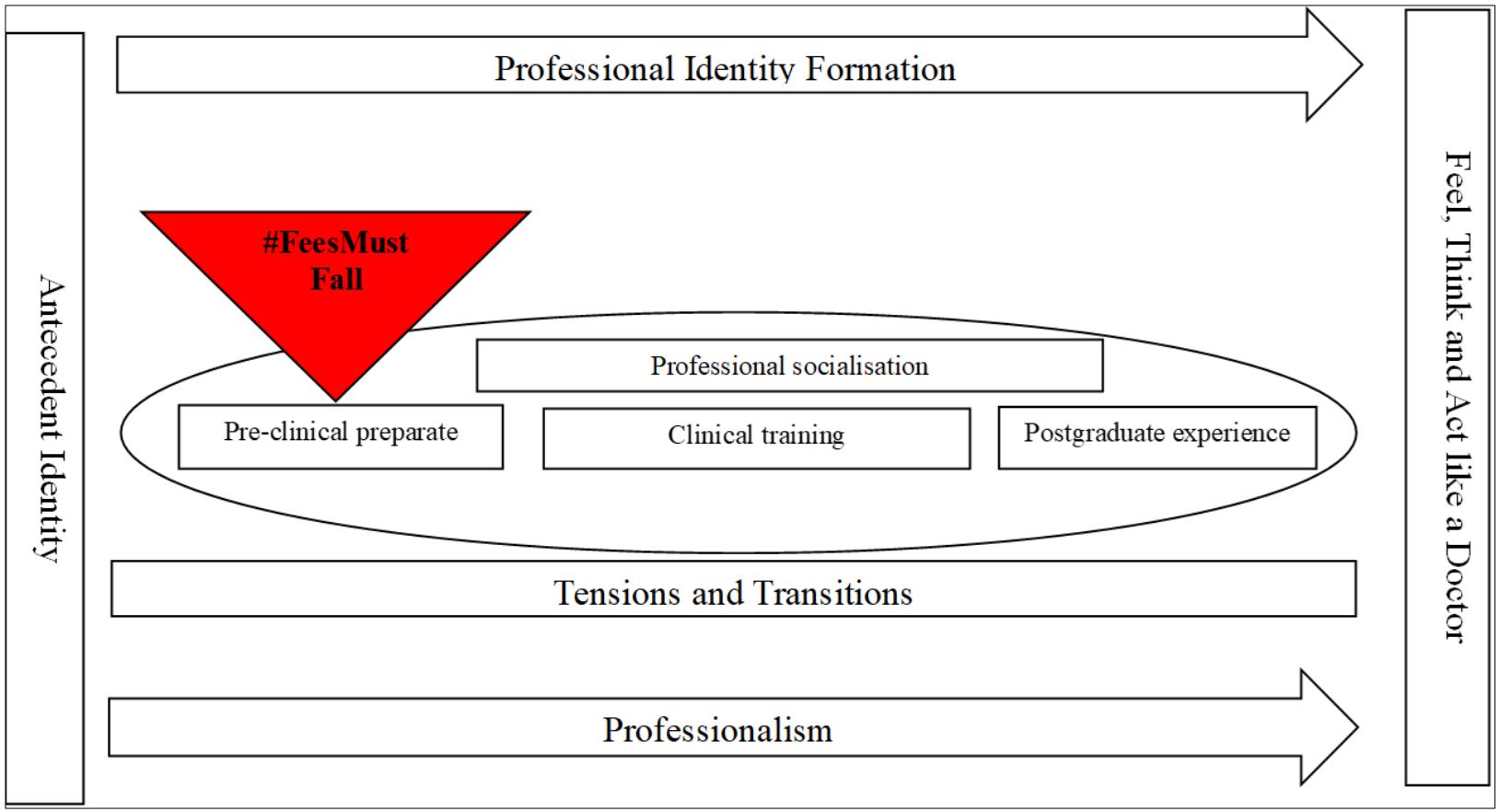

Figure 1.2 Conceptual framework for the study

Conclusion

In this chapter, I introduced PIF and discussed its domains, namely, professionalism, formation and identity. As part of identity, I discussed Ubuntu philosophy. This is followed by theories of PIF and factors that affect PIF. I could not discuss PIF without including socialisation of medical students, through Lave and Wenger's situated learning and LPP. I discussed #FeesMustFall protests, as they interrupted the journey of these participants during medical training. I conclude the chapter with a conceptual framework which locates this study within the journey of a group of students, once activists, from entry to graduation.

In the next chapter, I discuss the methodology and methods employed in this study.

CHAPTER 2 Methodology and methods

The previous chapter described the conceptual framing of this study, which included PIF, professionalism, identity theory and Ubuntu.

In this chapter, I discuss my philosophical underpinnings, philosophy of phenomenology and its perspectives. I discuss two types of phenomenology, descriptive (transcendental) and interpretive (hermeneutic) phenomenology and the advantages and limitations of phenomenology. I also discuss the methods used, namely, sampling, data collection and analysis, trustworthiness, and ethical considerations.

2.1 Philosophical underpinnings

A paradigm is underpinned by four elements, namely, ontology, epistemology, methodology, and methods.[115,116] The researcher's ontological and epistemological worldview informs the paradigm of choice. Ontology is a philosophy concerning the assumptions we make about reality which leads to us believing that something is real.[116] Epistemology relates to how we know something, acquire it or how we communicate that knowledge. It is the relationship between the knower (researcher) and the known or knowable.[115,116] Methods are the specific techniques used to collect and analyse data, while methodology is the grand design which underpins the type of methods we use.[116]

2.1.1 Who am I?

I am an interpretivist who believes that reality is socially constructed. One's experiences shape one's beliefs and how one views the world, hence the choice of a qualitative approach in this study. My ontological perspective is rooted within Ubuntu, an African way of being and knowing, where humaneness is celebrated and valued. Ubuntu holds respect and dignity in high regard. Epistemologically, Ubuntu is a way of knowing that is different or unique from the western way of knowing. Therefore, western ways cannot be regarded as the only way of knowing. Ubuntu celebrates 'we' as a collective instead of 'I', without devaluing the individual. It challenges the Cartesian, "I think therefore, I AM", by celebrating oneness, "Because YOU ARE, I AM".[117(p58)] I AM who I AM because of the experiences through interacting with others in whatever community I find myself. At every turn, who I become is shaped by the richness of being in these communities.

I believe that reality is socially constructed and that it can be influenced by one's context. Our experiences are influenced by the road we have traversed. These experiences shape who we become, how we react to the world and how we treat those around us. I grew up in a family that took pride in the values of Ubuntu, embracing every human being. My ontological grounding influenced my epistemological view of reality. My mother taught me to embrace, respect, and see good in everyone I interacted with irrespective of colour, the language they speak or how they express themselves. A sense of oneness was instilled in us from an early age. The children in the family, including visitors, sitting in a circle, would eat from the same large aluminium bowl and drink water or soft porridge from a calabash being passed around from one to the next. I always felt like the family motto was to not leave anyone behind, as demonstrated by two of my siblings. My siblings became my teachers when, as a child with a different ability (disability) caused by poliomyelitis, my primary schooling was delayed.

The participants in this study, through #FeesMustFall, reinvigorated that passion for being a conduit for the expression of human dignity. Human dignity in this instance referred to every student being afforded the dignity to realise their ambitions of uplifting themselves and their families. I was afforded a similar opportunity by a family I did not know, who funded my tertiary education. In a way, my family paid it forward by being conduits of human dignity for others. I personally needed to pay it forward by being an instrument of social change in whatever way I can, be it as a member of the University of the Witwatersrand Human Research Ethics Committee, my capacity as a Director of the Medical Programme or as a qualitative researcher. As a researcher, an academic and a clinician, I believe in fighting for social justice for all in all areas of my professional identity. This could be through research that highlights or uncovers injustices or teaching that instils a questioning mind in my students. As a researcher, I believe that behind every body of data/dataset there is a human story that we can all learn from, hence the route I have chosen in this research, qualitative research. Through this study, I believe that the voices of the African people can be heard in areas where they were never given a chance or understood, for example, in the medical-education community.

During the #FeesMustFall protests, I was an academic, a coordinator of years three to four of the undergraduate medical programme at the University of the Witwatersrand. When I started, the students (of all races) took it upon themselves to show me the ropes where my colleagues were not willing to do so. When I stepped into this office, some of the staff were not very

welcoming because they were disgruntled by the resignation of the previous coordinator who was a young Black man. They saw this as a race-related issue, but they were still not happy with my replacing him. As a result, I had resistance from some of the staff and colleagues, but students were my allies. I took all this in my stride, and I tried to do everything with love and respect. Through the students' reaction and warm welcome, I learnt to listen and hear their plight. I learnt to encourage them and support them in their good endeavours ever since. I feel indebted to the students and this study was, and is still, very dear to my heart. Two months after starting to work as an academic at the University of the Witwatersrand (Wits), #FeesMustFall erupted. Uncertainty and fear filled the campus atmosphere and the country as a whole. Although most people sympathised with this call, there were still concerns. While the intense strikes were going on, the majority of medical students stayed away from University and continued with their studying. Those that participated in '*toyi-toying*' (dance steps and singing performed at protest gatherings) were doing so in shifts and there would, therefore, be representation for medical students while their peers were studying. This allowed them to show that, although they were part of the struggle, they still protected their long-term purpose of academic achievement. Throughout the entire process of protest, these students displayed signs of professionalism, humanism, and accountability.

2.2 The philosophy of phenomenology

For the purposes of this study, this section will explore the philosophy of phenomenology. The Oxford dictionary defines phenomenology as a "philosophy that deals with what you see, hear, feel in contrast to what may be real or true about the world." The term stems from two Greek words, 'phainomenon' meaning, that which reveals itself or appearance and 'logos', meaning reason, doctrine or word.[118–120] Phenomenology is regarded as a study of phenomena as experienced and the exploration of their meaning.[119,121–123] The purpose of phenomenology is describing experiences from a first-person perspective without causal inference.[124,125] In a phenomenological study, perspectives and understanding are analysed to describe a shared meaning of lived experiences of a phenomenon for a number of individuals.[121,126]

The four leading figures in phenomenology, Husserl, Heidegger, Merleau-Ponty and Sartre,[127,128] all share the experience of how we express our humanity. The German mathematician Edmund Husserl was the doyen of phenomenology and Heidegger, his former student, expanded on his works.[126,127,129,130] Other philosophers like Sartre and Merleau-Ponty

further expanded Husserl's writings.[126] Heidegger, Merleau-Ponty and Sartre added building blocks to what Husserl created.[128] Smith sees phenomenology as singular while being simultaneously pluralist.[128]

Phenomenology originated mainly from two philosophical thoughts, i.e., Husserl's phenomenology of thought and Heidegger's phenomenology, the ontological approach of being.[129] The phenomenology of thought is based on the Cartesian "I think therefore, I am", while Heidegger concentrates on "I am" (dasein).[129(p2-3)] The difference between Husserl's and Heidegger's philosophical approaches is that 'exploration of thought pertains to epistemology, while beings actually exist in the real world'.[129,131] Heidegger's approach has shades of existentialism (moving away from the detached standpoint)[121] and ontology, maintaining that we are connected to the world we live in and we cannot extricate ourselves from it.[122,129,131]

Husserl insisted on examining an experience on its own terms, meaning, as it occurs.[130] He argued that researchers should abandon everyday experiences when interrogating such an everyday experience – refraining from any reflections, thoughts, visions, and memories of the experience, making the examination of the experience transcendental.[121,122,130] By distancing yourself from the experience, you are bracketing everything you know about that experience, also referred to as reduction or the natural attitude.[121,122,130] Husserl's approach requires several reductions, including eidetic and transcendental. In eidetic reduction, one concentrates on the essence of the phenomenon, while, in transcendental reduction, one looks at the nature of consciousness.[128]

For Heidegger, Husserl's writing was too theoretical and abstract. He rejected Husserl's transcendental approach,[121] by introducing Dasein, i.e., 'being' there. Being unfolded into being and time, reflecting the ontological aspect, with selfhood requiring the existence of others. This approach contextualised phenomenology by manifesting the worldliness of existence.[121] By adding lived time and engagement with the world, Heidegger introduced hermeneutics into the phenomenology dialogue.[132] Hermeneutics is a theory of interpretation.[120] Hermeneutics has three components to it, namely, an interpretative aspect and focusing on lived experiences; accepting researcher's experiences while collecting data and analysing; the combination of reflection and writing.[133] For Heidegger, the appearance of a phenomenon has a twofold quality. First, phenomena have visible meanings which may or may not be deceptive. Second, there may be concealed or unseen meanings.[128] Heidegger thus

defined phenomenology as a discipline whose interest is figuring out the phenomenon as it shows itself or is brought to light. He also wanted to interrogate the phenomenon in its latent or disguised form as it emerges.[128]

Merleau-Ponty shares the sentiments of Husserl and Heidegger but introduced 'perception' into the dialogue, birthing phenomenology of perception. He described phenomenology of perception as the 'embodied nature of relationships within the world'.[134,135] His approach was concerned with one's holistic self while interacting in the world. According to Merleau-Ponty, one's perception of the other emanates from one's own embodied consciousness. Merleau-Ponty believes that 'mineness' and 'aboutness' come from one's body subject. We feel through our bodies, which translates into our emotional experiences.[128]

Sartre added 'being' and 'nothingness' to phenomenology, suggesting that things that are missing are as crucial as those that are present. He extended existential phenomenology, positing that existence precedes essence. He believed human nature is about constantly becoming instead of being.[128]

2.3 Perspectives of phenomenology

Phenomenology is usually regarded as the cornerstone of the interpretive paradigm.[136] It is a research method while being a philosophical discipline at the same time.[122] It has gained traction over the years to bring the human-experience phenomenon to light.[136] Wojnar[136(p173)] lists seven perspectives of phenomenology, as indicated by Embree in the Encyclopaedia of Phenomenology, including:

- Descriptive (transcendental) phenomenology, concerned with how objects appear or are understood in pure consciousness.
- Hermeneutic (interpretive) phenomenology, which is concerned with "interpretation of the structures of experience" and how people who lived through that experience understand their experience and how people who study these experiences understand them.
- Existential is concerned with real human experience.
- Naturalistic constitutive phenomenology is about how "consciousness constitutes things in the world or nature."

- Genetic phenomenology is concerned with the "genesis of meaning of things within individual experience; realistic phenomenology looks at structures of consciousness and intentionality."
- Generative historicist phenomenology is concerned with "how meaning, as found in human experience, is generated in historical context of collective human experience over a period of time."

The two types of phenomenology commonly employed in health or medical education research are descriptive (transcendental) phenomenology and hermeneutic (interpretive) phenomenology.

2.4 Descriptive phenomenology

As previously mentioned, Husserl was the founder of phenomenology as a philosophy, particularly the descriptive approach.[122,136] Husserl believed that consciousness surrounds all human experience. He was set on eliminating human bias in the quest to achieve pure consciousness. To Husserl, phenomenology is the 'essence of consciousness' and intentionality was an important concept to him with regard to consciousness. Interaction between the researcher and the object of research is of supreme importance. To achieve pure consciousness, the researcher must apply 'epoche', meaning suspending judgement to understand the phenomenon in its own terms. This is also called bracketing.[118,137] Wojnar speaks about three stages of bracketing, i.e, isolate the phenomenon from the world and inspect it; take the phenomenon apart and work out the structure, define and analyse it; and 'forget' your prior knowledge of the phenomenon while interacting with the participants. Husserl believed that this approach would render the findings valid and generalisable.[136]

2.5 Hermeneutic (interpretive) phenomenology

As mentioned earlier, Heidegger introduced hermeneutics into phenomenology when researching the meaning of being. Context in Heidegger's interpretive phenomenology is of utmost importance, which is divergent from Husserl's, where context is of peripheral importance.[136] In interpretive phenomenology, there is no need for the researcher to bracket herself or himself. There are several assumptions of hermeneutic phenomenology, namely, human beings as dialogical beings; a shared common understanding of our surroundings; we interact in a hermeneutic circle of awareness; the notion that understanding is forever in front of us; and explication requires a dialogical relationship between the interpreted and the

interpreter.[136] Interpretive phenomenology explicates human experiences in relation to sociohistorical political issues.[136]

2.6 Advantages of phenomenology

Phenomenology offers an opportunity to understand the meaning of a phenomenon from the participants' perspective.[123,138] It helps researchers to "fully understand complex, environmentally influenced phenomena, ranging from learner mistreatment and burnout to learners' experiences on a clerkship or interprofessional team".[133(p252)] It offers comprehensive nuances of a single phenomenon.[125] Through phenomenology, one can collect empirical data using qualitative research.[133] The researcher does not impose themselves on the findings but allows the participants to assign meaning to a phenomenon.[139,140] It allows one to collect rich data and the opportunity to repeatedly engage with participants to find out how the phenomenon evolves.[121,139] It provides an opportunity for the researcher to investigate a phenomenon in detail and in-depth.[121] It allows the researcher not to completely bracket themselves in settings where researchers have experienced a similar phenomenon.[122,130] This non-self-bracketing is guided by the type of phenomenology the researcher employs.[130] Phenomenology has the potential to develop new theories, as meanings assigned to the phenomenon have the potential to be unique.[141]

2.7 Limitations of phenomenology

Phenomenology is very difficult to conduct, particularly for novice researchers.[125] Phenomenology cannot be used where participants do not have an expressive language, as one has to hear the meaning of a phenomenon from their perspective.[142] Presenting the results could pose a major challenge, as the researcher, in trying to be scientific, might present the results in objective terms which exclude the "first person experience".[142 (p393)]

One other disadvantage of the western phenomenological approach, in my view, is the absence of an African way of being, i.e., an African ontological perspective, such as Ubuntu. Ubuntu has a unique conception of individualism and collectiveness that is different from a western way of these terms.[143] Adding a philosophical approach to "I think, therefore I AM" is divergent from an African Ubuntu philosophical approach which is rooted in collectiveness of "I am because YOU ARE" or "because YOU ARE, I AM".[144(p13)]

2.8 Autoethnography

Hearing my undergraduate experience at the University of the Witwatersrand resonate in the students' stories made me realise that I am part of this story. Autoethnography offered a way I could immerse myself in this research as a participant even though I am the researcher. As a qualitative method employed to analyse people's lives,[145] autoethnography allows social phenomena to be explored through the lens of researchers' personal experiences. Autoethnography is grounded in postmodern philosophy, thus allowing diverse ways of knowing.[146]

2.8.1 Definition of autoethnography

There are axes of continuum in autoethnography, emphasising the 'lived experience (auto), cultural experience (ethno) and the research process (graphy),'.[147–149] In autoethnography, the author includes data about themselves in relation to the others in a context to highlight the connection between them and the others, in this case, the participants in the study. It is a context-conscious (South African sociohistorical context and #FeesMustFall), self-focused (personal experiences) qualitative method.[148(p2)] It is rooted in the study of culture, namely, medical education culture in this study. The medical education culture is couched in ethnography.[148] Although the autoethnographic researchers are typically at the centre as a subject and an object of the research, I have only immersed my reflections and phenomenological experiences where intentionally relevant to enrich the participants' story.[148] Ellis speaks to my ontological belief in saying "autoethnography attempts to disrupt the binary of science and art".[147(p283)] Autoethnography has two components; "analytic autoethnography which is directed towards objective writing and analysis of a particular group" while evocative or emotional autoethnography allows the researcher's introspection on a certain topic assisting the reader to connect "with the researcher's feelings and experiences".[145(p281)]

2.8.2 Advantages of Autoethnography

The major advantage of autoethnography is the researcher's or narrator's use of personal narratives and experiences to access participants' private worlds. Narrators typically use first person accounts, thus centering their voices.[145] Autoethnography allows readers to reflect on and empathise with researchers and/or participants' lives. This method makes it possible for readers to see the world from the narrator's point of view, and sensitises readers to realities that they might have considered.[145]

2.8.3 Critique of autoethnography

It is criticised as being "too artful and not scientific, or too scientific and not sufficiently artful".[147(p283)] The concerns about autoethnography relate to the vulnerability associated with narrators' or researchers' exposing their thoughts feelings, which may evoke unpleasant feelings in the reader.[145] Other concerns relate to autoethnography having the potential to be self-indulgent, introspective and individualised.[145] This method may be regarded as less rigorous than other research methods and potentially emotional and therapeutic.[147] Autoethnography may also create ethical challenges: evocative autoethnography could involve narrating instances of the researcher's lives that include sensitive matters regarding the narrator and the participants.[145] Autoethnographers are sometimes judged to have used allegedly biased data.[147]

2.8.4 Rationale for using autoethnography in this study

Despite the potential shortcomings of autoethnography, it allowed me to move from being just an observer into participation mode which honours my subjectivity in the process, providing an opportunity to tell my truth while exploring the participants' truth. I was an undergraduate medical student at the University of the Witwatersrand more than thirty years prior to interviewing these participants. I am thus part of the institution's history. Autoethnography allowed me to acknowledge my subjective voice and embody my experiences, knowledge, reflexivity and praxis in this research process, as described by.[150]

2.9 Sampling

The target population for this study was 350 final-year medical students at the University of the Witwatersrand in 2020. Only students who had experienced the 2015-2016 #FeesMustFall protests and were in student leadership positions during these protests were eligible to participate in the study. Participants would have been in their first (MBBCh 1) to fourth (MBBCh 4) years or doing a pre-med degree during the 2015 #FeesMustFall protests. The medical students were purposively sampled. Purposive sampling allows the researcher to deliberately choose participants best suited to yield the deepest perspectives for achieving the objectives of the study.[151,152] The final-year medical student leaders, who were in MBBCh 1 in 2015, were invited, via email, to take part in the study.

When interviewing medical students, other prospective participants, including recent graduates who had experienced the 2015-2016 #FeesMustFall protests or were in student leadership

positions during these protests, were mentioned. I then proceeded with a snowballing technique to invite the individuals suggested by the participants. Snowballing refers to where a researcher is directed to potential participants, allowing their engagement in the study.[153] Participants were purposively sampled. Prospective participants were sent information about the study (Appendix 6) and consent forms for the interview and audio recordings (appendices 7 and 8). Thirteen participants agreed to take part in the study, eight students (four men and four women) and five graduates (four men and one woman). Of the thirteen participants, four were White (one woman) and nine were Black (four women).

2.10 Data collection

Semi-structured interviews were used to elicit participants' experiences during the #FeesMustFall protests and throughout their journey in medical training. Interviews, particularly unstructured ones, are the preferred mode of data collection in phenomenology, as they allow the interviewee to express how they feel, painting a picture of their experience.[154] There is a reciprocal component in a phenomenological interview, where the interviewee and the interviewer both generate knowledge.[155] I wanted to collect data on students' experiences while maintaining spontaneity on the participants' part.[155]

Thirteen interviews were conducted in 2020: eight with final-year students and five with recent graduates. Each participant reflected on their experiences during and after 2015-2016, when #FeesMustFall protests were at their peak. An interview guide (see Appendix 4) allowed probing of the following areas: the journey towards becoming a doctor, experiences during the #FeesMustFall protests, experiences of professionalism, and how #FeesMustFall impacted their professional identity development. Three interviews were conducted in person and ten on electronic platforms, due to the pandemic lockdown restrictions (Skype, Zoom, Microsoft Teams and WhatsApp video call).

I employed an interpretive phenomenological enquiry[140] rather than a descriptive phenomenological approach[130] because the aim was to understand the meaning of students' encounters. I chose this methodology because I wanted to recognise my own positionality in the story which emerges. My story is the lens through which I make meaning of the students' encounters. When interpreting the medical students' and recent graduates' experiences of PIF, I recognised that their experiences resonated with mine during apartheid. I thus opted to engage

with a “situated meaning of a human in the world” within the context of medical training in South Africa.[2,132(p24)]

2.11 Data analysis

he interviews were transcribed verbatim and analyzed in MAXQDA 2020. Using an inductive approach, each transcript was analyzed as an individual case for the essence of its meaning and how participants’ “experiences described influenced their being and becoming”.[2(436),130,138] “Coding was conducted line by line or at the paragraph level)[2(p436),156] to identify natural meaning units. “Codes were grouped into categories and categories into themes. The transcripts were read and coded first by all team members (supervisors) to create a common understanding”.[2(p436)] “Each case (interview) was then profiled” (i.e., I described the essence of each case and was further discussed and confirmed by the supervisors) “and then compared for similarities and uniqueness”.[2(p436),157] An in-case analysis and cross-case analysis were applied, and “thematic connections” were made across cases.[136,158] I subsequently employed an African lens as an embodiment of Ubuntu, such as metaphors to interpret meanings, that I saw in the data. I recognised this because of my ontological being and background. In the second article, I included an intersectional lens to highlight what the participants were experiencing.[2,9,159] Where possible, I requested participants (recent graduates, because I had their contact details) to check whether the stories I had written about them were a true representation of what they said in the interview. Regarding student participants, I was not able to apply member checking as they had left to start their internships at nationwide hospitals.

2.12 Trustworthiness

Trustworthiness refers to how confident we are that the methods we used, our data collection and interpretation assures us of the quality of study. Researchers use several criteria to ensure trustworthiness and one of those criteria is credibility.[160] One that I took cognisance of was the power dynamics between the students and me, as the researcher and the director of the medical programme. I was concerned that the participants would not be able to speak their truth, hence the Inclusion of a researcher who interviewed the first three student participants. However, the student participants were still not comfortable with speaking their truth before they were sure that they had succeeded in passing their final year. They were also ‘only comfortable speaking their truth’ to me rather than anyone else.

This research had an enormous impact on me, as I recognised my story in the students' stories and saw my Ubuntu ontological grounding in theirs. I was empowered to see my story mirrored in theirs through an African lens. I recognised the journey I travelled, physically and emotionally, in my professional socialisation through their journey, albeit 30 years apart.

2.13 Ethical consideration

The proposal was submitted to the Wits Human Research Ethics Committee (HREC) in August 2018 and amendments were made based on the requirements of the Protocol Assessor's Committee and Human Research Ethics Committee. The University of the Witwatersrand HREC approved this study in November 2019 (Appendix 1) and the University Registrar granted permission to conduct this study (University Registrar Permission letter – Appendix 2).

As the Director of the Unit of Undergraduate Medical Education, I could only recruit and interview graduates, as the undergraduate students were under my care. I sought assistance from colleagues in the University of the Witwatersrand Faculty of Health Science who did not have final-year students in their direct care. Mr Sfiso Mabizela invited students via email on my behalf and those who responded were then directed to Ms Abigail Dreyer to conduct interviews. However, few students heeded Mr Mabizela and Ms Dreyer's calls. I subsequently requested the HREC to allow me to recruit the students after they had received their final-year results confirming that they had passed and would graduate in December 2020. The HREC granted access to only recruit those who had passed and were no longer under my care as the Director of Undergraduate Medical Education. I only had a window of two weeks to conduct the interviews before the students left to start their internships at nationwide facilities. Seven more students volunteered to be interviewed but two could not participate because of changes to their graduation date and time. I thus interviewed five more students.

A psychologist, Ms Nasrin Kirsten, was on standby to counsel participants who had experienced trauma during the 2015-2016 student protest and for whom these issues surfaced during the interviews. However, none of the students needed counselling.

Conclusion

In this chapter, I introduced my philosophical underpinnings, the research method I used, phenomenology, and outlined the study process.

The next three chapters consist of research articles published from the study:

Chapter 3, Article 1: **'Rethinking professional identity formation amidst protests and social upheaval'**, published in *Advances in Health Science Education* (AHSE) in 2022.

Chapter 4, Article 2: **'Graduate reflections on professionalism: intersection of race, gender and activism'**, *Teaching and Learning in Medicine* in 2023.

Chapter 5, Article 3: **'Students' views on what professionalism means: an Ubuntu perspective'**, *Advances in Health Science Education* (AHSE) in 2023.

CHAPTER 3 Rethinking professional identity formation amidst protests and social upheaval: A journey in Africa

This chapter presents the first article published in *Advances in Health Sciences Education* (Impact Factor: 4.0). The article **'Rethinking professional identity formation amidst protests and social upheaval: A journey in Africa,** addressed the following objectives:

1) to explore the lived experiences of students during #FeesMustFall protests to explore how the participants perceive their professional development from 2015 to date and the influence of #FeesMustFall on their professional development

In this article, I introduced the African voice to the PIF discourse, employing the calabash as an embodiment of Ubuntu (Nguni languages) or botho (Sotho languages), as well as other elements of Ubuntu, i.e., *letsema*, which is the communal spirit of working together for the betterment of others and self, and I equated *lebollo*, which means initiation, to medical training. The calabash is reminiscent of PIF, as it starts off with the soft centre and ends up with a hardened exterior, facilitating its use as a domestic feeding utensil. The participants' story centres around the 2015-2016 #FeesMustFall protests, a period that became a campus curriculum (students learning about their role as future health workers with a strong advocacy role) outside the classroom, propelling students to the next level of their growth, forcing them to be advocates for those on the margins. The study highlights how larger sociohistorical contexts and contemporary social upheaval contributed to the development of professional identity.

I inserted my story autoethnographically in this article as I was hearing my story in the participants' stories. I narrated South African history, immersing my childhood and my journey through undergraduate training to working as a clinician.

I was awarded an Association of Medical Educators in Europe (AMEE) prize for a research paper presentation in 2022. There were 40 research paper presentations in this category and prizes for the top ten research-paper presentations. This article has encouraged others to look at their own context to find ways to contextualise PIF in their spaces.

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Rethinking professional identity formation amidst protests and social upheaval: a journey in Africa

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Abstract

The under-representation of minoritized or previously oppressed groups in research challenges the current universal understanding of professional identity formation (PIF). To date, there has been no recognition of an African influence on PIF, which is crucial for understanding this phenomenon in places like South Africa, a society in which the inequity of the apartheid era still prevails. In addition, there is little data examining how social upheaval could impact PIF. This study uses interviews with medical students to explore PIF within the context of social upheaval during the 2015–2016 protests that rocked South Africa when students challenged asymmetries of power and privilege that persisted long after the country's democratic transition. The combination of the primary author's autoethnographic story, weaved into the South African sociohistorical context and ubuntu philosophy, contributes to this study of PIF in the South African context. The use of an African metaphor allowed the reorientation of PIF to reflect the influence of an ubuntu-based value system. Using the calabash as a metaphor, participants' experiences were framed and organized in two ways: a calabash worldview and the campus calabash. The calabash worldview is a multidimensional mixture of values that include ubuntu, reflections of traditional childhoods, and the image of women as igneous rocks, which recognizes the power and influence on PIF of the women who raised the participants. Introducing an African ubuntu-based perspective into the PIF discourse may redirect the acknowledgement of context and local reality in developing professional identity.

Keywords African metaphor · Calabash · #Fees-Must-Fall · Professional identity formation · Social upheaval · Students' protests · South Africa · Ubuntu

> *We believe that in the long run, the special contribution to the world by Africa will be in the field of human relationship. The great powers of the world may have done wonders in giving the world an industrial and military look, but the great gift still has to come Africa – giving the world a more human face.*
> *–Stephen Bantu Biko (1946–1977).*

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Introduction

The African experience is not reflected in the current constructions of professional identity formation (PIF). This reality and the ongoing under-representation of minoritized groups (in the South African context, the oppressed) in research present a challenge to the current universal understanding of PIF (Volpe et al., 2019; Wyatt et al., 2020, 2021a, 2021b). The formation through education and development of medical professional identity in Africa, and especially South Africa, may be rooted in the ubuntu philosophy (Letseka, 2012) (for more on ubuntu philosophy, see Box 1), as well as other critical theories (Balmer et al., 2021; Cornell & van Marle, 2015), all of which have characterized the liberation struggles in the society at large. Almost three decades after the transition to a democratic dispensation from the apartheid regime, the effects of apartheid, a colonial tool, continue in the ongoing experiences of inequity in South African society (Modiri, 2012). In seeking to understand the impact of social upheaval and protest action on emerging medical professionals, this study unearthed an uneasy relationship between a deeply divisive past and the tensions of a modern society. The exploration of students' experiences from the 2015–2016 period has forced deep reflection into the primary author's experiences as a developing professional in the 1980s.

Throughout this paper, the voice of the primary author (MM) will be foregrounded and is often expressed in the first person. MM is a Black, differently-abled (physical challenge) South African woman who studied medicine in the apartheid era, a time in which racial inequality, gender and disability discrimination intersected with multiple asymmetrical relationships of power and privilege to determine her life experience. This study, which analyses stories from senior medical students and recent graduates from a South African university, is juxtaposed alongside MM's professional identity experiences thirty years ago. This paper has been written to allow for an authentic retelling of both the history of the primary author's experience in developing a professional identity in South Africa and the contemporary lived experiences of medical students who participated in a national effort to bring equity to medical education. In areas where the writing pertains mainly to the first author's story, the pronouns 'I/me/my' denote MM's experiences; by contrast, the pronouns 'we/us/our' denote the voice of the full authorial team.

Box 1 Ubuntu philosophy

The foundation of ubuntu is perceived as motho ke motho ka batho (in Sesotho languages) and umntu ngumuntu ngabantu (in Nguni languages), which translates as a person is a person because of other people or a human being is a human being because of other human beings. Social interdependence is very important in an African community (Letseka, 2012). Mbigi (2005) in the Ubuntu Collective Finger theory gives an image of a hand, which illustrates that no matter how strong the thumb is, it is useless without the other fingers. He mentions five fundamental principles of ubuntu- respect, dignity, solidarity, compassion, and survival. Ubuntu epitomizes moral norms and values (Letseka, 2012). It is respecting others, their experiences and where they come from and the wisdom, they bring through that. Due to the collectiveness of ubuntu, gatherings in communities are valued as a crucial contribution to cultivating wellbeing

Table 1 Race classification

Racial classification in this paper				
	Indigenous	Mixed descent	Asian descent	European descent
South Africans	Black	Colored	Indian	White
Non-South Africans	Black African			

A South African history of learning medicine

My journey to becoming a professional is distinctly different from what is reported in the prevailing PIF literature. Counter-storytelling is therefore important in breaking the mold of "dominant culture narratives" (Solórzano & Yosso, 2002) in medical education and training. I am a Black, differently-abled woman, a medical doctor working as an academic. An alumnus of an institution that, despite being the first to admit Black medical students in 1941, provided limited access to people of color through government quotas and ministerial consent (Digby, 2005). I attended medical school during the apartheid period in the 1980s and apartheid was overt during my training, but over time it has become covert, invisible, and difficult to confront. I will weave my narrative into the South African story and the history of education in my 'beloved country.' In doing so, I will argue that the South African context influences how PIF is acquired and developed and foreground the role of mental, emotional, social, and physical space in developing a professional identity. I do so partly because critical race theorists insist on "placing both the historical and contemporary issues in analyzing race and racism" in context (Solórzano & Yosso, 2002), hence the importance of telling the South African apartheid history in this paper.

As a colonial tool, apartheid was the formal legislative policy of the South African government between 1948 and 1990. The policy legislated the separation and governance of the society into racial and tribal groupings to entrench and preserve the privilege of a white minority. In the early 1900s, apartheid formalized segregation based on color, resulting in the racial classification of its people into white, Colored,[1] Indian[2] and Black (see Table 1). In the context of South Africa, race was socially constructed to create "superiority and dominance" (Solórzano & Yosso, 2002), using apartheid as an ideology embodying the inherent belief that whites are superior to other races (Lorde, 1992). The divisions among the different groups filtered into every sector of society, for example, schools, universities, hospitals, and means of transport, further promoting the racial divisions (Coovadia et al., 2009; Tobias, 1983). Given the unequal treatment of some groups, the United Nations declared apartheid a crime against humanity in 1966 (Coovadia et al., 2009; Dugard, 2008; Giliomee, 2003).

The control of education was a central tenet of the apartheid ideology, including limiting the progress of Black people in order to prepare them for lives of only servitude and manual labor (Giliomee, 2009), perpetuating white supremacy. Apartheid, in its nature, sought to minoritize each tribal group. In the tribal areas, this led to a series of 'bush colleges' for post-school education that developed over time. In 1951, a white institution, the University of Natal, created a Black section where Black medical students could be trained,

[1] Mixed race.

[2] People with their origins in the indentured laborer's recruited in the Asian subcontinent, as a substitute for forced labor as a form of slavery.

but the mixing of Black and white people was not allowed (Noble, 2004). Entry of aspirant Black students into the established "white" universities was severely curtailed through the Extension of University Education Act of 1959. More than 20 years later, in 1976, a medical school for Black students was established (Haynes, 1995). The ongoing disparities under apartheid (Bickford-Smith, 1995; Saunders, 1992; Swanson, 1977), including educational inequalities, formed part of the motivation for student protest actions in the 1976 Soweto uprising,[3] the 1980 school boycotts[4] and, more recently, the 2015–2016 student movement called #FeesMustFall, which is central to the research presented in this paper. Residential townships and their associated schools were constructed using the apartheid racial classification (Coovadia et al., 2009). In the early 1980s, I received a ministerial permit to study at the local "white" university, the University of Witwatersrand, a place I was not meant to be. I chose that route for several reasons, one of which is that, with a strong awareness of where I came from, I felt empowered to turn the lives of my family around.

My identity was shaped first by the community that I was born into and second by the community I grew up in and the experiences I had along my journey to and in medical school. I developed poliomyelitis at two years of age. Poliomyelitis, a viral disease, left me with paralysis of the left leg. Growing up, I realized that occupying the education space was the only way to move my family out of destitution and change their position in the broader societal space. People around me were overprotective, often limiting my agency, due to what they perceived as the burden of my 'disability'. Despite all their sorrows and sufferings, my family was sensitive about my disability, which led to a delay in my schooling. I was frustrated by not being allowed to attend school with others of my own age, but two of my older siblings became my teachers. They taught me how to read and write, and the dirt in our yard became our chalkboard.

Schooling for a differently-abled child comes with its challenges. I was mocked by other children. Walking with a foot in an equina varus position, with a tight Achilles tendon, was like being Achilles, the Greek warrior, 'invulnerable in all of my body except for one heel' (Chiodo & Wilson, 2006), having to walk barefoot in winter as I could not wear shoes. Later, I was admitted into the Black section (space) of a hospital to fix my left leg, to make it 'shoe friendly.' I was in a segregated hospital; white children had a beautiful playground while there was nothing on our side. The doctors, all white, would come to our ward for rounds, dressed in white safari suits and white coats. They were kind to us but could not communicate with us in our vernacular. I wondered if they did not see the injustice and the discrimination, which leaves me wondering now, more than 50 years later, about what influenced *their* professional identity formation.

Despite my experiences in hospitals, I was motivated to study medicine after the doctors had fixed my leg, perhaps even because of those doctors. My professional identity formation is richly imbued with empathy and respect through the intersections of my Blackness, my womanhood, and my disability in a country which had devalued all of these. Respect, a strong tenet of ubuntu, was a product of my upbringing. I was taught that you respect your elders by not addressing them by their first name, whether they are ten days older or ten years older than you. This principle from my childhood influenced my respect for seniority and hierarchy in medicine. This was often in conflict with my spirit of advocacy. I resolved this by challenging authority in a respectful way while developing a sense of

[3] https://www.britannica.com/event/Soweto-uprising.

[4] https://www.sahistory.org.za/article/growing-social-unrest-community-mobilisation-strikes-and-student-protests-western-cape.

Box 2 Letsema

Letsema means working together voluntarily for the common good. This is used in farming, building houses, etc., where the community is invited to assist one of the community members (Quan-Baffour and Lebeloane 2008). In this communal spirit, others sacrifice their time and sometimes their belongings to assist, for example, in cultivating someone's land in preparation for ploughing. At the end of this activity, a meal or drink is offered to those who sacrificed their time. It is during these gatherings where a calabash, used as a feeding utensil, is shown as an embodiment of ubuntu

Box 3 Lebollo

Lebollo is regarded as one of the most important traditions in preparing youth for adulthood, namely, initiation. Lebollo is a ritual that marks the transition from girl to womanhood or boy to manhood. The initiation rites may vary from community to community. In South Africa, the initiation schools are situated away from villages and are underpinned by the values, beliefs, and practices of a particular community. Lebollo allows one to belong to a certain community of those that have gone through a rite of passage. Lebollo is expected to achieve cognitive engagement, virtue, confidentiality, appreciation of knowledge, respect and more

ethical scholarship and advocacy during the early period of the human immunodeficiency virus (HIV) pandemic.

I was given a bursary for tuition when I entered the medical program in 1982. I travelled the 50 km from Daveyton (where I was allowed to live as a Black person) to the medical school, which was in a white area. Together with another Black South African young woman, we were given a room on the rooftop of a students' block of apartments nearer to the school, masquerading as janitors in case the police came looking for Black people living there illegally. I felt unwelcome, not necessarily by the university at that time, but by the political system throughout South Africa.

We were eventually moved to a residence hall for Black students in Soweto (the sprawling black township on the outskirts of Johannesburg, about 30 km from the university). Glyn Thomas (a former university registrar and vice principal) was instrumental in setting up this residence for Black students and as such Glyn Thomas House (GTH) was constructed in his honor and, because of his support, Black medical students now perceive this house as an act of defiance (Wits Alumni Magazine, 2020). Living at GTH while studying to be a physician was transformative in every way possible; it was a social and a political hub that allowed us, as medical students, to grow exponentially into becoming community-responsive physicians. It was a place and a space where the next protest against apartheid would be discussed and planned. It was also a place that the system—and the special branch police forces used to enforce its power—watched closely, because anti-apartheid activists frequently met at the GTH (Wits Alumni Magazine, 2020).

During my training as a medical student, particularly during the internal medicine clinical rotations, as African students, we would share a meal together before every long shift (on call). We used to take turns preparing those meals for a shift, which fostered a sense of community that fueled our hard work and compassion during those long and extremely busy shifts. This reminded me of my home, where, as the five youngest children in the family, we would eat from the same large bowl not individual plates, stressing the importance of oneness; where celebrations would be held with music made from African instruments and the calabash (see more about the calabash in the next paragraph) being passed around to feed and quench the thirst of guests and family. During these gatherings, elders would

tell us stories of where they come from and how they grew up. They would tell us how processes such as letsema (see Box 2) and lebollo (See Box 3) contributed to their growth and the growth of their communities.

A calabash,[5] mentioned above, is a ubiquitous household gourd, used across Africa as a cultural expression, including at social celebrations of birth and other initiation rituals. The calabash transforms from a vegetable with a soft center into a tool with a hardened exterior, facilitating its utility in domestic life. This transformation is reminiscent of professional identity development and formation. Symbolizing transition, the calabash is an essential part of African communion, holding water on some occasions and traditional beer on others (Ellece, 2010). Women are responsible for making the calabash or African pot, giving it a gendered character. During ceremonies, the calabash is passed around for everyone to drink from the same source, creating a sense of oneness within the community. The calabash offers South African communities an image of holding the thoughts and pride of a community together in one place and the spirit of the calabash embodies the feminine attributes of nurturing and strength (Ellece, 2010). The calabash is an embodiment of ubuntu.

Observing the calabash being passed around during celebrations taught me the importance of oneness and planting a seed for growth in and through others. The image of the calabash and other African metaphors has been a matrix of the formation of my professional identity, which is based on oneness, respect, and selflessness. As a small community of African students, we made sure that our friends or clinical partners were not left behind. If one of us was not able to study for whatever reason, we would all go to the hospital to examine patients, present to each other and learn together.

My journey serves as the backdrop for the study we share in this paper. This study recounts a dynamic journey of self-identity development long before venturing into the professional space and the subsequent formation of professional identity in post-apartheid South Africa. The study centers around the Fees Must Fall protests of 2015–2016, a period of national student social unrest. The social disruption during the #FeesMustFall 2015–2016 movement underscored the tensions around exclusion on financial grounds from institutions of higher learning, experienced by individuals of color or lower-income class. During Fees Must Fall, which was part of a larger decolonial process (Ndlovu-Gatsheni, 2018), social media served as a vehicle of communication and mobilization during this major social disruption throughout South African higher institutions of learning. The major aim of the #FeesMustFall movement was to make quality education affordable and accessible to all, particularly poor Black students (Habib, 2019). The new South African government had not lived up to its promise to make education accessible to everyone (Cini, 2019a, 2019b; Habib, 2019; Langa et al., 2017; Mpofu, 2017). #FeesMustFall became the rallying hashtag for free higher education. The protests remain a watershed in South African higher education. There is little discussion in the literature about the formation of a professional identity in the context of social upheaval.

Professional identity formation introduction

Holden posits that PIF is an integrative developmental process by which one establishes core values, moral principles and self-awareness, which all merge into individual values, beliefs and obligations (Holden et al., 2012). PIF is the confluence of identity

[5] https://www.nationalgeographic.com/science/article/planet-calabash.

development, professionalism and formation (Holden et al., 2012), a multifarious phenomenon influenced by clinical, non-clinical experiences, assumptions and ambient factors (Sarraf-Yazdi et al., 2021). Your personhood (personality), social structure and interactions play an important role in who you become or are becoming (Goldie, 2012). This is not an instantaneous but rather a gradual dynamic process. Based on the ring theory of personhood (RToP) (Radha Krishna & Alsuwaigh, 2015), becoming and identifying with the profession is shaped by various factors: the innate self, the individual, and relational and societal factors (Sarraf-Yazdi et al., 2021). This RToP, in a convoluted manner, echoes the saying in ubuntu philosophy, "I am because you are", emphasizing that you are because of where you come from, what community you were brought up in (Letseka, 2012). In a community of practice (Lave & Wenger, 1991), individual, relational and collective identities shape one's professional identity (Chandran et al., 2019). Each person brings their sociohistorical background into the PIF process and therefore this process is never the same for all trainees. Ultimately, professional identity is a confluence of professional and personal selves (Moss et al., 2014), which are also evolving. As Schrewe poignantly points out, the "I" of identity is irrevocably intertwined with and shaped by "the possibilities of being" that emerge from "one's own historical moment" (Schrewe & Martimianakis, 2022, pg. 11).

Students enter professional training with a certain identity, shaped by their developmental communities, and are socialized into another identity as graduate professionals (Cruess et al., 2015). An individual's professional identity formation is influenced by "who they are" at the beginning of their journeys and "who they wish to become" at their graduation (Cruess et al., 2015). PIF is defined as an idea of self, constructed based on attributes, beliefs, values, motives, and experiences (Slay & Smith, 2011). However, the idea of a single, universal notion of PIF in which students are forced to adopt the rigidly defined authoritarian and hierarchical identities of traditional medical teachers is being questioned (Helmich et al., 2017; Kaiser, 2002). The inflexible identity restricts the richness, diversity and uniqueness attainable in one's identity as a medical student (Kaiser, 2002). This may ultimately harm "one's confidence and sense of self-worth" as a doctor (Kaiser, 2002).

There are pitfalls in the PIF discourse which seem to result from notions originating in Western contexts of what a professional identity is and how it is created. The calabash represents something that is different from the Western perspective. It is a metaphor and a space to think about what ingredients are needed to create something that everybody can participate in and partake in. On the other hand, the Western ways of thinking about PIF are rigid or militant. They focus on the individual, not the context and not on the interrelationships. From the ubuntu perspective, these theories do not fit and PIF needs something that thinks about the relationship among these different things.

By expanding studies to include non-Western settings, the field may begin to unearth the nuances of how identities unfold rather than forcing them to conform to Western understanding (Helmich et al., 2017). It is important to explore PIF in different geographical and political contexts because PIF is a dynamic process (Cruess et al., 2015) that changes over time, molded by the contexts and spaces in which the professional development occurs (Cruess et al., 2019). Helmich proposes three approaches or considerations to answering the question "*Who am I.*" These considerations relate to your personal identity; your identity focusing on understanding yourself in relation to others, and your identity relating to a community (Helmich et al., 2017). In particular, Wyatt and colleagues argue that minoritized groups are often excluded from contributing to the dominant perspectives within the PIF canon (Wyatt et al., 2021a, 2021b) and

challenged the dominant perspective that neglected to consider the intersections that characterize belonging to multiple minoritized groups based on gender, race and disability. Others, such as Conway-Hicks, interviewed participants who identified with "not from an advantaged background" and uncovered themes relating to "being and becoming a doctor" that displayed a hidden curriculum contribution, which silenced markers of socioeconomic "under-privileged" groups (Conway-Hicks & de Groot, 2019).

Previous studies explored "layered identities" through social relations such as "structured power, history" and others (Collins, 2015; Johnson, 2021), in which factors like race, gender and ethnicity lead to transient professional identities, in which individuals may be "privileged in one circumstance" while being marginalized in another (Crampton & Afzali, 2021). For example, a Black man may be privileged in the training space where he works with other Black patients and simultaneously be marginalized in a room full of white physicians. Considering "layered identities" within medical students' professional identity is important because such aspects as race, gender, and ethnicity constitute forms of oppression in South African apartheid (apartness) and its ongoing legacy (Johnson, 2021). There is a paucity of data coming from Africa and South Africa on PIF, a continent that has been ravaged by colonialism, oppression, and war, and will undoubtedly add a different view of PIF.

This study describes and analyses the worldviews and experiences of medical students and recent graduates who trained during the #FeesMustFall 2015–16 protests, focusing on the time before and during their pre-clinical years in medical school. In so doing, we explore aspects of participants' identities before joining higher education and their development of professional identities, considering both my experiences and theirs within the larger South African socio-political context.

Methods

Background and researcher reflection

I used my historical experiences as a lens for analyzing the data, and in doing so the participants and I co-created the initial interpretations, followed by an additional interpretation by members of the research team (LG, AG, and AK).

Before the student and recent graduates' interviews, the first author reflected on and interpreted the meaning of her own lived experiences by first writing the story of her life and how she came to medical school (Laverty, 2003; Matua & Van Der Wal, 2015; Van Manen, 2016; Wojnar & Swanson, 2007). The entire team (LGT, AG, AK and TW) used the first author's lived experiences as an analytical lens and analysed this personal story using critical theory (Solórzano & Yosso, 2002).

LGT and AG are both people of color who were students at the same institution as the first author during the '80 s decade. LGT and the first author were classmates and friends in medical school and shared some of the same clerkship rotations during medical training. All three of us experienced the tumultuous socio-political context of South Africa. To this study, LGT brought guidance, medical education, and social accountability expertise, while AG, with a PhD in education, brought structure to the supervision, and suggestions for theoretical frameworks and interpretive lenses, as well as emotional, educational, and technological support. AK and TW, both of whom had worked in North America, contributed a global perspective to the study. AK provided Global North expertise in the

supervision, as well as guidance on theories and ways to structure the paper. TW's role as a PIF expert was to raise questions about the context and data and to reflect on aspects of the first author's story to create a coherent narrative (Naidu & Kumagai, 2016).

Context and setting

This study was conducted at the University of the Witwatersrand, South Africa. It is a qualitative study with an African ontological grounding exploring medical students' lived experiences during medical training, which took place between 2015 and 2020.

Design

We used a qualitative, interpretive phenomenological enquiry (Shaw & Anderson, 2018, 2021), rather than a descriptive phenomenological approach (Reiners, 2012) because we were interested in understanding the meaning of students' encounters. Further, I did not want to bracket (LeVasseur, 2003) myself during this process, as required by descriptive phenomenology. Additionally, in interpreting the medical students' and recent graduates' experiences of professional identity formation, we recognized early in the study that my experiences resonated with the students' while I trained under apartheid. Therefore, we opted to engage with a "situated meaning of a human in the world" within the context of medical training in South Africa (Laverty, 2003).

Participants

A purposive sample was drawn from senior clinical students and recent graduates, followed by a snowballing technique. The participants had been students in their first to fourth (MBBCh 1–4) years of the medical program during the #FeesMustFall 2015–2016 protests. All the student participants were in their final year (2020) of undergraduate training (MBBCh 6), as they had been in their first year during the protests. Two of the undergraduate medical students were graduate entrants into the medical-degree training while others had entered directly from high school. The medical graduates were in the first two years of their postgraduate training (internship) at the time they were interviewed. Student leaders were initially approached because of their active involvement in the #FeesMustFall movement; their recommendations then began the process of snowball sampling. An email was also sent to the 2020 final-year class, outlining the purpose of the study, and inviting those interested to take part. Those who showed an interest in the study were sent study information and consent forms for the interview and for audio recordings via email. There was also a psychologist available in case the participants needed counselling.

Data collection

Interviews were conducted with students and recent graduates. Senior student participants were provided with data to facilitate the interviews when required. In total, 13 semi-structured interviews were conducted in 2020, of which eight were students in their final year

Table 2 Summary of Participants

	Demography	Source of funding
Postgraduates		
PG1BM	Black South African male	Government bursary, fully funded
PG2WM	White South African male	Government bursary, fully funded
PGBM, graduate entry	Black South African male	Initially missing middle, later privately funded
PG4BM	Black South African male	Government bursary, fully funded
PG5BF, graduate entry	Black South African female	Partially funded
Students at the time of study		
S1BF	Black South African female	Government bursary, fully funded
S2GWM, (graduate entry)	White South African male	Family funded
S3GWF, (graduate entry)	White South African female	Self-funded
S4BM	Black African male	Government bursary, fully funded
S5BF	Black South African female	Government bursary, fully funded
S6WM	White South African male	Government bursary, fully funded
S7BM	Black South African male	Government bursary, fully funded
S8BF	Black South African female	Government bursary, fully funded

and five were recent graduates. The interview protocol asked students to reflect on their experiences during and since 2015–2016, when the #FeesMustFall protests were at their height. The interviews explored each participant's journey prior to their entry into the medical program (pre-admission), their journey through the program (student experience) and, for some, their journey beyond their training (the graduates). We used an interview guide to allow us to probe the following areas: the journey towards becoming a doctor, experiences during the #FeesMustFall protests, experiences of professionalism, and how #FeesMustFall impacted their professional identity development. The participant set consisted of five women, of which one was white and four were Black South African, and eight men, four of whom identified as Black South African, with one Black African (not from South Africa) and three white men. The extracts from the participants' comments are identified using BF for Black female, BM for Black male, WF for white female and WM for white male (see Table 2). Three interviews were conducted in person, while ten were mediated through electronic platforms due to the pandemic lockdown restrictions (Skype, Zoom, Microsoft Teams and WhatsApp video call). The University of Witwatersrand Human Research Ethics Committee approved the study.

Data analysis

The interviews were transcribed verbatim and analyzed in MAXQDA 2020. Using an inductive approach, each transcript was analyzed as an individual case for the essence of its meaning and how participants' experiences described influenced their being and becoming (Matua & Van Der Wal, 2015; Reiners, 2012). Coding was conducted line by line or at the paragraph level (Azungah, 2018) to identify natural meaning units. Codes were grouped into categories and categories into themes. The transcripts were read and coded first by all team members to create a common codebook. Each case (interview)

was then profiled (i.e., the essence of each case was discussed and described by the first author and was further discussed and confirmed by the co-authors) and then compared for similarities and uniqueness. An in-case analysis and cross-case analysis was applied and "thematic connections" were made across cases (Bazeley, 2009; Wojnar & Swanson, 2007).

We used ubuntu to interpret the themes and their connections. Ubuntu is a South African ontological perspective, a different worldview from the Western notion of being. It originates from the concept of being (Muxe Nkondo, 2007) and can be translated as *personhood* or *humanness* (Kwizera & Iputo, 2011). The translation is not *being* as Heidegger describes it (Larsen & Adu, 2021) but an African way of being. Thus, it is not the Cartesian way of "I think, therefore I am," but rather a more inclusive understanding of being summed up as "because we/you are, I AM." Therefore, it is not a theory, but an ontological perspective and way of life, and is an entirely different way of knowing, seeing, and doing the world than what has henceforth been included in the PIF literature.

I used an ubuntu philosophy as an analytical lens to examine PIF among South African medical students, and in doing so applied metaphors to describe the findings. We used three South African languages, Sesotho, IsiZulu and IsiXhosa. For example, we use a hand metaphor similar to the one described by Mbigi in the collective finger theory (Mbigi & Maree, 2005), "matsoho a hlatswana," which translates to "a hand cannot wash itself but depends on the other hand," to communicate interdependence and mutual growth.

Findings

To communicate our findings, we used the metaphor of a calabash, which represents a powerful transformation of a vegetable with a soft center into a tool with a hardened exterior to represent the transformation of South African students from undergraduate training to a fully-fledged physician. The calabash is meant to serve as an image of professional identity formation. As mentioned previously, Ubuntu originates from the African ontology, by which individualism is respected while interdependence is viewed as superior (Kronenberg et al., 2015; Muxe Nkondo, 2007). Despite the racial differences among participants, the principles of ubuntu were shared across indigenous and non-indigenous cultures, as they are in society (Muxe Nkondo, 2007), and participants entered the institution of higher learning with ubuntu home-based values, as well as a history of segregation and differential treatment for different races. They joined the campus calabash with ubuntu-based identities, socialized into another identity by the heat of #FeesMustFall, cementing the values of "I am because you are." Using the calabash as a metaphor, we organized students' experiences in two ways: a **calabash worldview** and the **campus calabash**, by first exploring students' childhoods, then moving to university life, and then ending with the disruption caused by #FeesMustFall protests. Findings are presented in a story format with quotes from the participants.

A calabash worldview

The findings show that students involved in the protests discussed the power of their upbringing and the ways in which the ubuntu philosophy shaped their personal and

professional identity. In these discussions, we found that students discussed their reflections on a traditional South African childhood, the women in their families serving as rocks who raised, fed, and guided them, *Lebollo* (Sesotho for initiation), the traditional rites of passage from adolescent to adult, from student to professional, and *Ugqirha* (isiXhosa for doctor), using their bodies as healing instruments.

The values of ubuntu

Participants described bringing a sociocultural richness into the higher education spaces. Ubuntu embraces serving others without expecting anything in return (Kwizera & Iputo, 2011). Throughout this study, participants described caring for others as part of who they are as human beings and the ways it manifests throughout their journey to becoming physicians. The African metaphor of the calabash allows for a reorientation of PIF to reflect an ubuntu-based value system, in which the four-fold collective values of the ubuntu framework (i.e., survival, compassion, solidarity and respect) (Molose et al., 2018; Nussbaum, 2003; Schreiber & Tomm-Bonde, 2015) can be explored. For example, to express ubuntu, participants frequently discussed orienting themselves to the needs of others confirming that matsoho a hlatswana: "*helping others around you and seeing the change you make (S8BF"); "standing together"* (S2WM)*; and "looking at the needs of those around you"* (S3GWF). They also discussed having a strong sense of appreciating and respecting their elders, hierarchy in the South African context, and caring for their fellow human beings:

> *The struggle is that we are brought up from families that are ubuntu driven, that are value-based and that value-based system in a sense of an elderly…is always an elderly. And the young should always toe the line in relation to that power dynamic. That we didn't learn at Wits. (PG4BM)*

For many, the new university experiences were an opportunity to transform themselves, and participants expressed wanting to take what they learned in their upbringing and begin to interact with others who represent the patient population they would be treating. The love for diversity and their desire to know about other cultures reflected an essential part of their being. Some participants described feeling liberated from interacting only with those who looked, acted, and thought like them. For example, a participant who came from a very conservative community initially wanted to commute from home to the university campus every day. He was intrigued by the diversity he encountered during a tour of the residence halls and subsequently changed his mind about living there.

> *When I came to Wits and to residence, it was completely different, everybody was English, there were different races, we were white, Black, Indian, multiracial, or multi-colored people, and everybody brought a piece of them to the table. (S6WM)*

This participant learned about other cultures and recognized that the thought processes of his peers were completely different from his way of thinking. He became immersed in the diverse calabash of language, culture, politics, and sociocultural richness, and expressed his growth as someone becoming better than previous versions of himself, "*I mean, if you had any conversations with somebody then it was clearly different to what I thought at the time" (S6WM).* In other words, the students brought their childhood value system with them, and mixed it into the diverse value systems and personal experiences with others to create a rich and nutritive environment.

Mosadi ke lejwe la moralla[6] *(woman is an igneous rock)*

The participants described the women in their lives as their rock. Male participants spoke fondly of their mothers and female participants spoke about the strong role mothers played in their lives. Some of the female participants were raised by single mothers and had a sense of women being stronger than men. There was a strong presence of the powerful voices of strong women, women who raised them, women who fed them, women who guided them and women who showed them how to be.

> *And I think for me having like that kind of female background where my mom is my primary caregiver and my aunts are teachers who give so much, not only to their own children, but to their students…it motivated me, and it made me see like the power of kind of being over men and it made me kind of like a feminist. (S8BF)*

In South Africa, women balance the calabash on their heads filled with water, without holding or supporting it and walk for miles without spilling a drop. It is a mark of their strength and balance. Women hold their families together and nourish them just as they carry a calabash carrying water or food for communal nourishment. There is a saying in IsiZulu[7] that celebrates the power and strength of women, "*Wa thinta abafazi wa thinta imbokodo*," translated "*you strike a woman, you strike a rock.*" This sentiment was heard throughout the stories of these participants in that women are the rocks in their lives.

Lebollo—rite of passage

Choosing a university at which to study medicine was a well-thought-out process for many students. They did not just want to study medicine but wanted an experience that transformed and supported them, akin to a traditional South African rite of passage.

> *Initially I wasn't sure where I wanted to go, didn't have a particular university in mind. For me it was just whichever university I could get in I would go to. And then Wits accepted me along with one or two others, and then I had to make a choice in the end and then Wits was the choice that I made. And yeah, I think I had quite a change in perspective initially…coming to Wits, it was a lot different than I actually expected, but also different in a good way. I think it exposed me to a wide variety of people, thought processes, and everything. (S6WM)*

Participants experienced their university life as a transition from adolescence to adulthood in ways that reflected a traditional rite of passage. They viewed the experience of becoming a physician in a way that positioned the knowledge they received about life, growth, resilience and how to deal with challenging matters, as a form of transformation. Although they did not use the term, their expression of growing is reflected in the concept of Lebollo, which is commonly used by the Basotho people meaning to "*facilitate transition to adulthood*". *Lebollo* in Sesotho is a ritual that marks the transition from girl to womanhood or boy to manhood. In South Africa, these initiation schools are situated away from villages and are underpinned by the values, beliefs and practices of a community, which students made a conceptual connection to as they trained to be physicians.

[6] Woman is an igneous rock in Sesotho- one of the eleven official languages in South Africa.

[7] IsiZulu is one of the eleven official languages in South Africa.

Lebollo allows you to belong to a certain community of those who have gone through a rite of passage. Lebollo is expected to achieve cognitive engagement, virtue, confidentiality, appreciation of knowledge, respect and more. In lebollo, one is isolated in the initiation process and yet still with others, just as it is in medical training. In some cultures, one cannot practice as a healer until you have gone through this rite of passage, which is similar to practicing as a Western medical doctor; you must go through medical-school training before you practice.

Ugqirha[8]*—my body as calabash*

Ugqirha is the word for a medical doctor in the IsiXhosa language. Becoming a doctor was important to participants as they wanted to feed and nourish others into good health. This deep-seated yearning to heal others through their bodies sparked the desire in them to become doctors. Some of them were attracted by the inherent power that doctors hold and the doctors' standing in the community, as this participant explained.

> *I know that General Practitioner [Name withheld] you know, sometimes people just go to him, even if they are not sick, the guys they go to him for advice or…so there was this thing that a doctor had in the community that anyone else didn't have. (PG1BM)*

Selfless concern for others was the core reason some participants wanted to join the profession, as they were eager to "*help people*" (S7BM), "*to make a difference*" (PG1BM), to be like an "*uncle who helped others*" (PG1BM) or an *"aunt, a teacher who helped or uplifted members of the community*" (S8BF). Seeing members of the community coming to show gratitude to teachers, nurses, and doctors in the community ignited in these participants the yearning to be like those respected members of their communities.

> *So, like, that was kind of like my inspiration, like seeing how many teachers I had in my family, and I was just like being a doctor in its way is also becoming a teacher, I guess…ja…so that was like my…I didn't have like a doctor-doctor, but I just had other people in my life which was more how working in the public system in South Africa can help others. (S8BF)*

Some participants were guided by parents' desire for their children to be respected members of society, someone who exceeded what the parent might have achieved. A parent encouraged her daughter to study medicine because she felt that as a nurse she was not as respected as much as doctors in the clinical space.

> *And my mom is a nurse and she'd always be like, you know, we get treated this way, this way, this way, you'll be more respected as a doctor, all that stuff. (PG5BF)*

Family members who were healthcare workers were a motivating factor for some of the participants. Having a family member who either had a chronic disease or needed regular hospital check-ups was another motivating factor. Their motivation was either ignited by the respect for the doctors who looked after their family members or by the disgust that arose in the participants because of the terrible state of the public-health system. The participants' intention was to change the way the public-health system is run in South Africa, to look after the poor who could not afford private health care.

[8] Ugqirha is a medical doctor in IsiXhosa, one of the eleven official languages in South Africa.

I grew up in a kind of like underprivileged family and I always use like the public health care system, and I was just like okay, I'm going to help people rather than go into like finance or the sciences, right. So, for me it was just kind of like if I work in the public health care system, I can make more changes. (S8BF)

One of the participants, who is white, was guided or pointed in the direction of studying medicine by a White Sangoma.[9]

So, I didn't think I'd do it in Grade 11 but a sangoma told me that I should do it, was the first time when they told me that I should do it. I applied and then for some reason they decided to let me have a chance, so that was that. (PG2WM)

These extracts reflect the multiple levels of motivation expressed for studying medicine, from the status it gives, the sense for healing, the sense of generational progress and ultimately the hearing of a calling.

In combination, participants' stories invoked an image of students thrown into a large calabash where they were mixed with people of different backgrounds; they met people who do not look or speak like them but brought a rich diversity of experience that contributed to the creation of something nutritive for the whole community. Some lived on campus, while others commuted from other places. However, eight to nine months into 2015, university life changed. As a result of some students facing financial exclusion, a fire erupted in the calabash and students shut down the university, demanding that university fees fall. This period in their development as physicians is framed in two ways, ***Campus Calabash*** and ***Fees Must Fall, a divine interruption***.

University life

Campus calabash

Initially, the students were living and thriving on the nutrients provided by the calabash as they transformed themselves into physicians. The calabash held all the ingredients for growing, which ebbed and swirled around to ensure that all flavors are expressed. Stepping into this space molded the participants, adding another layer onto their identity, taking them onto the next step of their formation. Different spices of life in this calabash seasoned them into different beings who had to adjust in giving and receiving knowledge. Challenged on a deeper psychological and emotional level, participants were iteratively softened and hardened throughout their time in training, laying the foundation of resilience and empathy. Some came from rural or township backgrounds and others from suburban areas. Some carried strong South African Black historical backgrounds that rendered them materially poor but socially enriched.

I was coming from a rural school, a quintile 1[10] *school in Limpopo province. And coming into university that was predominantly of those who were advantaged, we had to do a lot of adjusting, so my university years were challenging in that sense. And other factors that included social, eco-*

[9] A traditional healer in South Africa. It is usually Black Africans that are trained by a healer but in recent times we have seen white people that also go through training. This is a calling from the ancestors.

[10] South African public schools are categorized into 5 groups for purposes of allocation of financial resources. Quintile 1–3 are non-fee-paying schools while 4–5 are fee-paying schools. https://www.education.gov.za/Portals/0/Documents/Legislation/Call%20for%20Comments/NATIONAL%20NORMS%20AND%20STANDARDS%20FOR%20SCHOOL%20FUNDING.pdf?ver=2008.

nomic, and family-related struggles were there, but mostly academically, those were the challenges that were related to the previous disadvantage. (PG4BM)

One group came from privileged backgrounds, in communities with modest living standards and surrounded by high-achieving expensive schools. In this calabash, these privileged participants realized that, before they were thrown into this beautifully decorated vessel, they were not aware of the less fortunate:

I was a white student from a private school. By no means was I able to self-fund at a private school and self-fund at Wits, but at the same time in my life I've had incredible opportunities of education. (PG2WM)

Despite the varying levels of privilege and disadvantage, the students collectively experienced struggles transitioning from school to university. The participants had different levels of proficiency (i.e., technological proficiency) and had to embark on steep learning curves as they engaged in higher learning. They had to rapidly adjust to the tertiary environment. Their struggles were academic, economic, social, and family-related: "*We had to learn and adapt quite quickly. But the environment was supportive and nurturing"* (PG4BM).

They came into a big city from different spaces, from small towns and rural environments, all adjusting to new experiences. Being South Africans with a history of segregation, they were used to living with people who looked like them, who shared a similar culture and religion. This environment was a culture shock in a "good way".

I think I had quite a change in perspective initially…coming to Wits, it was a lot different than I actually expected but also different in a good way. I think it exposed me to a wide variety of people, thought processes, and everything, so I could say it was a bit of a culture shock initially, but in a good way. I mean, you learn to know about other people's struggles and what they face and what they sacrifice to actually get where I was at that time as well. (S6WM)

It was not only the white students who experienced shock, but also the Black students, as expressed by this participant, "*I never went to school with any other person who is not Black, so for me it was a racial shock when I arrived in an environment that was predominantly white"* (PG4BM).

The participants found their voice and the freedom of various forms of expressing themselves. For these participants, being on campus was an enriching curriculum on issues of life. In that environment, they experienced what life could be and gave them an example of what they would encounter in the communities as future doctors. For the first time, they saw men having sleepovers with men, men dressing as women and men wearing their hair in locks. Initially it was a shocking experience, but this taught them the value of freedom of expression. Understanding this is crucial to their development and caring for their future patients as free beings. This forced them to reflect on who they are, what they thought men or women should look like, dress like and behave. This is the epitome of learning as transformation.

We had guys who would braid their hair in bright colors, guys who would wear dresses, guys who would have sleepovers with other guys, you know, and they were explicit about their sexual orientation. It was foreign to most of the people coming from rural areas, but by the time you come out of Wits you realize that you know what, as much as I was not exposed to that, that's how people should be allowed to express themselves. (PG4BM)

During the preclinical years, their role models were academics who looked like them and race was an important factor, more so for the Black students. Students also shared some formative experiences with only a subset of their medical school class. For example, students who stayed in a particular men's residence spoke very fondly of that residence. According to the participants who stayed there, it was nurturing, where senior students mentored junior ones. A white participant who stayed there found it to be a place that contributed to his growth as a South African. He learnt more about other cultures, the history of the country and different cuisines. He was grateful to have lived in this residence as a white South African, as the experience he got was the training he needed before going into the community as a doctor.

Fees Must Fall, a divine interruption

In 2015, the start of the Fees Must Fall protests, created a divine interruption as it forced everyone to reflect on who they are, what they bring and their privilege or lack thereof, in the campus calabash, which started swirling and spiraling lives around to the next level of growth. This was a similar transformative process to lebollo, a process that made boys men and girls women. In the lebollo process, there is "knowledge production and transfer" which is meant to ensure the sustainability of nations (Maharasoa & Maharaswa, 2004). In a similar vein, the protesters attained knowledge about themselves, the calabash community, and the country. No one should be left behind was, in a way, the motto of the protests. Lebollo is the summit of the acculturation process, which Fees Must Fall facilitated to mold their formation and identities.

The following section is written for a non-South African audience in which the historical context has thus been interwoven into the narrative to clarify the intersection of the students' stories with the development of their professional identity.

The participants expressed #FeesMustFall protests as a response to the tuition fee increase for 2015 in institutions of South African higher education. The protests were a fight for the basic human right to education after the government had reneged on promises made when it took the reins in 1994, when it had promised free education for all. Twenty-one years post-independence, mainly Black students were facing financial exclusion. In fighting for social justice, the students shut down the university to bring about that change. Participants felt that protests were a means of communication because they were not being heard. Fees Must fall started at the University of Witwatersrand (Wits) in October 2015. The movement spread through social media to all institutions of higher learning in the country, becoming a movement within a larger movement.

> *I believe that I became a better advocate, firstly for issues, that were fighting for societal issues, and ultimately for patients' rights as well. So, it changed, and as I alluded before, it gave us a confidence, and this feeling in that…and I would say for a lack of a better word, the entitlement of space. (PG4BM)*
> *Because that's what we were promised, or rather what our parents were promised, and they told us that, no, you my child will go to school for free because that was promised to us as well. So, it gives you that sense of anger that why are we supposed to go through such difficulties 26 years after democracy? (S7BM)*

While there was agreement in general about joining the protest, participants expressed major tensions in the 2015 first-year medical class about taking part in the protests. These disagreements were along racial lines, with the white students wanting to continue with

classes. At that time, the privileged students did not see the need to protest. Despite all these tensions, some of the participants mentioned how much they have grown since 2015. For some they were conscientized about the needs of others and realized that the protests were a necessary way to make these needs known.

> *So that's when the racial divide started, because on the group we'd fight and everyone…like we'd be organizing marches, we'd be organizing, okay, which march are we going to as like students, what are we doing, what are we doing? And the white students would just be like, oh, no, we actually don't want any part of that; we don't want…like we're okay. So, like, it was kind of like they didn't want to learn, they didn't want to open their eyes. (S8BF)*

According to the participants, protestors initially held meetings at the Senate House, the seat of university governance. Participants described how students renamed this building Solomon Mahlangu House in the spirit of decolonization. Participants reckoned that renaming these spaces was a gift to themselves, a reward for years of struggle. Occupying that space held an important place in their minds, hence the changing of the name to Solomon Mahlangu.[11] Renaming this space gave participants a sense of belonging. They felt that they owned this space alongside the previously advantaged white students. In turn, the white students were being conscientized that the Black students were claiming, and are part of, the space.

> *So, we felt that at that moment in time decolonizing that kind of space and renaming it to Solomon Mahlangu House was more of a gift to ourselves, to say, you know what, at least, inasmuch, yes, this institution may be against us, but we feel some sense of belonging. (S7BM)*

The protests illuminated shades of grey in both Black and white participants, also between male and female students, a mixture of privilege and deprivation. A large proportion of Black students, rich in the knowledge of the country's history and culture, but lacking financially, were now facing exclusion. On the other hand, white students who were financially secure were now experiencing whiteness as deprivation: during the protests, some white, although emotionally invested and immersed in the movement, still felt excluded from the movement. Having not lived through the personal experiences of those in need, they lacked something; they felt incomplete, and they were trying very hard to be in that space. There was a lot of guilt, guilt for being, guilt for having funding, guilt for being privileged, and guilt for the way women were being treated. Women were sidelined, made to feel like they did not belong in the leadership of the movement.

> *So, no matter how much I got involved in the protest, the more and more I realized that I was just on the side-lines, that I wasn't a student who was deeply affected by it, or as affected by the increment stuff as some of my colleagues. (PG2WM)*

Participants felt that they did not get support from academics, some of whom were willing to continue with classes excluding a large proportion of students. Some of the activists in the medical program were victimized and labelled by academic staff as troublemakers. They were seen as disruptive and depriving the "paying" (PG2WM) students of their education. The situation became racialized, as those who were attending classes were mainly white. Subsequently, the attending students were forced out of their classes, a move that

[11] https://www.sahistory.org.za/people/solomon-kalushi-mahlangu

was initially taken as a violation of their rights. This action was also labelled as unprofessional. Those participants who had been forced out of the classes mentioned that they later realized the protests were necessary. This dawned on them when they learnt about the looming financial exclusions of some of their classmates and stressed that change had to come.

> *It brings forth whether when you stand up for something you believe in denounces your professionalism, just because you're not going with the flow, … I think a lot of minds that don't always just do what they're told…have always like in history been people that have brought about change. (S3WF)*

When students had exhausted every avenue and there was no headway, they elected to march to the Union Buildings,[12] which are the seat of South Africa's government. This was the most non-racial march ever seen in the country since the women's march to the Union Buildings in 1956 (Legoabe, 2006). Participants said the students were united irrespective of colour or gender; they were marching and singing together.

> *There are the strong, incredible, standing together, fighting together, marching together, pleading together, that was so positive and brought people so close together. (S2GWM)*

The march was peaceful until the President refused to come out to address them in person. Someone set a fire outside the Union Buildings and pandemonium erupted.

The campus calabash, lit by the flames of #FeesMustFall, instilled unexpected determination and growth in the students. Participants described being in a "war zone" (PG1BM), where they were learning to "*become better advocates*" (S8BF) as part of their professional responsibility. #FeesMustFall also challenged the way many of the students were brought up, having to suppress some of the values instilled in them during their upbringing, to win the war. For example, this participant struggled with the South African value of respecting those in power, *"I'm not attacking him because I'm disrespectful but I'm attacking him because of the power space he occupies, because of the office he occupies"* (PG4BM).

Through this experience, the participants, especially those who had come from positions of racial and financial privilege, realized that everyone has a story that needs to be heard and respected. They became activists and realized the importance of cultivating this role as a future physician, whether it be in a protest or in the clinical space.

Discussion

I have lived through the period known as the South African apartheid, which silenced voices from the margins, and I used this experience in my research to understand the professional identity of students involved in the #FeesMustFall protests in 2015–2016. The participants' stories about their involvement and the ways it impacted them echoed my own journey as a trainee during a time of silencing. It made me think about the advocacy that Steve Biko portrayed as a medical student (Biko, 2017). The results reveal to me personally that, as things changed into the post-apartheid era, they ultimately remained the same.

[12] https://www.sahistory.org.za/place/union-buildings-pretoria.

In writing this paper, I recognize that this is not a typical genre seen or employed in medical education, as this representation of what counts as a research study is somewhat different to the prevailing literature. I articulated the findings in a different way because, as a researcher, when I looked at the data, I saw shadows of myself in a different time and a different age. Therefore, I have intentionally taken a different approach in writing to underscore other ways of doing things, seeing the world, and communicating it, other than what has been sanctioned as legitimate ways of disseminating research in our profession. What counts as 'acceptable' within our disciplines is normed around Western constructs, which marginalizes and silences other ways of being. In writing differently, I am intentionally engaged in what Ramugondo supports as "everyday doing [that] disrupts societal dynamics of dominance" (Ramugondo, 2015). In other words, what we do in our everyday lives in the personal, clinical, and research space can either disrupt or perpetuate dominant forms that seek to keep some in perpetual oppression. By adding my voice to those normally heard in the Global North and working to legitimize different ways of doing things, my goal is to push our community to consider how to disrupt power structures that seek to keep some groups out, just as the political parties did during the apartheid era, and as rising tuition fees threatened to do during #FeesMustFall.

The results of this study underscore the role that childhood values play in creating a professional identity, and larger ontological systems that inform physicians' worldviews. The buds of students' professional identities emerge long before students enter clinical training or institutions of higher learning, in contrast to the "anticipatory socialization" (Brown et al., 2020) typically discussed in the PIF literature. Rather, molding occurs in their homes and communities through the principles of ubuntu and their experiences with the South African healthcare system. It also highlights how larger sociohistorical contexts (Wyatt et al., 2020) and contemporary social upheaval contribute to the development of one's professional identity (Wyatt & Zaidi, 2022).

While much of the PIF literature concentrates on what happens in the pre-clinical (Niemi, 1997) and clinical (Cruess et al., 2016) years, our results show that students come to medical school with many of the attributes that are needed to become caring physicians. The foundation of their professional identity was already present even before they undertook their undergraduate years, which is in contrast to much of the PIF literature (M. D. Holden et al., 2015). By only considering Western notions of PIF and the role of culture (Volpe et al., 2019), researchers and medical educators are missing other conceptions of what contributes to a professional identity and the role of one's personal background, such as gender and ethnicity, the yearning to give back to their communities and the culture of exclusion (Wyatt, et al., 2021a, 2021b). Therefore, one implication arising from this study is that medical educators should get to know their students on a personal level, to nurture the values, beliefs, and practices that are already developed by their home communities. Rather than shaping medical students to be the 'right kind of doctor' (Frost & Regehr, 2013), perhaps medical educators could rethink how we socialize medical students into the medical profession and minimise aspects of the hidden curriculum that lead to dissonance, hopelessness and apathy (Doja et al., 2016; Hopkins et al., 2016; Silveira et al., 2019).

One of the most important findings in this study was that students fought for social justice, a characteristic of being a physician entrenched in the physicians' charter (Blank, 2002) as 'health' advocacy (Frank & Danoff, 2007), yet it was packaged in a different form. While much of the literature in North America talks about being an advocate at the level of the patient, in this study students were advocates for each other and an equitable training system.

Additionally, this study shows that #FeesMustFall became an important part of the hidden curriculum as participants learned things they could not have acquired in a classroom (Muxe Nkondo, 2007). Participants' political consciousness was planted and grew, including as the privileged witnessed the difficulties experienced by others during this period of social upheaval. Despite the legacy of apartheid, they fought for survival as a collective, Black, rich, and poor, and people from the top side of society understood issues experienced from the underside. The privileged stood in solidarity with those at risk of financial exclusion out of compassion for fellow human beings. Whereas apartheid prohibited different racial groups from working together, the social upheaval of #FeesMustFall brought them together. Participants still experienced tension when they had to suppress their values to win the battle and employing disrespectful tactics as a political tool; however, the values participants embodied in the calabash were embedded in the participants. These findings underscore the need to further examine acts of professional resistance in medical education and the effect it has on trainees' socialization into the profession (Ellaway & Wyatt, 2021).

There is some PIF literature within the Global North that points to the notion that sociohistorical contexts are important to the development of PIF in minoritized or previously ignored groups (Wyatt et al., 2020, 2021a, 2021b). In the American context, slavery, discrimination, and structural racism manifests in the way that PIF is expressed and develops among African Americans (Wyatt et al., 2020, 2021a, 2021b). On the other hand, the South African context brings a somewhat different context of developing PIF. Analyzing PIF as an "outsider within" (Hill Collins, 1986), as the first author has always felt in this Western-dominated space, reveals something that has not been seen in the PIF literature other than in work in the American South (Wyatt et al., 2020). In South Africa, PIF is influenced by the values of ubuntu, a history of apartheid and political strife, where space is highly guarded.

This introduces a very different sociohistorical twist, where PIF is developing within a context where one is fighting for and taking up space in order to belong and create opportunities for future generations. This is not just relevant to the Global North but relevant to everyone. This work therefore adds to the PIF literature the notion that there is a larger context to PIF, showing that everyone brings their own personal and social/cultural contexts to the professional identity development process, and events such as social upheaval can redirect the professional identity formation of medical students. While there are more women and Black medical students in the medical programs, much of the Western PIF literature in medical education remains rooted in the old dominant ideologies. Through this paper, we are bringing a different ontological perspective, when all we have is one perspective from the dominant ideological system. Members of groups from 'other' contexts—contexts other than those in which the current 'universal' definition of PIF was derived—experience a disjuncture because Western values clash with their own values. This allows us to re-imagine PIF as defined by space, time, and context, while also illuminating the limits of current conceptions that have only been acknowledged through studying dominant groups in the Global North.

Additionally, this study demonstrates that the PIF journey can be long, complex, and take unexpected turns. It starts at home for a South African child. It can be found in social upheaval—even in these moments when medical students were engaged in social upheaval and viewed as unprofessional. For these participants, fighting for social justice became a critical aspect of the identity formation process required for a physician. Their curriculum and identity formation were located in everyday life, not in a classroom or a clinical space.

We hope that our study demonstrates that medical education research and training should encourage the exploration of ways of thinking about what should be considered in

studying PIF other than those common in the Global North, and the importance of other ways of knowing, being, and doing than what has been previously considered. Medical education spaces have become global stages, and data and ideas about how best to train physicians need to be interpreted from a wide range of cultural vantage points. In this global world, the training of doctors can also occur in spaces with a culture significantly different from that in which they were raised and socialized. As such, how then do we best support all physicians' professional identity formation without erasing the richness and value of the varied culturally bound identities our learners bring with them to their training?

As this study shows, voices from outside North America, especially Africa, are not seen nor heard. Potential obstacles may include Africans experiencing silencing and bias in the publishing process because the stories they tell from this part of the world do not confirm to what has been established and accepted by various authors. However, in telling our own stories, using our own culture and metaphors to reach others who are not from Western culture, to whom the Western notion of PIF literature is foreign, has the potential to enhance identity formation for burgeoning physicians around the world.

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Declarations

Conflict of interest This work was prepared by a military or civilian employee of the US Government as part of the individual's official duties and therefore is in the public domain. The opinions and assertions expressed herein are those of the author(s) and do not necessarily reflect the official policy or position of the Uniformed Services University or the Department of Defense.

Ethical approval The University of Witwatersrand Human Research Ethics Committee approved the study.

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CHAPTER 4 Graduate reflections on professionalism and identity: Intersections of race, gender, and activism

My second publication, **'Graduates' reflections on professionalism and identity: Intersections of race gender and activism',** published in Teaching and Learning in Medicine (Impact Factor: 2.7) narrates the stories of the five graduate participants. The article addresses the final objective of the study:

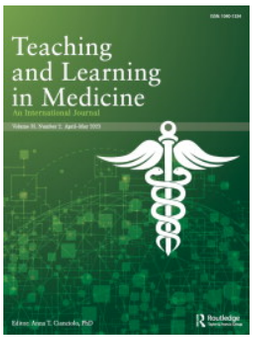
1) to explore how recent University of the Witwatersrand graduates perceive different dimensions of professionalism in the context of medical education in South Africa and their learning experience at the University of the Witwatersrand.

> Professionalism as a construct is weaponised to police and punish those who do not fit the norm of what a medical professional should look like or behave, more so when medical professionals in training engage in protests for social justice. In addition, professionalism silences trainees, forcing them not to question anything that looks or feels wrong in their eyes. Socialisation in medicine, in both the undergraduate and postgraduate training spaces, poses challenges for contemporary medical professionals who are expected to fit the shape of the 'right kind of doctor'. Intersectionality seems to impact how medical trainees experience professionalism, be it intersections of gender, race, how they dress or adorn themselves, how they carry themselves and who they identify as. Although there is literature on the challenges pertaining to professionalism, not much has been written about the weaponisation of professionalism in medical training, particularly in the South African context. There is also a paucity of data on experiences of professionalism during or after social upheaval. [9(p2)]

In this article, I explored the experiences of the professionalism of five medical trainees during protests and after protests, extending into their postgraduate training. The recent graduate participants reflect on professionalism and how their identities were being muted in the clinical space.

This article highlighted the marginalisation of those who present and appear different from the western norms of professionalism. It has brought to light the scepticism of medical educators towards individuals who do not fit the norm. I presented this paper in AMEE 2023 and it was received very well, with comments like, 'It's personal and yet general', and other positive

comments except one, were made. There was an American woman who was taken aback by how daring I was in presenting my findings. She mentioned that in her hospital they had high rates of infections and they forced everyone to cut their hair short, cut their nails, etc, and claimed that infections subsided. When I asked why she thinks that peoples' appearance bring infection into the workspace and whether they had looked for other sources of where this infection might be coming from, she said, 'It is because the epidemiologist said so.' I relay this story here to show how rigid some educators are or how the older generations are still prejudiced. It also confirms how professionalism is weaponised and that those who do not fit the norm are taboo.



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Graduates' Reflections on Professionalism and Identity: Intersections of Race, Gender, and Activism

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ABSTRACT

Phenomenon: Professionalism as a construct is weaponized to police and punish those who do not fit the norm of what a medical professional should look like or behave, more so when medical professionals in training engage in protests for social justice. In addition, professionalism silences trainees, forcing them not to question anything that looks or feels wrong in their eyes. Socialization in medicine, in both the undergraduate and postgraduate training spaces, poses challenges for contemporary medical professionals who are expected to fit the shape of the 'right kind of doctor.' Intersectionality seems to impact how medical trainees experience professionalism, be it intersections of gender, race, how they dress or adorn themselves, how they carry themselves and who they identify as. Although there is literature on the challenges pertaining to professionalism, not much has been written about the weaponization of professionalism in medical training, particularly in the South African context. There is also a paucity of data on experiences of professionalism during or after social upheaval. ***Approach***: This is part of a study that explored the experiences of professionalism of five medical trainees during protests and after protests, extending into their postgraduate training. The main study had 13 participants, eight students and five graduates, who were all interviewed in 2020, five years after the #FeesMustFall protests. For the five postgraduate participants, we looked at how gender, race, hairstyles, adornment, and protests played out in the experiences of professionalism as medical trainees at a South African university. We employed a qualitative phenomenological approach. An intersectional analytical lens was used in analyzing the transcripts of the five graduate participants. Each transcript was translated as the story of that participant. These stories were compared, looking for commonalities and differences in terms of their experiences. ***Findings***: The participants, four males (three Black and one white) and one Black female, were victimized or judged based on their activism for social justice, gender, and race. They were made to feel that having African hairstyles or piercings was not professional. ***Insights***: Society and the medical profession has a narrow view of what a doctor should look like and behave – it should not be someone who wears their hair in locks, has body piercing, or is an activist, least of all if she is a woman, as professionalism is used as a weapon against all these characteristics. Inclusivity should be the norm in medical education.

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Introduction

Professionalism is not a universal construct and varies across cultures.[1] However, regardless of cultural context, the conceptualization of the ideal doctor is based on the western view of professionalism, which excludes people who do not conform to its rigid prescriptions. An increase in literature shows that professionalism is weaponized against medical trainees and used as a means to promote conformity.[2–6] The western view of the ideal doctor is reinforced through racial discrimination in medical organization's professional policies,[3] and is being weaponized against non-conforming individuals with body piercing, tattoos, or dreadlocks.[3,6,7] For example, while the medical education fraternity aspires to promote equity and academic freedom, the western notion of professionalism looks down on those who dare to be different or are different.[3] They

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experience discrimination and frequent reminders that they must be obedient to western notions of what it means to be a doctor. In an effort to continue to catalogue and illustrate the challenges trainees face, this study narrates the stories of five participants involved in a national effort at creating social change in South Africa (SA). These five graduates were part of a sample of thirteen participants involved in this effort and were chosen because their stories illustrate how race and gender play out in medical education as well as the importance of context, geographical and cultural considerations in the conceptualization of professionalism.[1]

Professionalism

The concept of professionalism remains ill-defined in the published literature. Ong et al.[8] found 58 definitions of professionalism within 162 articles on the topic. Despite its widespread use, there is no universal agreement about what professionalism means, but most scholars agree that it encompasses humanism, altruism, excellence, and accountability, with a strong foundation of clinical competence, communication skills, ethics and legal understanding.[7,9,10] Professionalism is frequently found evident in various characteristics, including virtues, aspirations, and humanistic actions, or within a set of skills that could be assessed to demonstrate competence or a process of identity formation in a particular community of practice.[1,11]

How professionalism develops in individuals is also a contested topic, evidenced in the multiple theories describing the way it develops. Development includes literature from value-ethics and morality, professional identity formation, and sociological theory.[1,11] In each case, these theories focus on the professional and their relationship to patients. Rarely, if ever, do these theories include influences from the communities from which the patient comes or their cultural background.[12] However, the development of professionalism may be influenced by interconnected factors, such as race, gender, and social class, which may lead to diverse processes of development and identity formation.[10,13] Research indicates nurturing professionalism in young professionals is likely dependent on employing a culturally appropriate foundation, an aspect that has not received a lot of attention.[8] For example, Ong et al (2020), define professionalism as 'an evolving, socio-culturally informed, multidimensional construct',[8(p.636)] which positions intersectionality as an important aspect of professionalism and professional identity formation. This is in contrast to the western definition of professionalism, which focuses primacy on patient welfare and autonomy. Such definitions place patients' interests above those of the physician. It refers to social justice, but fails to consider the intersection of cultural and contextual issues in the development of professionalism.[14] Such intersections and dimensions of professionalism may be particularly important in the context of SA, given the history of discrimination based on race, as well as other cultural dimensions, such as the expectation that women should be subservient to men. More to the point, professionalism in SA may be affected by larger socio-historical contexts, such as the legacy of apartheid and its aftermath.[1]

The evolution of South African society has been heavily influenced by the inequity put in place by apartheid. It is continuing to transform itself into a greater axis of a democracy where equal opportunities exist for all members of society, but, with an entrenched system of inequity, it is not there yet. Modiri argues that there are multiple complex inequalities with ripple effects that are still felt and perceived 20 years post-apartheid, strongly supporting the notion that 'critical race theory still matters in examining SA'.[15(p.410)] Even in the post-apartheid period, there are still structural (the intersection of unequal social groups) and political (intersection of political agendas and projects) aspects that influence the oppression of some individuals. Modiri[15] and Crenshaw,[16,17] noted how intersectional forces can have negative implications for higher education. Intersectionality, first coined by Crenshaw,[16,17] describes the complex, cumulative way in which the effects of multiple forms of discrimination (sexism, racism, and classism) combine, overlap, or intersect in the experiences of marginalized individuals or groups. The construct intersectionality has come to mean ways in which multiple identities intersect and interact with each other.[16] It is about the interlocking systems of oppression that act on someone to mitigate or enhance their oppression.[16] Intersectionality refers to different axes of oppression that act on the personal, social, the institutional and the structural, and which might affect the individual negatively or positively.[16] As a construct, intersectionality recognizes the importance of multidimensional facets of identity encompassing cultural, historical, and structural factors.[18] One aspect of resistance to apartheid was the SA student protests in 2015-2016 under the Twitter handle #FeesMustFall movement.

In October 2015, the Fees Must Fall protests, using the Twitter handle #FeesMustFall, spread through the institutions of higher learning as students fought for a reduction in tuition fees, among other social issues. Some of these issues included decolonization,

transformation, and the insourcing of workers, as the current government promised free education for all when it was put into power in 1994.[19,20] The aim for #FeesMustFall was to make "quality education affordable and accessible to poor Black students"[20 (p.xii-xiii)] and "remains a watershed in SA higher education" to this day.[21 (p.6)] Intersections played a major role in how students experienced #FeesMustFall protests. Being queer, a woman, or Black led to different experiences in these protests, namely marginalization. White students initially did not understand or endorse the protests, whereas, for Black students, the protests ignited the pain of being overlooked by a government that promised free education.[21] These type of protests, in which social media is used to promote their case, has become a global phenomenon, even evidenced in the US during unrest emanating from inequities affecting people on the margins of society.[18] It is crucial for medical educators to understand how interlocking identities impact trainees' individual experiences.[18] The South African experience of the interlocking nature of oppression is enhanced by the country's history of segregation based on color and race, including discrimination based on gender.[22]

The South African historical perspective in medical education

A former white institution in SA, in reflecting on its role during apartheid, conducted a study exploring the experiences of Black alumni trained from 1945–1994.[23] The themes identified manifested in three ways, discrimination and its impact on medical training, perceived attitudes of white staff and students, and Black students' resistance to discrimination.[23] Before 1985, this institution required Black students to sign a document stating that their clinical training was not guaranteed and that they should "agree to excuse themselves from any class, clinic or demonstration where a white patient (or even dead body) was present', making Black students 'agents of their own exclusion".[23(p575)] According to the participants in this study, white academic staff were silent when they could have done more.[23] It is important to add that, despite possible punishment, these Black students resisted by entering into spaces from which they were banned.[23] These findings were similar to findings from another former white university.[24] Though established as the Black section for medical training in 1951, the Durban Medical School perpetuated apartheid's racism and discrimination in academic teaching.[25] Given the history of SA, critical lenses, including feminist and critical race theory, the latter nuanced to fit post-apartheid SA, as argued by Modiri[15], are crucial in analyzing matters of socialization in different situations in SA. [22,26] Therefore, using critical theory, particularly lenses focusing on race and feminism, may reveal or illuminate a completely different definition of what professionalism is, leading to a different socialization into the professional identity formation process. This study explores graduates' experiences of professionalism during the #FeesMustFall protests, the post-protest period, and experiences during their postgraduate training. We chose postgraduate trainees (interns or residents) because they have experiences of socialization as medical students and experiences as postgraduate trainees who are being incorporated into the community of practice. The authorial team is centering the first author's (MM) voice, by using "I, me, and my" and the use of "we or our" denotes the authorial team's voice.

Methods

This qualitative study explored students' lived experiences of medical training between 2015 and 2020,[21] and was located at the University of the Witwatersrand, SA. We used an interpretive phenomenological enquiry to understand the meaning of students' encounters in a clinical space, rather than a descriptive phenomenological approach which requires bracketing.[27–30] Participants and I (MM) co-created the initial interpretations, followed by an additional interpretation by the authorial team (LG, AG, and AK).[21]

A purposive sample was drawn from senior clinical (final year) students and recent graduates (called interns in SA or residents in USA), followed by a snowballing sampling technique. The participants had been in their first to fourth (MBBCh 1-4) years of the medical program during the #FeesMustFall 2015/2016 protests.[21]

Thirteen semi-structured interviews were conducted in 2020, of which five were recent graduates and eight were students in their final year. This paper will concentrate on the five recent graduate participants (Table 1). I (MM) chose the five recent graduates because their experiences as pre-clinical undergraduates during #FeesMustFall, students in their clinical years and interns (residents) would provide a robust picture of their experiences across their medical training. I asked participants to reflect on their experiences in the medical program and work experience during their internship. An interview guide allowed me to probe their experiences of professionalism and how #FeesMustFall protests impacted their professional identity development.

Table 1. Summary of participants.

Participant's pseudonym	Pseudonym origin	Title of participant's story
Zwonaka	Traditional African 'Beautiful'	Black woman with dreadlocks and a nose ring
Peter	Biblical 'The Rock'	White, progressive man with an unconventional hairstyle
Asinamali	SA historic protest name. 'We don't have money'	Black man from the missing middle during #FeesMustFall
Nyakallo	Traditional African 'Believes in dressing professionally'	Black man, an activist and a mentor who believes in dressing the part
Moitseki	Traditional African 'Activist'	Black man, an activist with an African hairstyle

Positionality

Intersections of race, gender, and disability played out in my (MM) career as a doctor in various forms. First, in an ageist, gender-based way. For example, during postgraduate training in a consulting room, a question would be asked, 'Nurse, where is the doctor; is he still coming?' Second, in a racist way, when an Afrikaner man wearing a safari suit (a matching jacket and trousers originally worn on safaris in the African bush, but commonly worn by Afrikaner men in the 1970s and 1980s),[31] long socks, with a gun in his sock, refused to allow me to treat his comatose teenage son. Eighteen years after practicing as a pediatrician, I went into full-time teaching as an academic at the University of the Witwatersrand, my alma mater, the medical school where I trained as an undergraduate. Nearly several decades later, I still had to navigate through discrimination and sometimes heavy-handed power dynamics. Through these intersections, being a woman who is Black with a different ability, I learnt to embrace everyone I met.

Two members of the authorial team (AG and LGT) are colored (of mixed race) [2] South Africans, non-physician, and physician faculty members, respectively, of my generation. The other two members of the authorial team (AK and TW) are North American collaborators, whose role is to position my South African work in the international literature by suggesting non-South African ways of looking at the data for positioning in the international context.

Analysis

This is my analysis with the support of the authorial team. I (MM) tried to relay the participants' stories as they experienced them, rather than interpreting them through a particular lens. Although the analysis could have examined these students' stories through multiple layers of oppression including individual, social, structural, and institutional, the focus of this paper is on the experiences of these recent graduates based on different intersections of their identities, not necessarily on different layers of power. I chose this form of analysis because I believe that the layers of power they experienced are already intertwined in the institutional, structural, and sociohistorical aspects of their identities. I looked for content in the participants' experiences that speaks to transgressions of professionalism as they might be viewed by the medical education fraternity. These transgressions might be in the form of appearance that is likely not deemed appropriate by the profession. I also looked for instances where their identities might be muted in some way, where they may be silenced because of their gender, color, activism, or lack of funding.

I regarded the interview transcripts for each of the five participants as narratives of the participants' personal stories.[32,33] After reading each story and distilling the main elements, then using intersectionality as an analytical lens, I compared the stories with each other through constant comparative analysis. I chose an intersectional lens to see how race and other multiple identities of these participants intersected.[16] I read each story several times and then the meaning of each sentence or paragraph was analyzed looking for transgressions or participants feeling of being muted. Intersectionality-informed analysis allowed me to perceive how the multiple socially constructed identities interrelate.[3] The SA sociohistorical context feeds into how their experiences played out because of the legacy of apartheid that is intertwined in SA society.[21] I tried to understand how participants resisted hegemonic norms of professionalism that may be unique to SA, the tension they encountered in their training and the intersections with power, especially discrimination based on race and gender.[34,35] To engage in member checking, I sent each of the five participants their relevant part of the article and asked them to comment on whether their story was accurately portrayed. I then incorporated their feedback into their story in the article. I told each of the five stories appropriately, interspersing quotes from the participant's transcript to highlight the findings.

I (MM) used pseudonyms to avoid making participants identifiable. Each pseudonym was part of the analysis in that the names that I chose were part of my analytical process. Reading these stories took me through a journey of the SA history of protests that included theater, music, dance, poetry, literature, and how people adorned themselves. I personally wore dreadlocks as a budding neonatologist as a form of defiance (transgression) against the prevailing notions

of professionalism. I waited until I qualified as a pediatrician before I wore my hair in locks as I feared being victimized (being muted). This defiance opened a door for younger doctors and nurses in our unit and the rest of the hospital to wear their hair in this way. The stories of these participants took me back to instances when I felt excluded either as a woman with a different ability or being Black. For these participants, I chose mainly cultural names that may not necessarily be obvious to the global reader but are an essential part of their story. The South African reader will understand these pseudonyms, but I will expand on them in the discussion for the Western or Northern Global reader. The study was approved by the University of Witwatersrand Human Research Ethics Committee (HREC Medical) (Clearance Certificate Number: M180864).

Findings

In these transcripts I saw professionalism issues relating to appearance, including references to how an ideal doctor should look. This led to participants being judged for appearing different from the norm, such as wearing unconventional hairstyles. It was not only the participants that were on the receiving end of doctors' prejudice but patients who looked different from the medical professionals or those who could not express themselves in the Queen's language, i.e., English. I also saw the participants' identities muted in several ways, such as not being allowed to embrace their activism, being accepted with what they bring, i.e., their 'African-ness' into the training spaces or being muted because they were forced to leave the university during the #FeesMustFall protests.

Participants described experiencing higher education as an alienating space, particularly the institutions at which their training took place. They found their training environments oppressive, and rife with widespread discrimination based on both race and gender. Below are the participants' stories and the ways their experiences intersected with professionalism. The stories include quotes (in quotation marks if less than 40 words) from their transcripts.

Zwonaka, a Black woman with dreadlocks and a nose ring

Zwonaka's parents decided she should study medicine, and she was content with this decision because she wanted to help people. However, two of her family members had studied at her alma mater before her, and they had found it extremely racist. She was reminded of this when she saw students who were activists during the Fees Must Fall protests being victimized. She recalled a Black registrar in training saying to her,

> I hope you're not a Fees Must Fall person. I just hope you don't have that attitude, and if you do, don't put it on Twitter, don't even go liking those pages. Keep it in your house because you will not progress.

She knew during #FeesMustFall, if one is at the forefront of the protests, medical educators in the clinical space will "chop off your head". As such, on all her rotations, Black registrars in training would warn her "not to be a difficult person" if she wanted to succeed in the program. She was always alerted about the underlying racism in some rotations: "These people grew up in a certain world, they can't see the world for what it really is. They only see the world for what they've grown up to believe it is." For Zwonaka, being Black and a woman brought a great deal of heaviness, which was an "unnecessary invisible load" to carry. She alluded to the fact that racism was overt during apartheid and her experiences resonated with the feeling that post-1994, the "invisibleness cuts deeper and you have to deal with it in an invisible way".[21(p.3)] Victimization of friends who were speaking out against "the hierarchy and racism in medicine" made her question her chosen profession, which she felt is "meant to heal" but does the opposite.

During her internship, she saw whiteness and being male as privilege and entitlement, as one of her peers was getting away with unprofessional behavior. According to Zwonaka, white interns were "given the benefit of the doubt but interns of other races were not afforded the same treatment." She perceived failing to fail as a western notion of professionalism where students, especially white ones, are allowed to proceed despite unprofessional behavior, leading to communities facing the consequences of the students' failure to fail.

Zwonaka believed she experiences different challenges being a woman and Black in medicine. In her case, she was policed about her hairstyle, dreadlocks, and body piercings. She was told by someone above her that "it [was] interfering with my beauty, the nose ring specifically." She experienced not only being judged by the medical team, but by the nursing staff as well, who told Zwonaka to change her looks to find a husband, "this consultant doesn't have a wife, now he's not going to think of you as an option because of this nose ring." The nurses asked her, "why do [you] have dreads, why don't [you] have a weave?" Medicine left her feeling that a woman is of no value without a man by her side and that it was impossible

for her to have one given the ways she chose to present herself, yet she was determined not to succumb to these pressures.

Zwonaka witnessed doctors "shouting at people because they don't know English properly", doctors who did not "greet patients", which was against what they were taught as medical students. She regarded the western notion of professionalism as "barbaric, because people aren't people, they are just numbers." She said this notion "doesn't see context", "doesn't understand where this [patient] is going back to". Zwonaka posited "that Western medicine thing is Sandton-based,[3] they don't understand the people they are treating." In clinics, doctors were ignoring patients' backgrounds and were only concerned about pushing the queue to finish seeing many patients on time. She would, therefore, be scolded for taking too long when seeing a patient, which created a great deal of dissonance for her, as she felt that what she was doing for the patient was not being valued by the senior doctors. Professionalism involves a patient feeling positive post-consultation, that their questions have been answered and that the doctor listened to and heard them. "How one treats patients and everyone around them says a lot about their professionalism."

Zwonaka witnessed widespread bullying, with colleagues and friends being plunged into depression and routinely using antidepressants. Unchecked power trickled down from the most senior academic to the physician-in-training, with the most junior doctors on the receiving end. This bullying was traversing color lines and genders, as she had been on the receiving end from both white and Black women, as well as men. She said that reporting bullying was of no use, as the system would believe the perpetrator who might be a renowned clinician or researcher. What was evident to her is that what was taught in medical school was not apparent in her workspace. She was determined to create a safe space for those that came after her, to be a person they could consult regarding any issues they might have in clinical spaces.

Peter, a white, progressive man with an unconventional hairstyle

Peter experienced growth and a multitude of emotions, which included severe pain, during the #FeesMustFall protests in 2015. To him, it was an "emotional roller-coaster". For the first time Peter realized what some of his Black friends and classmates were going through when facing financial exclusion from the university. Although he had immersed himself in the #FeesMustFall movement, he felt he remained "an onlooker", which he described in the following way: "No matter how much I got involved in the protest, the more and more I realized that I was just on the side-lines, that I wasn't a student who was deeply affected by it." It was during this period that he "grappled with issues of race like I've [he's] never done before." From a position of privilege, he was tormented by "how institutions treat poor people, institutions treat Black people, how government treats Black people and poor people."

Peter felt that the institution, his alma mater, was "oppressive and is out to get people" and he was concerned about those who had less means than he. According to Peter, there were individuals who were trying to make things better for the students, but their efforts were thwarted. To Peter, the institution did not care about poor and Black students. Peter said that, during #FeesMustFall, "Professionalism wasn't modelled from [sic] the institution or the people that were meant to." The student leadership had to busy itself with raising funds for students who were not allowed to register unless they paid some of their debt. This reminded Peter of his friend who was self-funding and had to work during weekends to cover his living expenses and tuition fees. This left Peter gutted to the core. According to him, "racism, the sexism that students experience on a day-to-day basis, on every single ward round and every single tutorial, you know, it was palpable."

Peter recalled that in one of the ward rounds he had an argument with a white physician. This argument started when the physician implied that other physicians had a problem with his hairstyle. This conversation turned into a discussion of #FeesMustFall, where a Black student who was active during the protests was labeled by the physician as trying to "steal [other] people's education." Peter's account indicating victimization of the #FeesMustFall activists correlates with Zwonaka's experiences. He described how a "student [activist] was victimized as somebody who was derailing the education of white students who are compliant [and] are now not having access to the education that they are paying for based on people like the student [activist]."

Peter saw Black students having to act as interpreters during ward rounds. White physicians assumed that, if the patient is Black, someone who looks like them is bound to know their language, in this case, Black medical students. He used an example involving assessment at another 'white' university in SA, describing how, during assessments, particularly practical ones, "Black students would start with a mark below zero and work their way up in contrast to white

students who start at a 100% and work their way downwards."

Peter wondered what "professionalism looks like in a South African context" and felt that "we've inherited [a] rigid set of standards from the western environment". He added that the students' response through #FeesMustFall showed "another aspect of the attitude of professionalism".

Asinamali, a Black man from the 'missing middle'[4] during #FeesMustFall

In 2015, when #FeesMusFall started, Asinamali lived off-campus due to financial constraints. He could not get funding because this was his second degree, making #FeesMustFall close to his heart. Asinamali felt rejected by the "system and government", classified as someone who is not poor enough to receive government funding but not rich enough to afford paying for a medical degree. He almost sounded relieved when the term "missing middle" came into use: "I just did not have the word for the missing middle, and I was very glad when later it started coming to the fore and I realized, oh, I was not the only one with that kind of problem."

When the institution was shut down due to the protests, Asinamali had to move back home as he was self-funding at that time. Reflecting on this period, he felt that the recently qualified medical practitioners did not display advocacy by not supporting the #FeesMustFall movement. Asinamali was expecting this group, students who had experienced similar challenges in the recent past, to show support by vocalizing their discontent. Asinamali is now focused on furthering his career in medicine. Reflecting on this, he posited that the western notion of professionalism had a poor or non-existent advocacy role, saying, "we felt unassisted by other former students," "people in the professional world, young lawyers, people who graduated as recent as the year before". He went on to say, "we didn't see other graduate doctors coming through." He posits that, "when people move to professional spaces, they behave like those whatever systems they've gotten into, as it would have them behave." He was happy that, through #FeesMustFall, the "plight of students is better understood."

Nyakallo, a Black man, an activist and a mentor who believes in dressing the part

Growing up in the township, Nyakallo, like most other children, wanted to be a teacher, a police officer, or a nurse, as was common in the townships. A general practitioner (GP) ignited the spirit of healing and leading in Nyakallo, and this GP became his role model. Nyakallo came into medicine wanting to be like that GP, but that was not long-lived. He met an astute professor during a surgical rotation who made him change his mind. This surgeon was an excellent teacher, which swayed Nyakallo into yearning to become a specialist, a surgeon.

During #FeesMustFall, Nyakallo was in the first aid team, in the frontline to assist students who were injured. However, he felt tension during the #FeesMustFall protests, when the student body instructed them that "as medical students you are assisting only students, not security police." To him, this was uncomfortable, as it ignored the values of the profession, but he had to grudgingly comply as a member of the student body. Nyakallo posited that, during the clinical years, he experienced subtle racism, where Black students were merely called as students (or just pointed at or identified by clothing items - "hey, student wearing a blue shirt, tell us the answer") despite wearing name tags, whereas white/Indian counterparts were called by their names. This prevented students from experiencing a "sense of belonging." Students felt excluded on that basis.

During clinical rotations in the fifth and final years, Nyakallo started noticing behaviors that he would not want to replicate as a doctor. He described how the unbecoming behavior of senior medical staff affected him:

> [You] go into med[ical] school with this notion of how to be a good doctor, with all the idealistic [notion of] whatever a good doctor is. And then maybe the exposure of a professor talking harshly to a registrar in our presence [or] sometimes it's directed to us, [the good doctor notion] goes away.

It was during these instances when patients, particularly elderly women patients, would call students, as Nyakallo remembers, and educate them about the principles of ubuntu. They would show them an example of an excellent doctor who embodied ubuntu, an Indian professor in internal medicine, encouraging them to "be like Prof X, [saying] this is how a doctor should behave. This doctor respected them as patients and as human beings. A "doctor who sits down with them" rather than hovering above them when discussing their treatment. A doctor who made them feel that their stories and opinions matter.

However, Nyakallo felt that the negative behaviors of people meant to be their role models became imprinted on the students. The students were imitating their medical seniors' bad behavior in their workspaces. "This doesn't just stop in medical school,"

Nyakallo said, "you start seeing it beyond medical school." He provided the following example:

> [T]hat is what I just see, it goes away to a point [at which], when you address patients now. I see it with some of my colleagues…so we are very young, you know, young and then an elderly patient comes, and I feel like we still have to address that patient as an elderly patient, you know, besides just treating whatever they have, there's that respect that one must portray.

Nyakallo was concerned about what professionalism means to the younger generation. "I'm looking at junior doctors, which is us, we are slowly losing it." It had become something to which he does not relate. Nyakallo discussed his concern about junior doctors not respecting the profession, as shown by their inappropriate dress code and improper behavior. Junior doctors are seen in the communities inebriated and they appear at work with signs of being intoxicated the night before. Nyakallo had respect for nurses and physiotherapists "because of how they conduct themselves and their dress code," which is "better than that of most doctors".

Cultural dimensions of professionalism, in the South African context, "that respect that one must portray" was critical in Nyakallo's view, to how patients are addressed or treated. To Nyakallo, respect for elders was paramount, irrespective of whether they are patients or not. Nyakallo raised concerns about young doctors who address elderly patients by their first names. This to Nyakallo was a western notion of professionalism, not an African one.

Moitseki, a Black man, an activist with an African hairstyle

Moitseki classified himself as an activist who was in the forefront during #FeesMustFall: "I felt that I was part of the action of Fees Must Fall, rather than Fees Must Fall happening in the space that I existed. "He stated that #FeesMustFall shaped his university experience until he graduated. Prior to entering university, Moitseki had never attended school with white people. Everyone at each of his schools was Black. Moitseki posits that, during #FeesMustFall, as a collective, the students achieved and experienced victories in two parts, the student's victory, and the worker's victory. He described how the students' victories were multifaceted:

> There were certain political narratives that were driven. [W]e believe that part of the victory was conscientizing the students of the issues that were there, and the race and power dynamics that existed within that space. So, the first change was the awareness that the movement brought in the student population itself, becoming aware of the power dynamics that were related to race.

Moitseki went on to say that "white students were privy to certain spaces, privy to certain privileges that we were not having precisely because of our color." He explained how the #FeesMustFall movement also conscientized white students about the body of Black students taking up space and owning alongside them:

> [B]oth parties were recognizing that we exist in a space that is competitive racially and the white students had to recognize their privilege, they had to recognize their space and the perpetuation of racial power.

Black students started fighting for space and showing that they belong in spaces where doors were previously shut for people of color. "There was a sudden change in political awareness and consciousness of self in existing within a particular space." He realized that not only race was being brought to the fore but also gender issues. LGBTQI (Lesbian, Gay, Bisexual, Queer, Questioning and Intersex) groups and women were raising their voices:

> LGBTQI groups, so they also found expression[s]. And we were conscientized, all of us were conscientized. [B]y the end of it, when [a] woman stood to speak you would understand that firstly she's a comrade, and [secondly], she's an activist at her own right, before you even look at the fact that she's a woman.

Moitseki reflected on issues that were raised about students feeling the tension of professionalism related to #FeesMustFall. He classified these issues into two groups, a protest part, and a post-protest part, depending on whether they" exhibited a particular behavior during [the] protests" and transitioned seamlessly into the clinical space.

> I could make the transition. In the hospital I was never the noisy one, I was never disruptive, I wouldn't stand up and say that, no, but Black registrars are being disrespected by consultants and so forth. Although that might have been their struggle, I understood that there I was in a professional space where I had to learn, and my responsibility was to patients, and it was a responsibility of learning. But I don't know, and I'm suspicious that, that transition might have been informed by the fear of victimization.

Moitseki went on to say that, although he became a better advocate after #FeesMustFall, he was still wise, he knew which battles to take on and which battles not to tackle. He felt that #FeesMustFall also

gave the students "good arrogance in the clinical space" where one felt that "you can't look down on me, I belong here". Moitseki said that #FeesMustFall gave them confidence that "no matter how you can look at me, I belong here" and maintains that it made them better professionals. #FeesMustFall gave them the confidence to resist things they did not like, and this carried through into their work environment.

In Moitseki's postgraduate training workspace, as an intern, more than 95% of the population was Black. The patient population was Black, and most professionals were black, with whites and Indians in the minority. To Moitseki, the positions were reversed in his workplace, where he did not have to fight for space and a sense of belonging. This contrasts with his colleague, an Indian woman, who did not feel that sense of belonging. He says that most of his Indian friends classify themselves as Black. However, in this workspace, an Indian colleague feels that she was ostracized because of her color. Moitseki went on to say that, for as long as there is structural racism, "Black people are not racist, they are still fighting for space." He believes that race, "financial muscle" and power are entwined.

He described how the issue of race invoked memories of "a young Black consultant [in the clinical rotations]", who made them feel "that we belonged in the space". There was always a sense of belonging, knowing that there was someone in a higher position who looked like them and probably knew and understood their struggles.

On issues of professionalism in his work environment, Moitseki alludes to patients, particularly African elderly ones, finding it difficult to understand the contemporary dress code and hairstyles of the younger generation of doctors. He talked about how elderly patients had mixed reactions toward him, with respect but also with reservations particularly to his African hairstyle:

> I think there's that generational gap, there's that expectation from the generation that was trained twenty years ago, [that] a medical doctor should come out like this. Should come out wearing a white coat, with a haircut, combed hair every day, and a tie. And there's this notion from myself and others that hair doesn't matter, the politics of black hair shouldn't be seen in the workspace, I shouldn't be told to cut my hair. I don't think we are unprofessional.

Discussion

In this study, I (MM) chose pseudonyms and the titles of the stories to reflect my analysis. Zwonaka means beautiful; I was highlighting the fact that, dreadlocks, nose ring and all, she is beautiful. For Peter, I chose a biblical name as his name is biblical, not necessarily implying that he is religious, but his concern for others showed deep-seated sacrifice. Asinamali means 'we have no money' in Isizulu language and was a political slogan in SA through the years of apartheid. Nyakallo, which means 'happiness' in the Sesotho language, was appropriate as he is happy to assist and mentor others, as well as strongly believing that professionals should always dress professionally. Moitseki means activist in the Sesotho language, he called himself an activist, saying that #FeesMustFall protests did not just happen in the space he was in, he was involved in instigating the protests. The participants' stories display two things, firstly, their transgressive approach to ideal professionalism, and, secondly, the muting of their identities.

These participants' perceived transgressions were committed because they chose to be their authentic selves, which was not part of the norms of medicine. They struggled because society, including the medical fraternity, has a certain image of how a doctor should look, as well as how they should behave, speak, and dress.[36] This image does not include individuals who have body piercings, tattoos or dreadlocks, as these are deemed unprofessional.[6,37–39] However, what these experiences are really akin to is discrimination, although it is couched under the concept of medical *professionalism* . By challenging these norms through African hairstyles, body piercing and speaking out against injustices, participants were subjected to being policed. As such, the concept of *professionalism* is weaponized instead of being used to affirm one's identity.[6]

Part of the problem is that current definitions of professionalism do not consider the evolving nature of this construct. The twenty first century doctor continues to be bound by definitions that were penned more than 20 years ago by mostly Western authors[7] and it is onerous for younger doctors to abide by the rules set by earlier generations.[40] Despite there being more women, people of color and people who are more open about their gender and sexuality,[41] this study shows they continue to be held to former ideas and norms around professionalism. What makes this particularly challenging is that although in North America scholars suggest that students and staff be trained on how to deal with racism,[34] in a country like SA, with a history of apartheid that continues to influence all aspects of society today, how does one challenge racism, which can be subtle and invisible, and therefore difficult to confront? How do these conversations get started to problematize these issues? We argue that it begins by medical doctors telling their stories about what it means to be a professional and where physicians

experience tension. In doing so, assumptions around professionalism can be interrogated for the ways in which they exclude some groups, while forwarding others all in the name of the profession.

While we have attempted to tell these stories here, this study is not without limitation. First, the participants largely focused on their physical presence, but there are other aspects of professionalism that might be considered in future work, such as interactions that physicians have with patients that differ from the norm, different approaches to clinical diagnosis and treatment, as well as other deeply embedded expectations for what it means to be a physician. As this is a phenomenological study, we concentrated on what participants feel is their identities and the experiences they had based on those identities.We were also limited to the number of participants in the study and the extent to which they could reflect on their experiences in ways that show how professionalism can be problematic.

Conclusion

The concept of professionalism is used to marginalize certain individuals' and groups' experiences to maintain a shared identity within the profession of medicine. However, as new kinds of trainees enter our system, especially those whose ideas and values fall outside the norm, we must reconsider these professionalism definitions to be inclusive of other ways to think about what it means to be a professional.

Disclaimer

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Notes

1. https://www.sahistory.org.za/article/history-apartheid-south-africa
2. https://www.sahistory.org.za/article/race-and-ethnicity-south-africa
3. Sandton is an affluent suburb in the north of Johannesburg.
4. Students who were categorised as missing middle were those whose families earned more than R350 000 but less than R600 000 per annum did not qualify to receive Government funding.

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CHAPTER 5 Medical students' views on what professionalism means: An Ubuntu perspective

This publication in Advances in Health Science Education addresses the second objective relating to students' perceptions of professionalism during and after the #FeesMustFall protests of 2015-2016. The article interrogated professionalism using an African lens, Ubuntu, based on what the participants expressed in the interview transcripts. It became apparent that the current western notion of professionalism lacks humanity. The participants' stories painted a picture of professionals who are dismissive, ignoring context, and lack of knowledge of where their patients come from or are going back to. This is disconnected from those they are meant to heal. From the participants' perspective professionalism should adhere to the principles and values of Ubuntu. Therefore, I grouped participants' perceptions of what professionalism means to them using Mbigi's collective finger theory of respect, dignity, solidarity, survival, and compassion. This theory provides an image of concepts of needing to work together as a collective, for example, the thumb is useless without the other fingers.

Scholars from outside the Global North have compared and contrasted the charter to their own contexts, emphasising the similarities and what is lacking. In this article, I compared the Physician's Charter to Ubuntu philosophy to add the African voice to what has already been done. I found that there are values of Ubuntu philosophy that might incorporate the three principles of the charter, as well as its commitments. However, the charter does not emphasise humanism in professionalism.

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RESEARCH

Medical students' views on what professionalism means: an Ubuntu perspective

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Abstract
Medical training has become a global phenomenon, and the Physician's Charter (PC), as a missionary document, is key to training those outside the Global North. Undergraduate and postgraduate students in the medical profession are sometimes trained in contexts foreign to their social and ontological backgrounds. This might lead to confusion and blunders, creating an impression of what might look and feel unprofessional to those unfamiliar with the local context. Understanding the cultural backgrounds of the trainees is crucial, and the reverse is also as important. It is essential for clinicians and trainees to understand the cultural backgrounds of their patients to avoid miscommunication. In this phenomenological study, we recruited participants in 2020 who were in their first to fourth year of study of medical training during the #FeesMustFall protests. We used data from this extensive study looking at students' experiences during their training amidst protest and social upheavals in a South African tertiary institution. For this paper, we examined what professionalism means to the student participants using an African Ubuntu lens. Ubuntu and the Collective Finger theory were used to investigate what professionalism means to participants. The Ubuntu philosophy was compared to the PC. In the findings, the clinical space is hierarchical, silencing and the opposite of what Ubuntu means. In comparison to the PC, respect is overarching while compassion and responsibility are the most comparable to the Charter. This study adds an African voice to the professionalism discourse while showing African elements that could be aligned to the PC to challenge the current global discourses.

Keywords Professionalism · Medical clerkship experiences · Ubuntu · Physicians Charter · South Africa

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Introduction

The Physician's Charter has been invoked as a way of globalizing professionalism; however, it has been influenced only by voices situated in the Global North and Europe (Olive & Abercrombie, 2017). In an attempt to assess its relevance elsewhere, ideas around professionalism have been examined through other cultural lenses, demonstrating the ways in which this construct is both aligned and misaligned with other cultures. These studies are important in that they show that the Physician's Charter and professionalism, more generally, is in fact culturally bound. However, until now research has yet to compare the culture of Ubuntu within South Africa with these dominant ideas surrounding professionalism. This is problematic because many Southern African physicians work and train in Europe and the Global North and bring their cultural upbringing and training with them. And research shows that there is often cultural misunderstandings around professionalism when physicians from outside of North America work in this setting (Gosselin et al., 2016).

Given that our research team has consistently heard scholars from outside Africa discussing professionalism and the Physician's Charter in their contexts, and no published literature originates from Africa or Southern Africa, our work focuses on this topic. In this study, we add to the voices outside of North America and Europe by focusing on professionalism from Southern Africa using a local, ontological perspective known as Ubuntu, the connecting thread in Southern Africa (Mokhachane et al., 2022). We are studying Ubuntu and professionalism in Southern Africa because not only is there is a paucity of data on this topic (Mokhachane et al., 2022), but it is important to understand the relevance and fit of outside constructs within local contexts.

Physician's Charter and professionalism across the globe

The Physician's Charter has three fixed fundamental principles: the primacy of patient welfare—the patient should be placed above that of the physician, autonomy—respecting patient's autonomy, and social justice—promotion of social justice in the healthcare system (Blank, 2002). The Charter also added a commitment to a set of professional responsibilities such as professional competence, honesty with patients, patient confidentiality, scientific knowledge, improving quality of care, improving access to care, a just distribution of finite resources and scientific knowledge (Blank, 2002; Blank et al., 2003). Over the years, scholars in several countries have compared what is stipulated in the Charter to their local settings and different contexts to elicit its applicability (Bano et al., 2021; Ho et al., 2016; Ibrahim et al., 2021; Jin, 2015; Nishigori et al., 2014; Van Rooyen et al., 2004; Van Rooyen & Treadwell, 2007). Some scholars have contrasted the Western notion of professionalism or the Physician's Charter to other ways of knowing (Al-Eraky et al., 2014; Jotkowitz & Glick, 2005; Nishigori et al., 2014). Nishigori contrasted the Physician's Charter to Bushido (a Japanese code of conduct based on the ancient samurai warriors), while Jotkowitz compared it to the Jewish ethical perspective (Jotkowitz & Glick, 2005; Nishigori et al., 2014). Nishigori found similarities when comparing the Japanese concept of Bushido to the Physician's Charter (Nishigori et al., 2014). On the other hand, Jotkowitz mentions that the primacy of the patient in the Physician's Charter concords with Jewish tradition (Jotkowitz & Glick, 2005). However, he goes on to say that this first principle of primacy of the patient has been challenged as contradicting social justice (Jotkowitz & Glick, 2005; Reiser & Banner, 2003). Although Jin and Ho found similarities between the Physician's

Charter and the Chinese and Arabic charters, they also found differences or divergences regarding autonomy which is replaced or dominated by family-centered decision-making (Ho et al., 2016; Jin, 2015). Writing from Pakistan, Bano expressed concerns that the Physicians Charter did not consider patients' views (Bano et al., 2021). In combination, all of these studies demonstrate that although there are some similarities in the Physicians Charter and other cultural contexts, there are also differences that cannot be ignored. It is therefore pertinent for those outside the Global North interrogate this in their setting.

Other scholars, while not dealing specifically with the Physician's Charter, contrasted the Western notion of professionalism to their cultural or religious context (Al-Eraky et al., 2014; Ho et al., 2011). For example, Al-Eraky looked at the faith-rooted Arabian Four Gates model of Medical professionalism "grounded in the mind of the medical professional" (Al-Eraky et al., 2014). In the Four Gates model, the inner gate deals with the self, while the overarching gate deals with God. The second innermost gate deals with the task, and the third deals with others (Al-Eraky et al., 2014). Ho and colleagues questioned the appropriateness of the Western framework of medical professionalism and suggested that a professionalism framework should be culturally relevant to the local context (Ho et al., 2011). She explored tensions between western medicine and Taiwanese culture, identifying intercultural dilemmas where the western notion of professionalism was at odds with local values (Ho et al., 2017). The centrality of self-integrity, integrating the professional and personal roles, was the core difference between Taiwanese and Western notions of professionalism (Ho et al., 2011), with Taiwanese frameworks displaying morality and integrity as dominant features, possibly informed by Confucianism (Ho et al., 2014). In some countries, including South Africa, researchers found that students disagreed with some aspects of the Physician's Charter (Ding et al., 2018; van Rooyen, 2004; van Rooyen & Treadwell, 2007). South African students stressed the humanistic aspects of professionalism lacking in the Physician's Charter, while Chinese students endorsed the Physicians Charter (Ding et al., 2018; van Rooyen & Treadwell, 2007). These studies confirm that cultural and religious backgrounds play a role in shaping an individual's professionalism in their settings.

These contradictions are not surprising, as every culture has a different way of looking at professionalism and what it means in their cultural or religious context. (Ho et al., 2014; Nie et al., 2015; Nishigori et al., 2014). These are all based on different ontological systems, which include the European post-enlightenment antecedents of the Physicians Charter, notions from Asian countries such as China, Taiwan and Japan, ways of thinking and knowing from the Middle East, and others. However, there is extraordinarily little documentation on what professionalism means in Africa, especially Southern Africa, particularly without the overlay of European influences. Africa is a large, heterogenous continent, and conceptions of professionalism differ from region to region based on the dominant ontological system. However, in Southern Africa, Ubuntu (or its cognates in different languages) is the ontological thread that connects the vastly different cultures across the region.

Professionalism and Ubuntu

Ubuntu is an embodiment of humanism, which makes it ideal as a foundational overarching principle of professionalism from a Southern African perspective. The Ubuntu philosophy has eight overarching values that taken together guide the conduct of individuals in their interactions with others (Box 1 and Fig. 1).

Box 1 Mangaroo and Coetzee's definition of Ubuntu

"Compassion (humaneness, human rights, humanity, spontaneity friendliness and helpfulness); **forgiveness** (understanding and consideration); **responsibility** (respect, obedience, giving unconditionally and sharing); **honesty** (good vs. bad and open-handedness; **self-control** (order, dignity, informality, redistribution and spirituality); **caring** (sympathy, appreciation and empathy); **love** (kindness, charity, tolerance and peace; and **perseverance** (strength, commitment and cohesion)." (Mangaroo-Pillay & Coetzee, 2022) (Fig. 1)

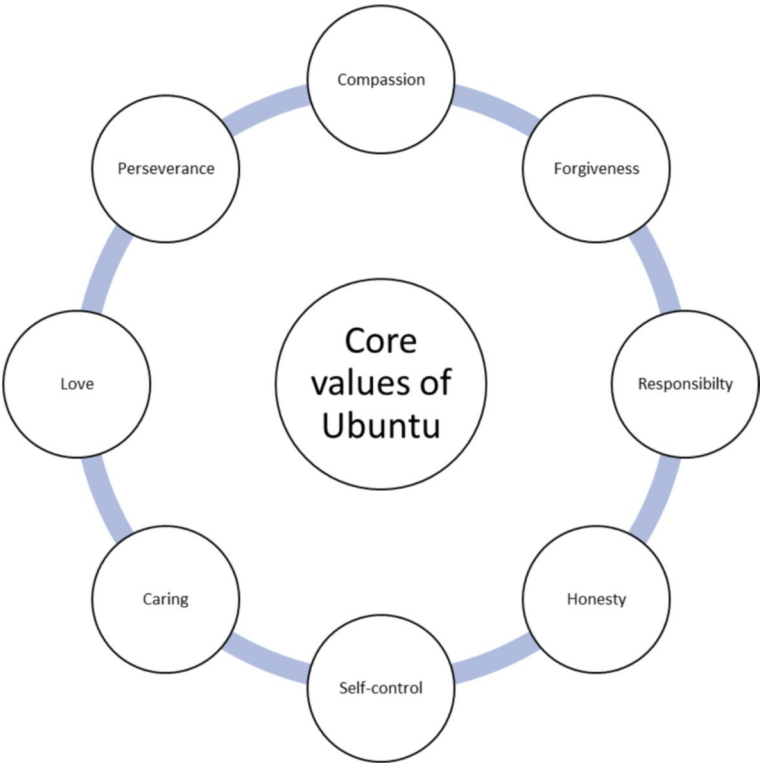

Fig. 1 Eight principles of Ubuntu (Mangaroo-Pillay & Coetzee, 2022)

Ubuntu philosophy uses metaphors instead of theories, for example, the hand in Mbigi's Collective Finger Theory (Barac et al., 2021; Letseka, 2013; Ngubane & Makua, 2021). A thumb, although extraordinarily strong, is rendered useless without the rest of the fingers. As a collective, the fingers can form a fist that is hard to break. Mbigi developed five principles, one for each finger: solidarity/collectiveness, survival, compassion, respect and dignity to represent strength in unity and working together (Mbigi & Maree, 2005). Ubuntu embraces collectiveness and denounces the individualism celebrated by Western cultures; it could unite students and professionals from diverse cultural backgrounds and promote trustworthiness in the profession. If added to the professionalism discourse, Ubuntu might enrich the discourse resulting in other cultures recognizing and understanding what professionalism means for the Southern African-trained medical professionals. In this paper, we used various sources, including the Oxford and Merriam-Webster Dictionaries and Ubuntu

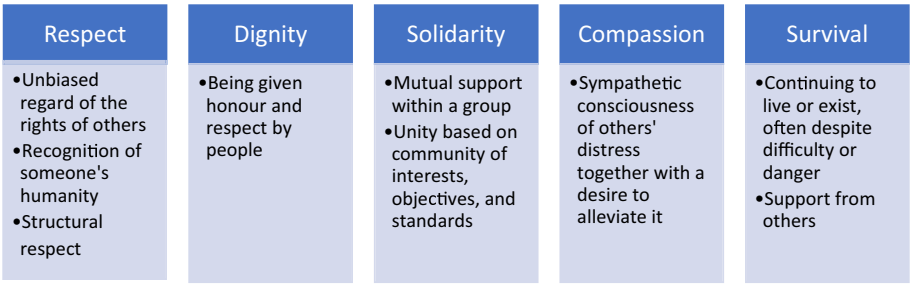

Fig. 2 The definitions of respect, dignity, solidarity, compassion, and survival were used in the analysis section

literature to define the five values included in Mbigi's metaphor (Letseka, 2012; Mangaliso, 2001; Mbigi & Maree, 2005; Molose et al., 2018) (Fig. 2).

Research question

Guiding this study was the following research question, "*What are South African students' experiences of professionalism during their journey towards becoming doctors and what does professionalism mean to them?"* This paper is written by the first author with input from the authorial team. Where the writing pertains to the first author's voice, whose ontology is Ubuntu, the pronouns 'I/me/my denotes her voice and experiences, in contrast, the pronouns 'we/us/our' denotes the voice of the full authorial team. We switch back and forth between voices to denote personal experiences from those of interpretation.

Methodology and methods

Using students' experiences in their clinical environment, my analysis, with the input of the authorial team, focuses on the relationship between Ubuntu and professionalism in the Southern African context. This study takes place within a broader study exploring medical students' lived experiences during medical training between 2015 and 2020 at the University of the Witwatersrand in Johannesburg, South Africa (Mokhachane et al., 2022).

Regarding the three papers, the aim of the first paper was to describe and analyse the medical students' and recent graduates' worldviews and experiences centred around #FeesMustFall protests. (Mokhachane et al., 2022) The second paper was to explore graduates' reflections and experiences of professionalism during three periods, i.e., during the fees must fall protests, the post-protests period and during their postgraduate training. (Mokhachane et al., 2023) The current analysis is to examine these SA students' experiences of professionalism and what this construct means to them. In this paper, we aimed to go further in depth examine students' experiences of professionalism and what it means to them. For this study, we selected eight students. Two previous articles used this same data set to explore their professional identity formation amidst protests and social upheaval, as well as the learners' reflections on professionalism. In each of these articles, the thread of Ubuntu ran through them, (Mokhachane et al., 2022, 2023), and therefore this article focuses on this construct specifically.

Methodology

The intention of this study was to understand the meaning of students' encounters in the clinical space, so an interpretive phenomenological enquiry (Shaw & Anderson, 2021) was applied rather than a descriptive phenomenological approach (Mokhachane et al., 2022; Reiners, 2012).

Sampling

Participants were all recruited in 2020 with students sampled from the final year class, while graduates were already working in various hospitals. These students were former leaders which I have interacted with in my role as a coordinator in the university but whom I was no longer supervising. Most of the participants were either in student leadership during the Fees Must Fall protests or activists. We chose the eight students because they specifically reflected on professionalism as a construct in the interviews. Choosing them for this paper was a way of finding out whether their differences impacted their experience of professionalism. Sample size was informed by information power (Malterud et al., 2016).

Data collection

Semi-structured interviews were conducted with eight students in 2020 on their experiences in their medical training program (Table 1). We used an interview guide to probe the following areas: the journey to becoming a doctor, experiences of professionalism, and how #FeesMustFall protests impacted professional identity development (Mokhachane et al., 2022, 2023). The student participants comprised four women, one white and three black, and four men, two white and two black. The extracts from the participants' comments are identified using BF for black female, BM for black male, WF for white female and WM for white male (Table 1). Three interviews were conducted in person, and five were mediated by an electronic platform, Microsoft Teams, due to pandemic lockdown restrictions.

Data analysis

The interviews were transcribed verbatim and analyzed in MAXQDA 2020. Each transcript was analyzed as an individual case for the essence of its meaning and how participants'

Table 1 Summary of participants

Students at the time of study	Demography
S1BF	Black South African female
S2GWM (graduate entry)	White South African male
S3GWF (graduate entry)	White South African female
S4BM	Black African male
S5BF	Black South African female
S6WM	White South African male
S7BM	Black South African male
S8BF	Black South African female

experiences described influenced their being and becoming using an inductive approach (Matua & Van Der Wal, 2015; Reiners, 2012). Coding was conducted line by line or at the paragraph level (Azungah, 2018) to identify natural meaning units. Codes were grouped into categories and then into themes. The transcripts were read and coded by all team members to create a common codebook. Each interview was then profiled (the essence of each interview/case was discussed and described by the first author and further discussed and confirmed by the co-authors) and then compared for similarities and uniqueness. In-case and cross-case analyzes were applied, and 'thematic connections' were made across cases (Bazeley, 2009; Mokhachane et al., 2022; Wojnar & Swanson, 2007).

I (MM) did not impose an external theory or Ubuntu as a construct onto the data. This is because Ubuntu is the ontology through which the participants and I see the world, and in this study, I am making this visible to the reader. I did not use an a priori framework to apply to the data, but the students brought up Ubuntu, and I was able to see it because I knew how to recognize it in others' words and experiences. As the primary author, I employed Ubuntu philosophy as an analytical lens concentrating on its eight core values and Mbigi's metaphor, as mentioned in Figs. 1 and 2 (Mangaroo-Pillay & Coetzee, 2022; Mbigi & Maree, 2005). A deductive analysis then followed this using the framework in Fig. 2. For example, "I always give deference to those who are older" was a quote from one of the participants, which using the Ubuntu framework was coded as *respect*. This excerpt was coded as *respect* because, in South African culture, individuals are expected to obey elders, even if they are only a day older. The final level of analysis included grouping the participants' perceptions of professionalism using the hand metaphor and then the eight values of Ubuntu were compared to definitions of professionalism outlined in the Physician's Charter (Table 2).

Positionality

I (MM) was trained in a white institution with a Western notion of professionalism, which sometimes conflicted with the Ubuntu values of my upbringing. The rest of the authorial team are educators, researchers, and administrators who work in the health professions education and have many international collaborations with individuals from different cultural backgrounds.

Trustworthiness

To verify the trustworthiness of findings, when writing the graduates paper, the primary author asked participants to comment on the paper before submission, to ascertain whether they agree with the narration of their stories. However, this was not possible with the students as they had already left the institution by the time the transcriptions and the papers were written.

Ethics

The study was approved by the University of Witwatersrand Human Research Ethics Committee on the 26th November 2019. (Clearance Certificate Number: M180864).

Findings

The results show that Ubuntu undergirds these eight South African medical students' understanding of what it means to be a professional and how to enact professionalism in this context. To demonstrate the ways in which Ubuntu guides their understanding, we have organized the findings in the following ways. First, the participants' experiences of professionalism and being socialized into being a physician using a narrative style and illustrated with quotes. Second, we use of Mbigi's Collective Fingers Theory values, (Mbigi & Maree, 2005) namely respect, dignity, solidarity, compassion, and survival, as a means to present the data on what professionalism means to participants. (Mbigi & Maree, 2005) Examples from the data or quotes are included for clarity. This is followed by a diagram summarizing the second section, i.e., the participants' experience of what professionalism meant to them, further categorized based on Mbigi's Collective Fingers Theory (Fig. 3). Finally, Ubuntu was compared to the Physician's Charter using the eight principles of Ubuntu (Table 2).

Medical clerkship experiences

Participants found the clinical space hierarchical. The power dynamics silenced them to the extent of being unable to speak up on behalf of patients, where they observed unprofessional behavior from the clinicians they worked with. They were silenced in the name of "being professional" (S8BF) for "fear of victimization" (S8BF) and professionalism as a construct was used to override what matters. Participants witnessed some of their peers "adopting the hierarchical behavior" (S2GWM), which they found challenging, as this participant described,

> *Medical profession is so hierarchical, and it is sickening to the stomach how hierarchical it is; I have experienced the most horrific…or witnessed, not personally experienced, the horrific, horrific hierarchical [behaviors] in medicine that are just so deeply ingrained that you can't even say anything in certain areas. And just based on that one thing, your own view of professionalism can be shifted so much, you know, because when your future is [at] stake, for example, your seniors are the ones who are marking you and giving you your results and everything, you know you feel as though you just need to slot in, you just need to keep quiet, and you just need to get through until you are at a point in your life where you can start deciding what is professionalism and what is not* (S2GWM).

The hierarchy was silencing because participants feared victimization. It also led to a hidden curriculum breeding hierarchical behavior in the next generation of practitioners.

The participants insist that the current notion of professionalism "is old fashioned, generational" (S8BF), "judgmental" (S8BF; S7BM) and that it "ignores context" (S8BF). They spoke of the discrimination they faced in the clinical space, which included racism, structural racism, and favoritism (S4BM; S5BF; S7BM; S8BF), and those in positions of authority over them were dismissive of those who did not fit the norm, "[I was] frowned upon for speaking up and having tattoos" (S8BF).

According to participants, patients were on the receiving end of overworked clinicians and doctors' unprofessional behavior. "Rape victims were negatively judged" (S7BM), "doctors being dismissive of patients" (S7BM), and "clinicians not following sterile precautions when performing procedures" (S2GWM). In multiple departments, patients were

not treated with respect, and sometimes students felt as though patients were being sexually molested right in front of them judging by the clinician's actions and what they said, for example, a male student saying:

> *You know, it's really sort of heart-breaking sometimes to see what some of the doctors do. I'll share with you a few of these things but they're quite sad and I still feel bad because I didn't say anything, but I mean, I didn't know what to do. But, for example, a doctor in [Y-department] [while conducting a vaginal examination on] a patient in front of everyone, while he's PV-ing he's saying, 'This is nice and tight,' exactly how I like it. He says that!* (S4BM).

This quote shows that the culture of medical education in South Africa does not consider Ubuntu. There were multiple examples where doctors were disinterested and disrespectful to patients and their peers. Without realizing it, doctors sent a negative hidden curriculum to the students about what it means to be a professional. Some students realized what type of doctors they did not want to be, while others adopted the behavior of the very clinicians who mistreated others.

The students raised negative and positive issues regarding their experiences of professionalism during their preclinical years, at the height of South Africa's #FeesMustFall protests and throughout their clinical years. They saw patients treated dehumanizingly by those meant to assist them with their healing process. Sometimes patients' treatment was based on judgement emanating from how they contracted their illness. For example, rape victims were made to feel as though it was their fault. Participants believed that every person has a story that needs to be heard with empathy and compassion. According to the participants, Ubuntu should be the foundation of how health professionals interact with patients, as discussed below.

In this next section, we present the participants' data according to Mbigi's Collective Fingers Theory of respect, dignity, solidarity, compassion, and survival.

Collective Fingers theory

Respect

Respect was regarded as crucial, "not necessarily how you look but being open-minded and understanding of each other" (S8BF). Respect was also regarded as "knowing that everyone in front of you is a person" (S6WM) and that "everybody has a story" (S6WM), therefore "make them feel like human [beings]" (S6WM).

> *We should treat each other with respect. We all come from different backgrounds, and we need to respect that. Respect where I come from as a Black woman; I hold myself to high standards. Respect is very important, not how you look but being open-minded and understanding of each other. Professionalism is outdated and not realistic in our setting. It is a privilege being in this profession- you hold these lives and make decisions for these lives. Be a human, not a title, not a career. It is a privilege that you are here. Put emphasis on respect, open-mindedness, and willingness to listen to other people's stories* (S8BF).

Participants felt that respect has no color, age, gender, or social class. They posit that respecting everyone, irrespective of where they come from or how they look, was embracing their humanity.

Dignity

Participants propose that informality allows being "relatable to patients" (S8BF), which affords them dignity and yet carrying "oneself professionally" (S8BF) is still attainable. Participants were adamant that every person can be afforded dignity by listening to their stories before judging or treating them.

> *The manner in which they treated patients, the manner in which they approach patients, the manner in which they…I can't say harass, but demeaned the patients, undermined them. Not really understanding the reasons why they are here, why they have their illnesses, you know…some would even judge them for, you know… gynae, for example, they'd even suspect that the patient possibly went to go do an illegal abortion when it was not even the case. So those are the things, and it imprints on us as well because some people might accept that and see like that is normal. So, then you find that this very same student who becomes a doctor treats patients like that in future* (S7BM).

Patients were not treated as humans but as lesser beings.

Solidarity

Participants felt professionalism is "speaking or standing up on behalf of others" (S3WF) as they did during the protests. To them, "standing up for what is right or wrong" (S8BM; S2WM), advocacy was intricately connected to professionalism, and it was a "human rights issue" (S8BF).

> *I think 2015 was just seeing student leadership as well as solidarity, that was the main positive, and the fact that we did get a zero percent increase, which allowed some students to come back into 2016. So, I think 2015 did have a fruitful result* (S1BF).
>
> *I'd put it as advocacy because, for me, it's like we work in such a messed-up healthcare system like it puts so much pressure on us and it overworks us because, like, we're so little compared to the population we're serving that we're not able to being the necessary or the required kind of advocates for our patients that we can be already…you know what I mean? So, like, protesting to get the government…or to get whoever to clean up their act, the CEOs of the hospitals to clean up their act so that we can do our job better and become better advocates for our patients, who are unable to be advocates for themselves* (S8BF).

Supporting each other and being advocates for both their peers and patients was important to the participants.

Compassion

Maintaining self-control, where one has "to manage [one's] anger for the sake of trying to help the patient" (S7BM), came first "no matter how angry one could be" (S7BM).

The participants perceived professionalism as "old fashioned and generational" (S8BF), while they also felt it as "silencing" (S7BM; S8BF), punitive and judgmental. They brought to the fore an example of a woman who was gang raped and managed to escape by jumping off a third floor of the building, fracturing her pelvis and legs. This "victim was judged" as if it were "her fault," and due diligence was not afforded to her by the doctors who did "not use a rape kit" for medicolegal purposes (S7BM). According to the participants, "victim blaming" was a common phenomenon. There was a time when they were left to console a patient after an encounter with a clinician.

> *And that everybody has a story, and that's something I find super interesting in life. I mean, everybody has a story from where they started, where they're now, what challenges they face, what things they overcame, what joys they've experienced in life. And it's there, it's like the only reason you can't access it is because you're not asking people or you're not showing an interest in people's lives* (S6WM).

Being cognizant that everyone has a story which might be heart-breaking, forces one to be compassionate to every person they meet, whether a patient or not. Doctors should make time to listen to patients' stories. That might unearth the kindness underneath the facade doctors put up to hide their emotions.

Survival

For these participants, survival sometimes meant keeping quiet when seeing senior doctors behaving unprofessionally, as per the example above.

> *So…ja…and there's so many instances where you see how patients are being treated, from surgery to internal medicine, the care, you know. People would just dismiss patients without actually understanding why they are here. So those are the things I saw; the professionalism there was very poor, to be honest. Because there's this hierarchy that, no, I'm the doctor, you're the patient, and therefore we cannot interact as equals and try to understand why do you have this illness. How can I help you further? I've seen many a time, many a time. Even from gynae this year even certain doctors are very problematic. But then again, we're like, you know what, we speak to certain like senior doctors, like no, we didn't like one, two, three, with this particular doctor because they treated the patient in this manner. That's how we go, but nothing could be done* (S7BM).

Survival does not always equate to speaking up and fighting, but sometimes in silence, one learns what to do or not do. They would return to the patient, comfort, and explain, clarify the situation, and answer some of their questions.

On reflecting, the participants said they had learnt what type of doctors they would like to be. For example, they would not want to be a doctor who disrespects patients and colleagues. They believed every person has a story, and they would endeavor to listen to their patients and colleagues alike. The participant's experience of what professionalism

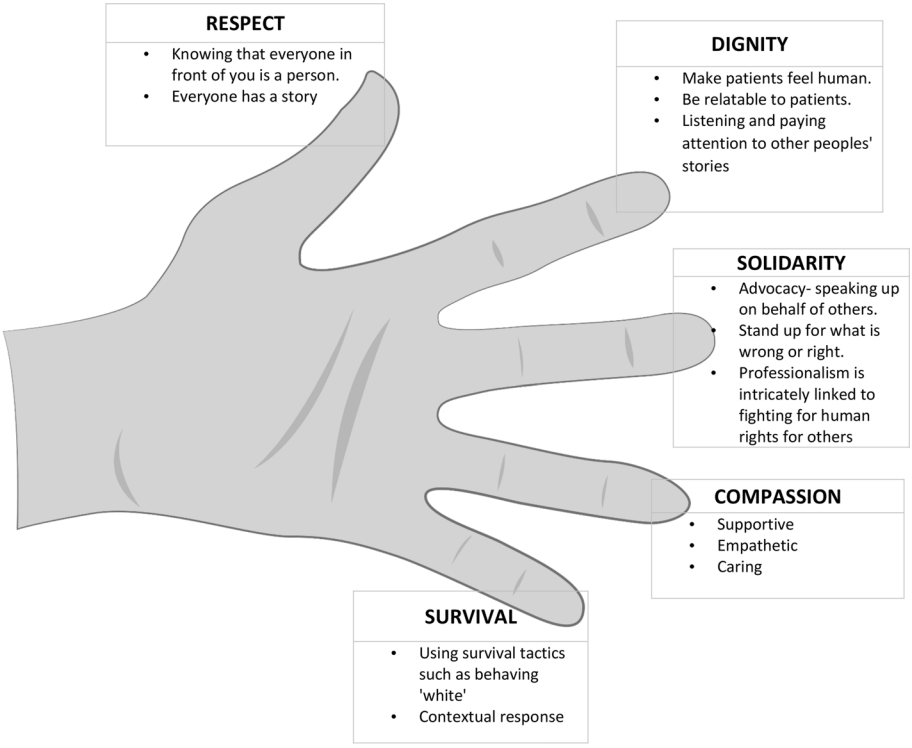

Fig. 3 Participants view on professionalism

meant to them was further categorized based on Mbigi's collective finger theory (Fig. 3).

Comparing the Physician's Charter to Ubuntu

In the table below, we compared the three principles and the ten commitments of the Physician's Charter to the eight values of Ubuntu displayed in Box 1 (Table 2). I did this because other people had tried to examine the Physicians Charter in South Africa. For example, Van Rooyen interrogated the applicability of the PC in the SA context, and her students did not entirely concur with the principles and responsibilities. They felt that the PC lacked humanistic aspects of professionalism (van Rooyen & Treadwell, 2007).

Discussion

Scholars outside the Global North (North America, Europe, and Australia) have compared the Physician's Charter with their context. Most of them compared this lofty, highly legitimate document, an encyclopedia of professionalism, with their context (Bano et al., 2021; Ho et al., 2014, 2016; Ibrahim et al., 2021; Jin, 2015; Jotkowitz & Glick, 2005; Nishigori et al., 2014; van Rooyen, 2004; van Rooyen & Treadwell, 2007). This phenomenon occurs because the Physician's Charter has become a normative document, and everyone

Table 2 Physician's charter and Ubuntu. Modified from Nishigori et al. (2014)

Physicians charter	Ubuntu (respect overarching)							
Principle	Compassion	Forgiveness	Responsibility	Honesty	Self-control	Caring	Love	Perseverance
Primacy of patient's welfare	√		√		√	√		√
Patient's autonomy	√		√					
Social justice	√		√					√
Commitment								
Professional competence	√		√					
Honesty with patients	√		√	√				
Patient's confidentiality	√		√		√			
Maintenance of appropriate relationships	√		√				√	
Improvement of quality of care	√		√					
Improvement of access to care	√		√					
A just distribution of finite resources	√		√			√		
Scientific knowledge	√		√					
Maintenance of trust by managing conflict of interest	√	√						
Professional responsibility	√		√	√	√	√	√	√

is interested in seeing how it compares to their specific context. In the published literature, it has been compared to various contexts, such as religious, cultural and Confucianism, among others (Al-Eraky et al., 2014; Ho et al., 2014; Nishigori et al., 2014).

However, when compared to Ubuntu, respect is found to be an overarching value and compassion includes all the principles and commitments stipulated in the Physician's Charter (Blank, 2002). Responsibility is the next value that aligns with all three principles and all commitments but one. The Physician's Charter's professional responsibility commitment is aligned with all the Ubuntu values except forgiveness. Other values, such as forgiveness, honesty, self-control, caring, love, and perseverance, do not feature as much as compassion and responsibility do.

As participants discussed their experiences in becoming physicians, they alluded in their stories that attending physicians did not share the characteristics that embody Ubuntu, even though they were surrounded by patients and students who were born and socialized into Ubuntu households. South African medical education training including professionalism have imported the Global Northern way of delivery, for example what professionalism is (Mokhachane et al., 2022). The difference in cultural orientations could emanate from the physicians' medical training, which may have espoused Western practices and behaviour. To these attending physicians that students referenced, some of which were Black and others white, there was only one right way of practicing medicine, namely the Western way. Hence the hierarchical, rigid, and silencing approach that lacks the humanity found in Ubuntu. I would postulate several other reasons for this behaviour. It could be the fruit of the hidden curriculum as they saw their seniors, particularly their role models, behaving that way and for them it has become the norm (Mokhachane et al., 2023). The academic public hospitals where these participants were trained are overcrowded, understaffed with an increasing lack of resources. This could also lead to burn out which might impact on how physicians interact with their patients.

This study demonstrates an Ubuntu specific way of expressing professionalism. We must therefore move away from the idea that professionalism is universally defined and instead see it as culturally and contextually bound. We urge the medical education community to look at professionalism from a specific cultural context as medical education training has become a global stage. Sensitization of international medical graduates deployed worldwide (particularly in Southern Africa) for training regarding cultural contexts is essential as their views of professionalism might conflict with an Ubuntu-infused understanding. Therefore, Western medical education or medicine globally should consider the person's cultural background, just as Ubuntu does, before passing judgement on their actions around professionalism.

In the spirit of what Nishigori started, moving away from the 'them and us' dialogue, we decided to add Ubuntu to the discussion, where the Physician's Charter was compared to Ubuntu (Table 2) (Nishigori et al., 2014). Doing this does not necessarily say they are the same, but it might confirm that context does speak to the universal Physician's Charter appropriately for the local context. There are similarities between Ubuntu and the Physicians Charter. However, the depth of humanness in Ubuntu goes beyond what is mentioned in the Charter. This is in keeping with the study conducted by Van Rooyen, where students stressed the lack of humanity in the Physicians Charter (van Rooyen, 2004). Whereas the Charter talks about 'commitments', which is an appropriate term, it has a connotation of being distant and militaristic (Blank, 2002; Blank et al., 2003). No matter how noble the idea of a universalist idea of professionalism might be, it lacks Ubuntu, that sense of humanness that says the doctor is not merely doing this as a duty, but also because they feel a sense of deep-seated caring for the humanity of someone else (Waghid & Smeyers,

2012). Talking about the language used in the Physicians' Charter matters because in the Ubuntu philosophy, words matter, and they should match the deeds portraying a sense of oneness (Masango, 2006).

In Ubuntu, the saying 'I am because we are' emphasizes the importance of community. The participants spoke about the importance of knowing the story of the person they met. This is in keeping with the African epistemology, which starts with "community and moves to the individual" (Hailey, 2008). Therefore, the doctor needs to inquire more about the person's community and how those individuals fit into that community. This was reinforced to the first author recently by people she met on her travels in the southern part of South Africa. When these people introduced themselves to her, they would mention where they came from before their names. This confirms the critical role communities play in their lives. This is in keeping with other ways of knowing and being, as displayed in Confucianism, Bushido, Arabic, Islam, and Judaism. Confucianism has a strong cultural influence and social history, highlighting the importance of context, where morality and integrity are paramount as guiding principles (Ho et al., 2014; Wong, 2020). Al-Rumayyan found commonalities between the Chinese, Japanese and Arabic cultural frameworks (Al-Rumayyan et al., 2017). As we have entered a global stage, we all need to be sensitive to others' backgrounds which might impact how they see professionalism.

This study is, however, not without limitations. Firstly, the sample was small, and it is possible that with a larger sample, the findings could have been different. Secondly, those who agreed to participate might have been people who are passionate about the well-being of others hence their alignment to Ubuntu philosophy.

In conclusion, this study adds an African voice to the professionalism discourse, while also showing that there are African elements that could be aligned to the Physician's Charter to bring about a greater sense of humanity.

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CHAPTER 6 Discussion, Conclusion and Recommendations

6.1 Introduction

This exploration of medical students' experiences of professionalism, PIF, and the impact of #FeesMustFall on their professional development contributes in several ways to the PIF literature and attainment of PIF and professionalism during a social upheaval. It shows that western theories of professional identity formation are not necessarily appropriate for certain contexts, particularly those in the Global South. It provides a unique way of being, seeing and understanding professionalism and PIF in an African context, where there is a history of social upheaval, protests, discrimination, and segregation. This study introduces metaphors in contrast to the theories emphasised in western notions of PIF. The study offers the global audience a licence to reflect on and question PIF in their individual contexts.

The chapter describes the integration of the findings from the three publications (chapters 3, 4, and 5), the synthesis of new subthemes and themes to answer the research question for the study:

'What are the University of the Witwatersrand medical students' experiences of professionalism, PIF, and what is the impact of #FeesMustFall on their professional development?'

I used meta-inferences drawn from the synthesised findings to modify my initial conceptual framework about the journey towards becoming a doctor (Chapter 1). I offer two models of Ubuntu as professionalism and Ubuntu professional identity formation (PIF) based on the synthesised findings.

6.2 Integrating the findings and synthesising new subthemes and themes

Integrating relevant findings from the three articles and developing new subthemes and themes involved multiple discussions with the supervising team who had different, yet related, conceptual understandings from the Global North and South. Combining their perspectives with mine, I was able to construct a coherent understanding of my own journey in writing this thesis, as well as the journey of my participants. We went through several iterations of synthesising subthemes and themes before reaching a consensus. Finally, I created an overarching narrative in collaboration with my research supervisors.

The first part of the integration process involved coding selected sections of each separate article, as shown in Table 6.1. Although I coded findings in all three articles, I also coded my autoethnography for the first article; I felt that it was not adequate to use only the findings from each publication because this excluded my experiences, which I regarded as data. I also coded the discussion for the second article because I had explicated the findings in the discussion, making this section relevant to answering the research question for the study.

Table 6.1 Themes from the three articles

Article	Sections coded
Rethinking professional identity formation amidst protests and social upheaval: A journey in Africa	Findings
	Autoethnographic section
Graduates' reflections on professionalism and identity: Intersections of race gender and activism	Findings and discussion
Medical students' views on what professionalism means: An Ubuntu perspective	Findings

The subthemes and themes developed from each article were combined in a joint display (see Appendix 5) and compared to synthesise new subthemes and themes representing the integrated findings. The ten synthesised themes were grouped into three overarching themes (Table 6.2).

Table 6.2 Overarching themes

Themes	Overarching themes
Racism	Sociohistorical context: the need to deconstruct professionalism
Hidden curriculum: professionalism as cover	
Hidden curriculum: professionalism as a weapon	
Tension between inherent values and reality	
Disrupting traditional constructs of professionalism	Professionalism reconstructing process
Ubuntu	
Letsema: cultivating a communal spirit of service	
Advocacy for the marginalised	
Intersections of race, gender, colour, social class, disability and identity	
Ubuntu as professionalism	Towards a humanistic culture

6.2.1 Sociohistorical context: the need to deconstruct professionalism

6.2.1.1 Racism

This lengthy section is written against the backdrop of our beloved country with its longstanding and profound racial tensions. Given our history, there is no simple way of dealing with this contentious issue. In SA, race is socially constructed, and we have lived with that construction since the days of apartheid.[161] Racism is foundational to all the walls cracking and falling in South African institutions of higher education. The participants came from backgrounds where they associated with people who looked like them and spoke the same language as them. They were used to homogeneity and being comfortable with those around them. It was on entering University that, for most, it was the first time their race became a spotlight in the environment they were in.[2] It was in these institutions that they encountered structural, cultural, agential, and relational challenges.

Race is associated with biological and physical traits which include hair texture and skin colour.[162] In South Africa, there are four socially engineered major apartheid racial groups: White, Black (African), Coloured, and Indian. During the apartheid era, Coloured, Indian and Black people were classified as non-whites, a term that made the White race superior. Racism is believing that racial differences portray an intrinsic supremacy of one race over another. It breeds discrimination and prejudice against the race judged as inferior, creating a Black/White binary.[163] There are four types of racism, i.e., internalised personal racism (includes private beliefs and biases towards those who look different from you); interpersonal racism (racism between interacting individuals); institutional racism (racial inequalities based on education, healthcare, etc); and structural racism (racism based on laws, regulations and rules that support the unfair advantage of one group over another).[164] There are other types of racism that I have not included above.

In SA, eugenics and religion played a significant role in the construction of race.[161] The story of race in SA is the product of colonialism, where settlers turned indigenous people into slaves. In the Cape in SA, social construction was embedded in the 'biological' superiority of Europeans as per Blumenbach's comparative anatomy and skull analysis.[161] Science contributed to the pervasive construction of race in SA. Afrikaner Christian Nationalism gave impetus to the racist ideology.[161] Therefore, Christianity, as a colonial tool, and colonial scientists brought the cancerous seed of racism to the African shores, a perpetual seed that continues to destroy people's lives. This cancerous mole infiltrated every sector of society,

including education. In 1994, SA 'non-whites' gained freedom from the apartheid regime.[2] In this section, I use stories that serve as exemplars of racist legacies of former White institutions of higher education.

Mr Nelson Mandela, the first Black president of South Africa, was a law student at the University of the Witwatersrand, my alma mater, from 1943 to 1949, where he experienced the rawness of racism and suffered humiliations and being called *kaffir* (a pejorative term for Black people in South Africa). He was the only African in his Bachelor of Laws (LLB) class. Ramoupi emphasises how racism at the University of the Witwatersrand delayed Mandela from obtaining his LLB degree even before the advent of apartheid, which only started in 1948.[165] He goes on to say that the claim by some of the 'liberal' White universities, the University of the Witwatersrand and the University of Cape Town (UCT), that they opposed apartheid, is not apparent in how Mandela was treated at the University of the Witwatersrand and Archie Archibald Boyce Monwabisi Mafeje at UCT.[165]

Mafeje, a South African anthropologist and activist, who acquired degrees from UCT and the University of Cambridge, became a professor at several universities in Africa, Europe, and the USA.[166] He applied for a senior lecturer post at UCT in 1968 and was appointed, which the University rescinded because the government threatened to withdraw their funding. Mafeje tried several times to return to his alma mater; in 1990 and in 1993 he applied for the AC Jordan Chair in African studies in UCT, with no success. UCT tried to make amends in 2003 by offering Mafeje an honorary doctorate and Mafeje did not respond to their communication.[167,168] The truth is Mafeje was too Black to teach in an elite SA White University and the quote below paints a picture where a former UCT Vice-Chancellor, JP Duminy, was valorising being Coloured and White as opposed to being Asian and Black. He was speaking about race relations regarding allowing other races to study in UCT. Hendricks referred to this as *paternalistic racism*:

> I see the situation between the Whites and Cape Coloured folk as one which can be brought to a happy solution. We are bound together by strong bonds of language, religion and custom and in the fields of education, economic standing and culture, the strides they have made during the last 30 years have been amazing [...] If we were the only two peoples on the racial scene, we could regard ourselves as fortunate indeed, but the picture is complicated by the presence of a substantial group of Asians and an indigenous African people that far outnumbers us.[168(p424)]

During apartheid, the so-called 'liberal' White universities were proponents of academic non-segregation but condoned social apartheid.[168] The fruit of this cancerous seed is still apparent in higher education or tertiary institutions in SA post-1994. The new government appointed in 1994 endeavoured to transform every sector of society. That transformation might have occurred to a certain extent in schools, but in reality tertiary institutions did not transform much, hence students' uprisings.[169] In these institutions, the pace of transformation was and is still very slow. Racism is still a major issue, as seen in the students' protests, such as #RhodesMustFall, #FeesMustFall, Decolonise the curriculum movement, Open Stellenbosch movement and the production and distribution of *Luister* (which means 'listen' in Afrikaans) videos, where students expressed how being marginalised led to severe pain and anger.[170] *Luister* consists of accounts of personal experiences by 32 students and a lecturer from a former White University where Afrikaans is the medium of instruction.[169,171] In this video, students mention how the colour of their skin has become a social burden and that being Black feels wrong. Being taught in Afrikaans excluded students who could not speak the language, or they dropped out of college because they were not coping with their studies.[170,171]

Institutional racism is still strikingly palpable in SA institutions of higher education. This speaks to how important space is, be it physical, mental, virtual or other forms. Experiences of transformation were highlighted in a negative light at another former White University in SA, which used English as a medium of instruction. Using the qualitative research method called photovoice, where participants interpret photographs they have taken, students exposed a lack of transformation and racialised spaces. In their institutions, Black students were being represented in disparaging ways, which impacted how they see themselves in that space. Students saw the whiteness of the institution and a lack of transformation in a 'transformed' institution. Black students were portrayed as lacking intellect and indolent.[172]

> [B]lack people are stupid or why do we actually allow them to come to University?[172] (p1886)

During #FeesMustFall, in medical school at Wits University, also a former White institution, Black students raised issues of not seeing academic staff, particularly professors, who looked like them in the learning spaces. They complained about how they do not feel represented in institutional structures and the lack of role models. Ramohai spoke about access in SA higher education for Black women academics, where social spaces are not open for Black women to

occupy. According to her, we are all focusing on access into these institutions of higher education but the critical question should be around the *quality* of access[173], which speaks to issues raised in the *Luister* videos.[162] She also talks about cultural practices and institutional structures that invalidate the presence of Black women academics and White males still dominate.[173]

Epistemic validation is also a challenging and thorny issue because knowledge from certain racial groups, particularly those in the margins, does not carry any weight.[174] Women are usually not heard in institutions of higher education and sometimes need a White man's voice as a backup to validate them.[173] There is still a bias towards Eurocentric epistemology as superior to other ways of knowing.[174] Eurocentric groups hold a dominant and privileged position in terms of their views being acknowledged and accepted compared to the marginalised groups.[174] The Eurocentric curriculum currently used in SA institutions of higher education reduces the ability to validate indigenous knowledge, more so in the former White institutions. Black students in these settings work twice as hard to prove their worth.[172,173] Participants who contributed to this thesis echoed what students from other institutions have said about experiencing racism, which is covered in a thin veil where you can see it and feel but find it very difficult to confront.[2,9] Medical students in this work resisted the hegemonic tendencies of institutions of higher education and government through protests and wearing their Africanness on a daily basis.[9] Below is a picture from a newspaper article where University of the Witwatersrand medical students were complaining about the University of the Witwatersrand medical school being racist.[175] The students were complaining about how a White student was passed when, according to the students, this particular student had failed. Historically some students boycotted the photo as a symbol of privilege, which was the case for our final-year class in 1988.



Figure 6.1 Wits students disrupt a final-year medical students class photo

[4]Photobomb: A University of the Witwatersrand class photo taking was interrupted by students protesting alleged racism in the medical school (Mail & Guardian, 1 December 2017)

Scholars around the globe have written about changing how race is portrayed in medical education. These scholars called out aversive racism in academic medicine, called out for racial justice in medical education and healthcare, as well as Black academic voices calling the medical education community to action.[176–181] Medicine and medical education, by extrapolation, are built on racism and segregation. Medicine has a sombre history from when human experimentation began, with the experiments on Jews, the Tuskegee trial, the Canadian paediatric malnutrition trial and more. In the US, Black medical schools were closed after the Flexner report of 1910.[182,183] Black students, including participants in this study, experienced major racism in the clinical space, where they had to try twice as hard compared to their White counterparts, while Kristoffersson reported the same in Sweden for minority groups.[184] The

[4] https://mg.co.za/article/2017-12-01-00-wits-med-school-hit-by-racism-claim/

overt discrimination against participants in clinical spaces may have been a result of structural racism.

Racism is regarded as a social determinant of health.[178] Student and graduate participants in this study mentioned how some of their peers ended up being severely depressed due to institutional racism.[2,9] Shim alludes to similar issues in the US, where medical students, residents and faculty encounter detrimental consequences of structural racism.[178] The medical community has played a major role in condoning the claim to use race as a proxy for pathology, thus demeaning the Black race.[179] Racism in medical education is a global pandemic, and it should be classified as such, as it might force the medical community to stand up and fight ~~it~~. It cannot just be left to Black academics, who already have to contend with the Black tax (where the Black middle class supports families financially, which might be direct or indirect);[185,186] it should be everyone's fight. Anyone who witnesses another human being racialised and ostracised and does not act or speak up is guilty of racism.

> It is not our differences that divide us. It is our inability to recognise, accept, and celebrate those differences – Audre Lorde

There is a history of racism at the University of Witwatersrand that spans decades.[165] As indicated in articles one to three, racism in medical education at the University of the Witwatersrand leads one to question whether, as a Black person, they belong in these spaces.[2,9,159] This impacts how one acquires professional identity formation (PIF). Some study participants indicated that, for one to be successful or taken seriously in the clinical space, they play White.[159] This is common during assessments, particularly oral or practical assessments because, if you 'twang,' you will be considered knowledgeable. To twang is a nasal pronunciation of words to sound White.[9,159] This is a hidden curriculum, discussed in the next section, that says to students, if you are White or speak like a White person, you are knowledgeable.

6.2.1.2 Hidden curriculum: professionalism as cover

The hidden curriculum (HC) is often not stated but refers to implicit values, norms and directives that students might embrace and adopt in preparation for their roles as doctors.[187] Students are meant to internalise values and codes which set boundaries on what is permitted in the profession.[187] The HC is a socialisation process that may be traced to sociology and education.[188] Social structures impact individual behaviour and the overt and covert subjective

meanings individuals attribute to their own and other's social actions.[188] Martimianakis et al. proposed that the HC we conceptualise is contrary to humanism and called for investigations into the value of humanism and HC.[188] In this thesis, I consider the inhumane nature of the hidden curriculum.

As mentioned earlier, socialisation occurs through legitimate peripheral practice which prepares students to become members of the CoP.[10] During this socialisation process, particularly in the clinical space, participants witnessed clinicians' unprofessional behaviour. Doctors were uninterested in and disrespectful of patients. Patients were dehumanised by professionals who were meant to heal them.[189] The dehumanisation process did not just end with patients, but spilt over to students. Patients were judged based on what illness brought them to the hospital. One example was a victim of gang rape, who escaped from the perpetrators by jumping from the third floor of a high-rise building, fracturing her pelvis. The doctors delayed examining her and ultimately when she was examined, they did not bother to use a rape kit for the examination.[9] The most troubling observation for the study participants was seeing their fellow students behaving like the doctors. They started seeing hierarchical behaviours and bullying in their peers. They posited that professionalism is generational and did not identify with attempts to maintain the status quo.[2,9] The HC portrayed by the clinicians and perceived by the students is similar to wearing a mask or cover. It is dehumanising, instead of portraying humanity and empathy and the desire to heal. One of the participants joined the medical profession because it is meant to heal but she experienced the opposite. From the participants' perspective, clinicians appear to be like wolves in a sheep's skin. In the medical profession, humanism should be their ideal goal, but the behaviour of clinicians is antithetical. How do you acquire PIF when you joined the profession for the purpose of healing others, only to find that the healers are venomous?

6.2.1.3 Hidden curriculum: professionalism as a weapon

"Professionalism is the cudgel of the status quo that is wielded selectively and subjectively".[190 (p389)] Professionalism has become a gatekeeping tool for social control and policing people, instead of a guiding tool.[190–192] Professionalism is a selective tool, used subjectively based on how the supervising professional feels. Williams and Fife put it succinctly by saying that, in this hierarchical medical profession, professionalism has become a master's sharpened weapon readily available to slice or cut to pieces those who do not 'comply'. Fife (a White man), in an article co-authored with Williams (a Black woman), posits that as a White man he has witnessed

the heavy-handed policing of professionalism on others without it being used to regulate him, while Williams felt constantly watched as a Black woman.[190] Professionalism places White norms as a reference point, excluding African hairstyles and locks; hence students sometimes act as if they are White.[191] It is for this very reason that I wore dreadlocks only after I had qualified as a specialist paediatrician: I knew that I would not progress in my field.[9] This is also true for individuals who do not fit the norm, such as members of the LGBTQI+ group, who face ongoing discrimination and microaggression and see professionalism as a weapon wielded against them.[193]

As mentioned in the previous section, professionalism was generational and has become a noose around the necks of the contemporary generation of medical professionals. The young women and men who were gracious and willing to share their experiences in this study mentioned that those in power were dismissive of individuals who do not fit the traditional notion of the right kind of doctor.[9,159] Tattoos, body piercing and dreadlocks were frowned upon and deemed unprofessional. They found the profession stifling, as those who spoke up faced punitive measures. The teachers (i.e, clinicians) muffled students' advocacy towards patients. They perceived professionalism as dictatorial and weaponised. Professionalism, employing 'white norms as referent', ignored context, culture and participants' way of being.[9,191,192]

6.2.1.4 Tension between inherent values and reality

Cultural incompatibility as a result of studying in a cultural environment that is different from your own culture creates tension.[2] Medicine is based on the global northern western White culture, which sometimes in the African sense is perceived as disrespectful. As an African, raised within Ubuntu-embracing households, I always perceived some medical norms and practices as foreign to me. I found it aloof, not connected to the people and communities being served. Doctors in their late twenties had the audacity to not only call a 70-year-old patient by their first name, but they easily call a very senior consultant by their first name. That is unheard of in an African household, particularly because respect does not just end in your household but is extended to everyone you meet.[2,144] I had thought that contemporary students whom I met when I joined academia in 2015 would be different from how I was as a student and a young medical professional, but they surprised me. The 2015 cohort of students, are called 'born frees', as they were born after SA attained freedom from the oppressive Apartheid Government.[194–196] I assumed that they would be freed from their family culture as they were born into freedom to socialise with whomever they wish, irrespective of their race.[194] These

participants proved me wrong in the interviews, as they brought up Ubuntu, directly or indirectly, as their ontological or epistemological background irrespective of their race or colour of their skin. Humanity was at the core of their being, running through their veins.[2,9,159] Rotating through the clinical space exposed these participants to the contrary, inhumane behaviour and appalling treatment directed at them, patients or junior doctors.[2,9,159]

Clinical spaces are meant to be healing but the experiences of participants have been a far cry from that. It is where the sick should be healed but participants saw many of their peers plunged into depression.[9] This increased the level of tension in them, as they had this notion that doctors are meant to be kind, patient, caring and keen to heal the vulnerable through expressing kindness, patience, care, and healing. They witnessed none of that in people who were supposed to be their role models, yet lacked Ubuntu.[9] Their inherent ontological and epistemological norms were in tension with the reality they were facing.[2,9,159] Patients were being disregarded, disrespected and mistreated in front of them, but they were silenced by the hierarchy and fear of being victimised.[9] Their values of respecting seniority were also in tension with their advocacy on behalf of patients.[2,9] They had to wrestle with advocacy and the yearning to succeed in this noble profession, as one of them was told by an attending registrar during the #FeesMustFall protests that, if she is a #FeesMustFall person, she will not progress.[9]

The participants faced incredible tension in these clinical-training spaces; speaking up was being disrespectful to your seniors while silence meant you agreed and supported how the patients, yourself or your peers were being treated. These tensions gave them sleepless nights, as some of them were on the verge of tears during interviews.[2] Despite the tension they felt, the participants found ways of resisting the dominant ways of western professionalism.[9] In settings like these, one acquires PIF differently from the norm, as you constantly have to deal with your onto-epistemological perspective and the foreign way of being and doing.[2]

6.2.2 Professionalism reconstructing process

6.2.2.1 Disrupting traditional constructs of professionalism

SA medical students, among other students, disrupted the traditional constructs of professionalism in several ways. They engaged in a revolutionary approach to fight for human rights in education,[2] fought against the outsourcing of workers[95,101,197–199] in cleaning services, a large number of whom were women, for insisting not just for transformation but for decolonisation in higher education,[197,200–203] and embracing their being and identity which is at

loggerheads with the usual norms of professionalism.[9] In addition to all that, the effective use of social media championed their cause and transformed #FeesMustFall into a vast movement that spread like wildfire.[100] Their fight was not just against institutions of higher education policy issues but they were challenging the government that has not kept its promise.[197] The students engaged in disruptive communicative strategies to be heard.[97,99]

This contemporary generation of medical students were rooted in their onto-epistemological grounding of Ubuntu.[2,9,159] They wore their African hairstyles with pride, pierced their noses to adorn themselves with rings, and had visible tattoos.[9] They were determined to be true to themselves, knowing that all these would be frowned upon in medical education and healthcare.[2,9,159] They knew that this would be regarded as a lack of professionalism in the traditional sense. However, this traditional sense of professionalism was silencing and excluding their way being.[2,9,159] The only way they knew how was to disrupt this foreign, exclusive way of being, as it felt dehumanising.[9] It was butting heads with their ontology, Ubuntu.[59] These participants raised issues about a lack of Ubuntu in the clinical space and how dehumanising those spaces are.[9,159] For them, it was difficult to develop a sense of belonging and identity formation when dehumanisation is the order of the day.[9,159]

6.2.2.2 Ubuntu

Ubuntu is an African philosophy that has had characteristic social relations in SA for ages. It is a belief system in sub-Saharan Africa where a child belongs not just to their parents but to the community.[48,204] Ubuntu is a cultural worldview, a glue that binds communities together, a view which captures what it means to be human.[48,204] Ubuntu has been found to be synergistic with theology that has a strong sense of humanism.[205,206] It is an ontological perspective that is at odds with the Cartesian western worldview and should therefore not be looked at through a western philosophical lens, but may be a useful heuristic in moderating the western gaze in professionalism.[48] Hence the participants' challenges with the western notion of professionalism and their argument that the behaviour of clinicians often lacked humanism. Ubuntu values individual identity while encouraging collective community identity. Through Ubuntu, I also have a strong connection with my community. I value my identity through the relationship and the bond I have with my community.[48] People who have Ubuntu or *botho*, in the Sesotho language, do not just greet one another, but go on tell you who they are and where they come from, while enquiring who you are and where you come from. This approach underscores the value that 'you are because of your community'. This is also true for the

African patients in that they value and trust a doctor who greets them, asks them who they are and where they come from. In the next paragraph, I reflect on my own experiences as a patient.

During this doctoral journey, I required medical attention and so became a patient several times. I offer my reflections on the personal experience of being on the other side of the provider-patient relationship. I concur with what the participants said regarding a lack of humanity and respect for patients in healthcare and medical education in our SA setting. During this period, I met several doctors trained at the University of the Witwatersrand and other universities in SA, young and old and a sizeable number of them did not show Ubuntu. Participants mentioned how the greeting of patients did not seem important to the doctors who taught them, which was my experience as a patient. I was comfortable with doctors who treated me humanely not because I was a medical doctor, but because *Ndingumntu* (I am a human being or I am a person). For example, an anaesthetist, a White University of the Witwatersrand graduate, who came to see me the night before the operation on my fractured 'polio leg', was a gentle, kind, and respectful older gentleman. He spoke to me, and we discussed issues that were of concern to me as a patient. He took a compassionate history and examined me thoroughly before looking at results, X-rays, and electrocardiogram results (ECG), unlike others who came to insert an intravenous line fifteen minutes before being wheeled into theatre. There were other several appalling incidences in the hands of some healthcare professionals: after discovering a lump in my breast, I had a mammogram and I was told that the mammogram showed that the lump on my breast was probably cancer; while the person was standing at the door; after being called by a sonographer, a radiologist, a young Black woman, just walked into the room, grabbed the sonar probe and started performing an abdominal sonar on me without introducing herself or telling me what she was doing and then walked out without saying a word to me. I reflected on Ubuntu from a patient gaze and I found no sense of Ubuntu in many of these doctors.

The participants spoke about how patients were guiding them regarding what type of doctors they should aspire to be, insisting that they should treat their patients with care and respect. Ubuntu is respecting everyone irrespective of whether they are educated or not, young, or old, Black, or White. Smith posits that Ubuntu is in contrast to mind-body dualism that is prevalent in medical education and healthcare as doctors use reductionist methods and ignore the experiences of patients in the process.[207] Patients' experiences during a consultation are crucial in their interaction with doctors, not the doctor's expertise. In my case as a patient, doctors were not interested in hearing my experience of the disease. They were more concerned about

what they need to do, to deal with the disease. Smith hit the nail on the head in what she is saying in the quote below, and this echoes my personal experience and what the participants are saying.

> The needs and desires of the patient too often are secondary to the technical expertise of the physician, whose focus may be more on addressing the disease than on understanding the patient's experience of it.[207(p722)]

Ubuntu creates interconnectedness of individuals in a community, leading to a bond that no one can break.[207,208] Ubuntu nurtures, builds and is all about sharing and building one another.[208] It allows everyone to have a say in the community, allowing every voice to be heard and decisions are made wisely after considering every voice. Ubuntu is an inter-humanist philosophy, which is culturally responsive, a philosophy of learning for life as it is portrayed in lebollo.[2,59] Lebollo prepares the younger generation for adult life, which could include cognitive engagement, virtues and wealth.[209] Ubuntu philosophy transforms one into a life-long learner. In 2015, when #FeesMustFall hit the country, it was a way of conscientised students freeing themselves and all the marginalised people in institutions of higher learning. As mentioned earlier, Ubuntu philosophy is similar to Freireian philosophy which strives to conscientise and liberate others.[59]

6.2.2.3 Letsema: cultivating a communal spirit of service

Letsema is when you work together for a common goal or for the benefit of the community or an individual.[210,211] Letsema can be used in any project, such as cultivating soil for a member of the community in preparation for planting. After completing the work, those who offered their time are fed and offered a drink from a calabash (described in Article 1, Chapter 3), showing the spirit of oneness. The University of the Witwatersrand students worked together during the #FeesMustFall to bring about change but letsema became a bigger movement when the rest of the students in institutions of higher education joined the protests.

> But letsema was not just a cooperative community effort. On the contrary, through letsema members of the community recognised that it would be difficult and slow for individual families to complete the cultivation of their fields on time if each family was to go it alone.[209(342)]

Letsema is a selfless collective effort where individuals involved are not necessarily expecting to be paid for their services. At the University of the Witwatersrand, students as a collective raised their voices to highlight various challenges that they were facing.

6.2.2.4 Advocacy for the marginalised

Institutions of higher education were experienced as oppressors by students when they increased tuition fees due to a shrinking national budget. These students were meant to be born-frees but this turned out to be a myth resulting in the "rebellion of the born un-frees".[212(p94)] The socio-economic context inherited from apartheid was being challenged, as it had been 21 years post-apartheid when students found themselves financially excluded from attaining a future they deserved. Mabasa speaks about the epistemic coloniality in neo-colonial corporate universities which continue with Eurocentric epistemological frameworks that ignore context and are marginalising the locals.[212] These universities are employing international benchmarking, which in itself is legitimate when looked at superficially, but it perpetuates coloniality and disparities in the local social classes.[212] International benchmarking encourages corporatisation of academia which leads to dependence on the marketplace, hence the outsourcing of support staff; in essence, cheap labour.[212] Collectively, these issues provoked the fire of rebellion. Not being able to further one's studies to reach one's full potential is disabling and to overcome this manifestation of their oppression, students realised that the only way they can conquer is through actions which may be characterised as 'epistemic disobedience'.[60,212] Epistemic disobedience as a form of reimaging ways of knowing in our African context means veering away from established Eurocentric epistemology and delinking our learning systems from the sense of coloniality.[213] Mabasa describes former White universities as neo-colonial and as such becoming instruments for the perpetuation of colonialism.[212]

In 2015 to 2016, students fought for those who could not afford to register to study in institutions of higher education, hence the eruption of the #FeesMustFall protests.[2] Their advocacy was not just limited to the student population but included the insourcing of workers, decolonising the curriculum and spaces of learning. During these two years, the fallist epistemic disobedience movement gained momentum in UCT, RhodesMustFall; Colonised education must fall; Afrikaans as a medium of instruction must fall; and outsourcing of staff.[97,203,212,214] There should be advocacy against racism, gender-based discrimination, and more.

6.2.2.5 Intersections of race, gender, colour, social class, disability, and identity

Identity categories such as race, gender, colour, and social class are sources of domination and bias.[215] These identities are the foundation of violence against those who seem different from the norm.[215] Black women usually belong in the margins of society, including academic

settings.[216] In academia, especially in institutions of higher education, women usually feel like outsiders within.[216,217] Women participants in this study faced more discrimination than men (see articles 2 and 3).[9,159] Participants in this study were also faced with racial discriminatory challenges every day (see articles 2 and 3).[9,159] Some of them used survival tactics such as behaving White to succeed in those racist spaces. They faced punitive measures for their African hairstyles, for having tattoos, speaking up or just being Black.[9,159] Muting their identities became an everyday phenomenon.[9,159]

Patriarchy and hierarchy have been anathema for me, throughout my journey as a medical student, as a clinician and an academic. In this journey, patriarchy has been a thorn in my flesh, in so far as the intersections of my womanhood, race, Blackness, disability (or different ability), social class and identity are concerned. As early as my childhood, being differently abled brought overprotection, being disregarded, or being mocked in everyday interactions.[2] As a student, medical school did not make things easier; my Blackness and gender did not make things better. I experienced outright racism, sexism and being excluded from certain activities, which I managed to do many years later.[2] Belonging seemed impossible, but the 'Ubuntuness' of my fellow Black (African, Coloured, and Indian and some White comrades) students, patients, Black healthcare workers, including Black physicians and some White physicians, gave me hope. With this community cheering me on, I started feeling and acting like a doctor '*onobuntu*' (portrays humanity).

I qualified as a clinician, climbing the academic social ladder but that did not change anything; I was still a Black woman with a different ability. I thought academia would be better, but I was wrong. It was worse. Racism, patriarchy, sexism, and differential treatment became an everyday challenge. From day one, I was tested and challenged on whether I can do the job or not. Some students, based on their race, religion, or their masculinity, found it difficult to call me Dr Mokhachane but preferred calling me Mrs Mokhachane. They could not fathom a Black African woman with different ability being a doctor. I had to constantly remind them that I am not married to my father. The worst one was not being allowed to speak around the table when everyone was introducing themselves to our new boss. I was the only Black African person in the room, among White and Indian clinicians. It did not stop there. I was discouraged from embarking on a doctoral journey by being told "your office is too busy; you cannot handle this". I was dissuaded from registering as a doctoral student, where I would be asked if I think I can do this. There was a reluctance to approve my application for University bursary funding.

If found working on my research proposal or ethics application, I would be given a list of duties that I needed to deliver before the end of the day. The students' experiences were no better than mine.

6.2.3 Towards a humanistic culture

6.2.3.1 Ideal professionalism (Ubuntu as professionalism)

In *Everyday Ubuntu, Living Better Together, the African Way*, a book written by the late Archbishop Desmond Tutu's granddaughter, offering the foreword, Tutu said:

> A person is a person through other persons. [218(p8)] [and he goes on to say]
>
> On any given day, we are each offered many chances to be the person who – whether it be through words, actions, or even silence and inaction – offers space to those we encounter to experience care and relationship.[218(p9)]

We have to be persons that offer safe spaces for our students and peers alike. No one person is an island. We need each other and our students and patients need us. That is what Ubuntu is all about.[9] I remember Professor Allwood, a psychiatrist who taught us in our fifth year of medical training. He was the epitome of Ubuntu as professionalism and, at some point, I yearned to specialise in psychiatry and to be like him, until I was rotated through a chronic hospital, in the southern rural part of SA, uMzimkhulu, when I changed my mind. Professor Allwood made psychiatry humane by exuding gentleness and kindness. We never heard him scream at nurses, junior doctors nor students. Years later, as a qualified clinician, I served with him in the Human Research Ethics Committee at the University of the Witwatersrand, and he was still as gentle and kind to everyone around him.

Ubuntu as professionalism is respect for everyone, even in hierarchical spaces. Respect flows in both directions, from the top to the bottom and vice versa. It humanises the spaces and gives everyone a sense of belonging. Humanity teaches us that everyone in front of us is a person and doctors should take heed of that. Clinicians should afford everyone dignity by listening and hearing their stories. In isiZulu, *Sawubona* is how one greets another. This means I see you, which is a sign of respect and the recognition that this is a human being. You might be at different social levels (i.e, professor or student) but respect knows no age, boundaries, or hierarchy. If you show a child respect that is what they will know, therefore what they will portray and give that back to you. The Bible says do unto others as you would like them to do unto you – that is Ubuntu.

With Ubuntu, strength lies in unity[218(p31)] and my mother used to say 'if you are united as a fist, no one will get between you'. A fist is stronger than the individual fingers and it is difficult to pull fingers apart in a fist position. If the educators work together, in the spirit of letsema, to guide, support and create safe spaces for their students and peers alike, there would be less tension. Below is a poem that speaks about the humanity of King Moshoeshoe, a founding king of the Basotho nation, who portrayed the counter-intuitive leadership inherent in Ubuntu. Written by David Cranmer Theko Bereng.[219] (translated by ds. Andries Odendaal from 'Lithothokiso tsa Moshoeshoe, le tse ling')

Table 6.3 King Moshoeshoe as an epitome of Ubuntu - a poem

Sesotho version of the poem	**English translation by Andries Odendaal**
O ile ea matla mohale	He went away, our Great Soldier
Moroba rumo la Chaka a b'a le khomeletse	The one who broke Shaka's assegai and bound it others
E mo hlolisitseng ka ho ratoa	Never before had a king been so loved by his people
Mona ho phomotse Thesel'a Motlama	Here he rests, our Great-Binder-together
Ba itsheditseng ho eena ba hlohonolofaditsoe	They who have leaned on him were blessed
Ba fumane molamu oa Khotso oo ba itshehetsang ka oona.	They got a long stick of peace to lean upon
Pelo ea hae, lere la ba fokolang	He was a walking stick for those who walked slowly
	For them who have already forgotten the blue of their hair
O phomotse Thesel'a Motlama bohle ka tsoho le fanang a ba abela	He sleeps now, The Binder-together, who bound with a hand that gave generously.

6.3 Modifying the initial conceptual framework

The ten synthesised themes can be viewed as a sequenced construction of the participants' journey from their communities into the preclinical, undergraduate and postgraduate clinical years, allowing the initial conceptual framework in Chapter 1 to be modified, as shown in Figure 6.1.

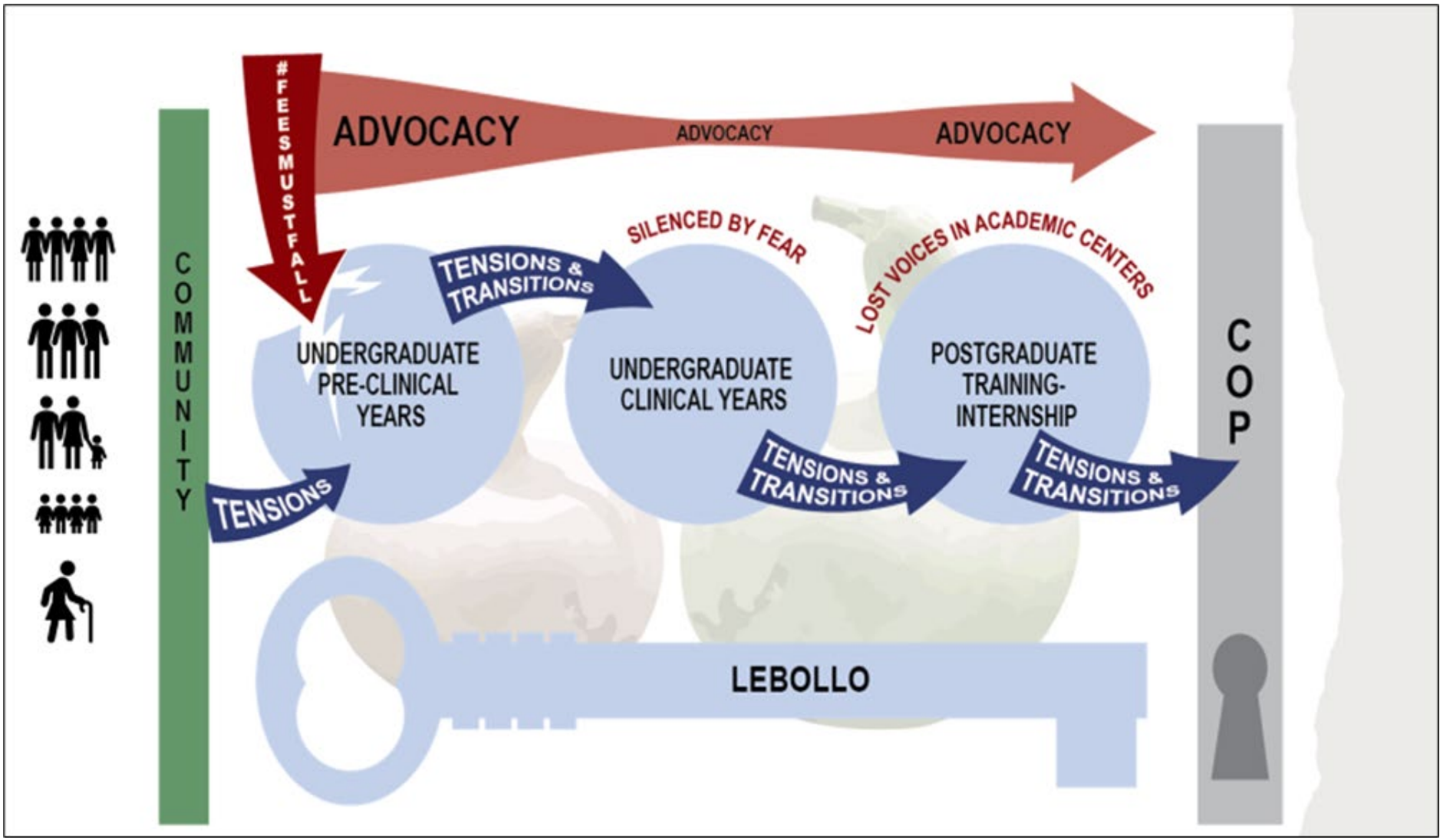

Figure 6.2 Tensions and transitions towards becoming a doctor (lebollo)

I introduced situated learning, LPP and CoP in the socialisation of medical students in Chapter 1 and will now expand on some of Wenger's work introduced earlier. Wenger's CoP is premised on three modes of belonging: engagement, imagination and alignment.[220] Engagement is defined as the "active involvement in mutual processes of negotiating meaning"; imagination involves "creating images in the world and seeing connections through time and space from extrapolating from our own experience"[220(p173)]; alignment means "coordinating our energy and activities to fit within broader structures and contribute to broader enterprises".[220(p174)]

Identity is intricately tied to belonging to an entity or community, hence the importance of including these in my discussion from here on. Communities of practice and LPP have been shown to heighten attainment of PIF as displayed by Orsmond in the five facet model employing Wenger's CoP and LPP.[84] Orsmond posits that through LPP students are transformed into different people who are constructing a new identity.[84] The five-facet model included the following; being in the clinical practice (space), becoming conscious of clinical practice, mutual engagement in clinical practice, joint enterprise in clinical practise and viewpoints of clinical practice.[84] In my reflections on Figure 6.1, I will include some components of the Osmond's five-facet model.

During the interviews and data analysis, the three modes of belonging come to mind. Firstly *engagement*, which appeared in three parts for me: my engagement with the data and students during interviews; my engagement with students' engagements and experiences in the clinical space, which in turn unearthed my experiences as a medical student. Later in the thesis, I will discuss how this engagement can be broadened to include academics in medical education. Secondly, *imagination* – I started imagining how things were by delving into SA history and cultural experience as already alluded to in this and previous chapters. South African historical and African cultural lenses afforded me the opportunity to bring in cultural attributes and processes that were successful in preparing young people for adulthood, i.e., *lebollo* as discussed in Chapter 3 and earlier in this chapter.[220,221] Finally, I started asking myself about alignment of lebollo LPP during medical students' socialisation in the clinical spaces.

My reflections on the findings from the study and my experiences allowed me to modify my initial conceptual framework. I modified Figure 1.1 based on what emanated from the data and the three modes of belonging, resulting in Figure 6.2. Figure 6.2 expands on my initial conceptual framework by focusing on students' personal experiences and engagement in the

journey towards joining the community of practice (CoP). I reflected about the tensions entwined with the transitions experienced by participants during their engagements with their peers, their teachers, patients, and institutional structures during a journey toward feeling, thinking and acting like a doctor. In my reflections on the students' story below, I will explain how lebollo came into being part of this figure. Using the African lens of Ubuntu, I added lebollo to modify the initial conceptual framework (Chapter 1). Lebollo in my understanding is equivalent to medical training that affords trainees the key into the community of practice (CoP). Lebollo acts as a key to a CoP for those who have undergone the rite of passage and is therefore synonymous with LPP.

The participants grew up in a variety of settings and came to the University of the Witwatersrand, Johannesburg facing that reality from different perspectives. This moment of transition was characterised by a series of tensions which recurred throughout their journey to becoming professionals. Transitions are important moments in a person's life because they are periods when individuals move to the next level of their growth or training, be it formal or informal. During these periods, the students were transformed to the next level of maturity as well as the next level in their medical-training journey. Every transition they experienced was challenging and brought continuing tension. For example, ~~they~~ the participants experienced tension when they moved from their communities into the University space – a transition from living with family that provided them with all their needs, to living independently and taking control of their own lives. They also experienced tension when choosing a university, not knowing whether they will be accepted in those institutions or not. Funding also created tension, as that was a determining factor of their success or exclusion.

Many of these students were the first to attend University in their families, which was daunting because they had no reference point to navigate these institutions.[222] They did not want to disappoint their families, which created more tension. Arriving in Johannesburg, the city of gold (Egoli), with a completely different ontological perspective was challenging. Coming from a rural environment, a suburb, a township, or a slum, the participants were immediately exposed to many people who were both different and similar to them. They saw different races, heard different languages, someone playing a guitar at the street corner, another dancing in praise. They were overcome with a sense of freedom, fear, or a combination of both. For some, coming from a rural environment to a city, challenged the way they think, which destabilised the values of their upbringing, values of Ubuntu, creating tension within them. For example, in

institutions of higher education, young people were interacting with adults on a first name basis. For the participants, this was unheard of, as they were raised to believe that respect is taking every adult as one's parent and never, ever calling them by their first names. Challenging authority came with tension, as this was not in line with their Ubuntu upbringing of respecting authority.[2,9,159]

The participants' successful transition into the University of the Witwatersrand was interrupted by the #FeesMustFall protests, a reaction against what students' felt was a ploy to push poor Black students out of the universities. These protests unearthed more tension in these participants, for various reasons. Some of the participants heard for the first time that their peers will not be able to register the following year for lack of funds. For some students, particularly the White participants in this study, deep tension occurred when they started reflecting on their own privilege as White South Africans. This reflection brought anger and guilt. During these protests, medical students volunteered to be in the first aid team to assist the injured, be it students, staff or police.[2] Another type of tension arose, when, as first aiders during the protests, the student body Instructed them not to take care of the police personnel, but to assist only injured students.

During the #FeesMustFall, the participants learnt about the history of their country and about youths and others who died fighting for freedom, such as Solomon Mahlangu and Steve Biko and I include another hero of my higher education time, Neil Aggett, a health advocate and activist who was a medical doctor, and a trade unionist, as a reflection of my student years – an example of a White man who gave up his whiteness to advance the wellbeing of others.[223,224] Students were encouraged by the spirit of Solomon Mahlangu – a freedom fighter who was executed by the apartheid government for what the government deemed high treason at the age of 23. The song "Iyho Solomon, a students' call for battle" reverberated throughout Senate House, a seat of the University governance during the first three days of #FeesMustFall.[107(p196)] In the spirit of decolonisation, without words being uttered, students dropped a banner that read Solomon House, changing the name of the seat of governance at the University of the Witwatersrand from Senate House to Solomon Mahlangu House.[107] Steve Biko, a medical student was another figure that ignited the students' energy. Steve Biko was the backdrop of 1976 students' uprising and #FeesMustFall.[2] He died in prison where the police and doctors who examined him colluded with the apartheid government regarding the cause of his death.[225]

Dr Neil Aggett, was a medical doctor at the [5]Baragwanath Hospital in Soweto by night and worked as an unpaid trade unionist by day. He was the organiser of the Africa Food and Canning Workers Union.[226] He moved to Johannesburg from the Eastern Cape after the 1976 Soweto students uprising.[226] He was a White man 'who went beyond the [W]hite left'.[227(p1)] He was the first White person to die in detention, when I was a first year medical student in 1982, after being held for seventy days without trial.[227] He was found hanging on the ceiling in his cell, with thoughts that his death might have been staged by the police after killing him or that he committed suicide in the form of denying the police the power and joy to torture him further.[228] Just like Solomon Mahlangu and Steve Biko, Neil Aggett was prepared to die for the prospect of a "just, non-racial, and non-sexist democratic future in South Africa".[226(p105)] The following quote depicts who Neil Aggett was, hence being the hero of our times as students and, in my view, these contemporary students are echoing what he stood for, fighting for economic injustice.[2,226]

> He transcended the boundaries of race in the most racially divisive of times, and inspired strong bonds of respect and love while engaging honestly with the complexities of his and his fellow South Africans' lives.[226(p105-106)]

During the #FeesMustFall protests, students were fed with information instilling in them a desire to be the best they could be, to change peoples' lives, to shape the country for the better for all who live in it.[2] In my view, judging from the students' reactions, they wanted to be the Steve Bikos, the Neil Aggetts of their generation and they were determined to change the world. They were thrown into a whirlwind of emotions, propelling them into various positions: leaders, politicians, helpers, advocates, etc. However, the antecedents for this new identity were triggered long before in the history of South Africa. These students were but a legacy of Black activists fighting against oppression. In 1994, South Africa transitioned from Black people's oppression into freedom, with the world looking brighter for everyone. The first Black president was inaugurated at the Union Buildings, and we, as SA citizens, were filled with a promise of a new country, free education for all, among other changes that were promised. It was a day of hope, of togetherness of *pula*, *khotso*, and *nala* (rain, peace, and prosperity). In 2015, 21 years after this promising day, the lines between the rich and the poor were widening,

[5] https://www.google.com/search?client=firefox-b-d&q=baragwanath+hospital+history

the transition into having a life of no structural racism was nowhere in the horizon and the students took to the streets to fight for their educational freedom. This forced students, participants included, to transition at various levels, from being voiceless, to speaking up and fighting like the likes of Solomon Mahlangu, Steve Biko and Neil Aggett. There was a shift in the atmosphere; the students were saying no more, we cannot pretend that all is perfect when it is not. Those whose home values taught them that you cannot show your disgruntlement through violence or disrespect realised that, even through that tension, they need to fight for the transition into educational freedom. This would propel ~~them~~ the contemporary students and those come after them into a state of financial freedom. This was the birth of #FeesMust Fall.

The movement spread like wildfire in the South African institutions of higher education, using the Twitter handle #FeesMustFall. It seemed as if Neil Aggett rose from the dead to teach them that freedom is for everyone, not just your own but the whole country, going beyond the borders of SA. I heard the voice of Paulo Frere saying to them, you need to be conscientised; you need to create your own freedom through education. These youngsters were quoting Fanon like no youngster I had ever met. They had transitioned into higher beings, young people who were prepared to die to self in order to liberate others, like Solomon Mahlangu. When the students argued that they cannot move forward leaving others behind, I heard Mandela saying to them [6]'It seems impossible until it's done', [7]'Courage is not absence of fear but triumph over it' and [8]'Education is the most powerful weapon you can use to change the world'. When they insisted that education can change their lives and those of their families, it echoed what Paulo Freire, the teacher, said, that [9]'Education is freedom'. This is what these young people wanted to do, change the world for all who live in it. For these medical students, Steve Biko and Neil Aggett taught them that, as a doctor or becoming one, you cannot say you are free until you have fought for the freedom of your people, your communities, and your patients. You start fighting now; you do not wait until you are qualified and, when you are qualified, you do not rest until you have contributed to the freedom of others.

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[6] https://www.azquotes.com/quote/185315
[7] https://www.goodreads.com/quotes/5156-i-learned-that-courage-was-not-the-absence-of-fear
[8] https://borgenproject.org/nelson-mandela-quotes-about-education/
[9] https://everydaypower.com/paulo-freire-quotes/

#FeesMustFall manifested as a curriculum of the classroom that catapulted their growth to life lessons, accountability, advocacy and pushed them from adolescence to adulthood, just as lebollo is meant to do.[2] To recap, Lebollo is a traditional process that transitions boys to manhood and girls to womanhood, which allows one to be part of a certain community of practice.[2] For instance, in the Sesotho culture, lebollo is like higher education, where young people are being prepared for adulthood and that is what #FeesMustFall delivered. #FeesMustFall created transitions to the conscientisation of challenges others faced at the time, transitions to gain the courage to speak up and be advocates and fight against societal ills.[2] This conscientisation was discussed in Article 1 (Chapter 3). As with every transition, this one was not without tension. The transition into the clinical space, in some way, set these students back, from being courageous to being timid and fearful.[2,9,159] In the clinical space, students felt they could not speak until they were spoken to; a place where there is an army of brotherhood.[2,9] The clinical space is where you cannot speak, even when you see your peers or teacher behaving unprofessionally or witnessing malpractice towards a patient. [189] However, there were still people who made them remember what they achieved during #FeesMustFall.[2] They entered the clinical space with confidence, with the ability to speak up, a skill they gained during #FeesMustFall but silencing was the norm. Tension became the order of the day, as they witnessed injustices towards patients and their peers but felt gagged by fear of victimisation by the people who would be assessing them. They had to make a choice of either being vocal or not progressing in their studies. They chose to be silent and vow that they would be different types of doctors who respect their patients. They would be a safe space (a person to go to when in need) for the next generation. I posit that for these participants the three components of the five-facets of PIF which speaks about being in clinical practice (space), becoming aware of clinical practice and mutual engagement in clinical practice did not manifest as Orsmond envisioned.[84] Their professional identity development and formation could have been negatively impacted by the silencing, hierarchical behaviour of clinicians who did not respect patients.[9,159]

Participants had an Ubuntu approach to professionalism which was in tension with what they were witnessing in the clinical space.[2,9,159] This tension of the western notion and their Ubuntu values continued into the postgraduate training space, including the silencing and muting of their identities. The silencing was particularly heightened in the academic-affiliated hospitals.[9] The participants believed that everyone has a story that needs to be heard, including their patients. Listening to others' stories is a way of showing respect and that you care.[2,9,159] These

young people made us realise that professionalism is not what we think it is. They said it is contextual, dynamic and it is clothed with freedom, freedom of who you are meant to be, not to be silenced, but having the freedom to speak your mind. As mentioned earlier, i.e., Chapter 3, acquiring PIF is similar to lebollo, a traditional process that turns boys into men and girls into women.[2] In my *imagined* belonging Lebollo, similar to LPP, is the key to the community-of-practice (CoP) membership. Prior to discussing the methods in this chapter, the figure below summarises what the participants experienced in their journey. As figure 6.2 above depicts, the participants came from their communities with Ubuntu-based values and experienced tensions with every transition. They were strong advocates during and immediately post-#FeesMustFall, but they were silenced in the clinical years' space and their postgraduate training (internship), particularly in the academic hospitals.

Activism is my rent for living on the planet – Alice Walker.

6.4 A model of Ubuntu as professionalism

As discussed previously, according to Wenger[220] there are three modes of being, i.e., engagement, imagination and alignment. In my perspective, as part of *engagement*, I interpreted the data with the *imagination* of how things were in the past, for South Africa and its history of education and how these ills can be transformed into something palatable. I thought of how the ontological cultural way of being can be incorporated for it to be in *alignment* with the contemporary medical education and yet different, inclusive and humane.

This chapter has described various ways of understanding our shared legacies, both within their oppressive and colonial framing reflected in my own ethnographic expression as well as the experiences of the participants. I have reflected on the need to transform our framing, education and practice of professionalism as a manifestation in a journey of professional identity formation. The outcomes of this study lead me to propose that a humanist culture, such as one embodied within Ubuntu, offers us a transformative roadmap for a generative sense of professional identity formation in South Africa and beyond, in contexts which may resonate with these stories and the histories in which they are located.

The graphic below proposes a three-phased roadmap for the achievement of a transformed sense of professionalism and professional identity formation:

- Understanding and interpreting historical and social context

- Reconstructing professionalism and professional identity formation as a reflection of global but essentially local contexts
- Building a humanistic culture of medicine rooted in an Ubuntu identity

Ubuntu binds people together regardless of how they look, speak or dress. It is a binder and a reconciler. The figure below depicts a journey towards Ubuntu as professionalism divided into three groups, as mentioned earlier, i.e., the historical and social context, reconstructing professionalism, and a suggested way forward. The synthesised themes on the left depict the historical context, while the middle section with the hand holding an arrow depicts the reconstructing process for change and the one on the right is the recommendation towards a humanistic culture.

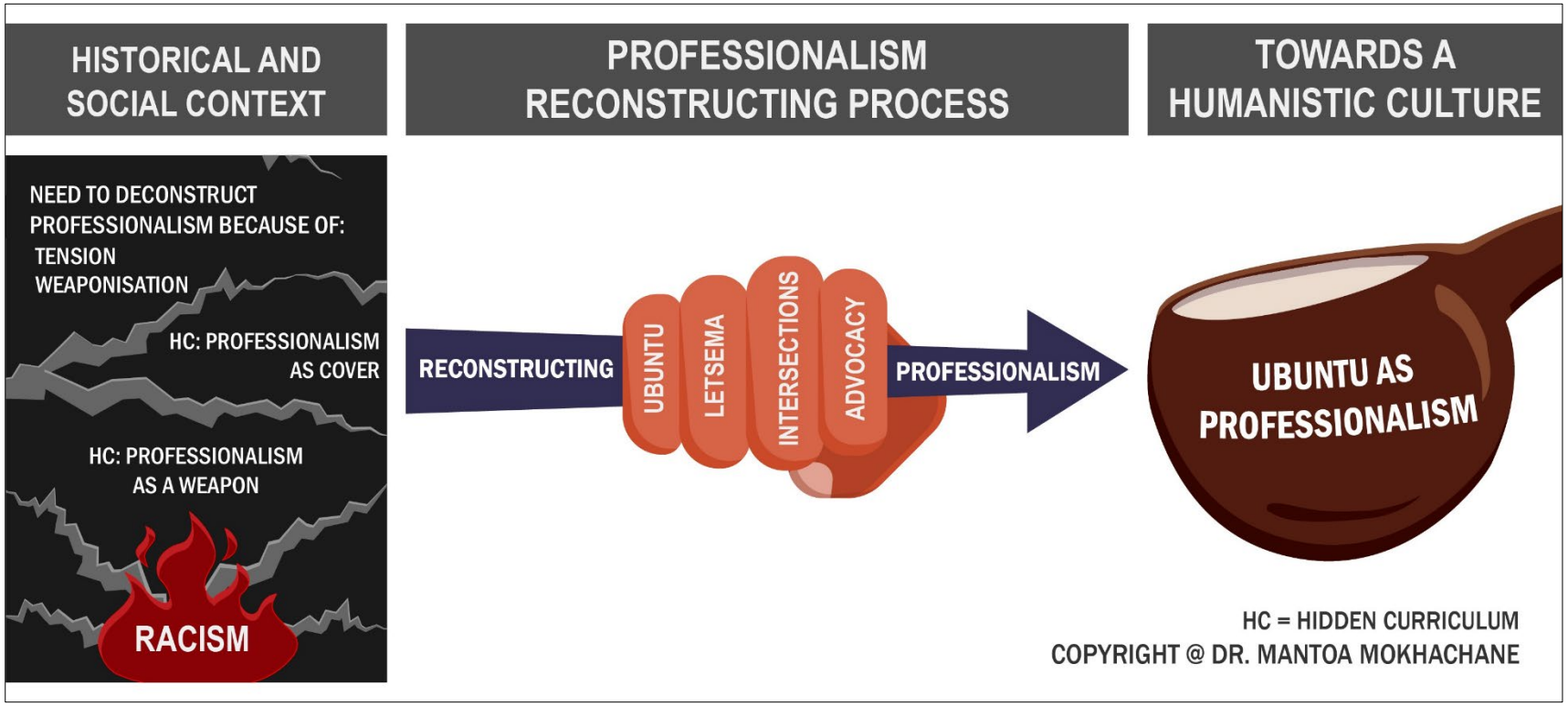

Figure 6.3 Model of Ubuntu as professionalism

The humanistic culture of Ubuntu urges one to interrogate whether Holden's model presented in Chapter 1 (Figure 1.1) could be modified to portray an Ubuntu model of PIF domains. Such a model would have domains founded in a humanistic culture; see Figure 6.4 below. With Ubuntu, social responsibilities and responsiveness is an important approach to dealing with societal challenges in a collective fashion.[229] Medical professionals should consider tackling social ills by whatever action is deemed necessary without always leaving it to the activists. Social responsiveness should be one of the major domains of Ubuntu-based PIF. The second one is Ubuntu as professionalism, as mentioned above (Figure 6.3). The third domain is the spirit of letsema, where everyone contributes to enhancing PIF, not just for the trainees but for the entire healthcare team. Letsema includes trainees' efforts to invigorate their PIF by being active in the clinical setting, by asking questions and emulating the good behaviour (hopefully) of senior clinicians. Letsema binds people together to achieve a common goal.[230]

In PIF, learners need others (peers and teachers) to succeed in their attainment of this formation, hence the importance of Ubuntu-based PIF. With Ubuntu, an individual's well-being is connected to the wellbeing of others, as shown in the phrase *a person is a person through other persons*.[231] PIF is therefore a collective identity attainment while simultaneously undergoing one's specific individualistic development of professional identity. Figure 6.4 shows a schematic representation of Ubuntu professional identity formation model.

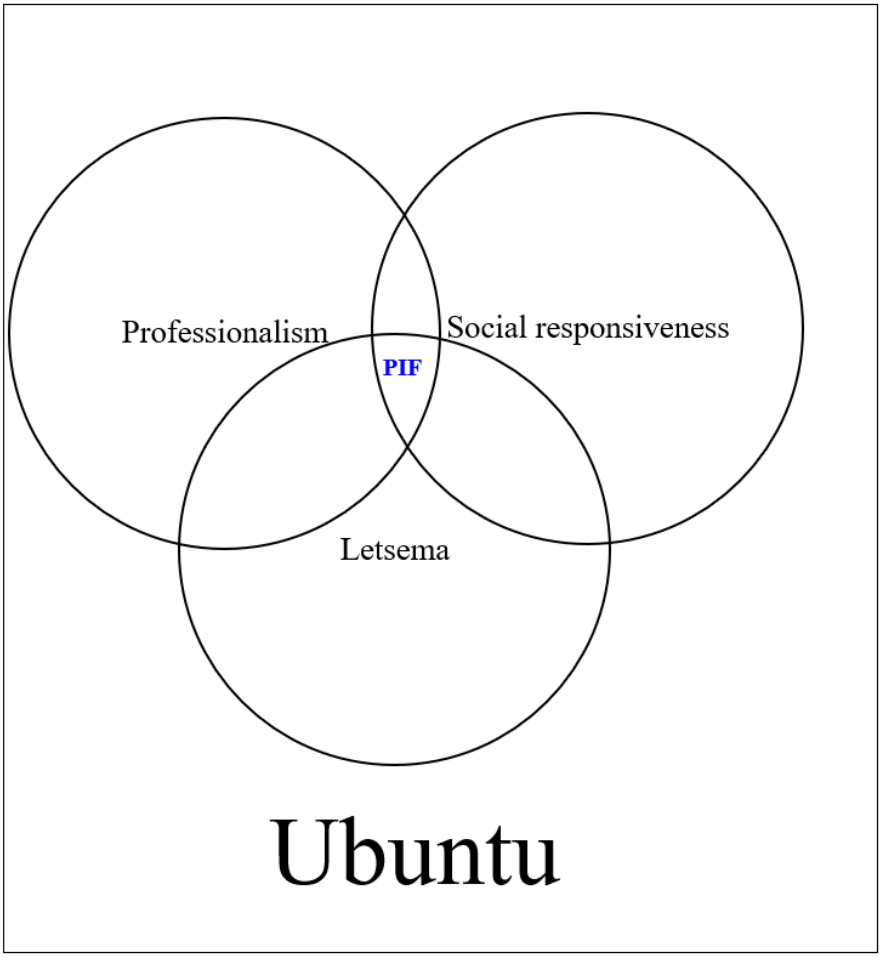

Figure 6.4 Ubuntu professional identity formation model

6.5 Limitations of the study

Recall bias, the phenomenon by which participants' recollections of events might have influenced data[232] could have impacted the kind of stories participants shared with me. The interviews were conducted four to five years after the #FeesMustFall protests due to several procedural delays, including obtaining funding for the study and ethics approval.

One of the major challenges was that my appointment as the director of the medical programme in 2019 precluded me from interviewing final-year students. I enlisted two colleagues to assist with the interviews; however, only three students responded to the invitations sent out by these colleagues. The students preferred me to conduct the interviews and preserve their confidentiality. After raising my concerns with the University's Human Research Ethics Committee (HREC), I was allowed to approach students during the two-week period between their final results being released and their graduation. This unfortunate timing may have

impacted the number of participants. However, the data collected provide valuable insights into the impact of #FeesMustFall on the 2015-2016 undergraduate medical cohort.

Another possible limitation of the study is the cross-sectional design; a longitudinal study might have been appropriate. However, the study design was influenced by the funding available and the urgency to explore and disseminate the experiences of the 2015-2016 undergraduate medical cohort affected by #FeesMustFall.

6.6 Conclusion

In this study, I intended to find out, 'What are the University of the Witwatersrand medical students' experiences of professionalism, PIF, and what is the impact of #FeesMustFall on their professional development?' I did not realise then that it would evoke memories of my own journey that are no different from theirs, albeit 30 years later. Just as I did, they experienced racism, segregation, discrimination based on colour, race, gender, social class and more. The western notion of professionalism was and is still in tension with their ontological being, irrespective of their differing racial backgrounds. *Bonke ba nobuntu* in IsiZulu or IsiXhosa and *ba na le botho* in Sesotho (they displayed humanity). Their acquisition of PIF forced me to dig into my humanity to see Ubuntu and how PIF could be acquired in an African setting, hence the introduction of African metaphors and other African ways of being and doing.

This research significantly added the value of context, culture, and the African voice in attaining PIF. The findings indicate that PIF and professionalism are influenced by context and culture, not just the ontological culture but the institutional culture as well. The context in this study is the SA history of apartheid and discrimination, while *culture* means individuals' culture of upbringing and that of the institution of higher education. The #FeesMustFall context shaped participants into becoming leaders of tomorrow. Some of these participants are now in leadership in academia, either training to become specialists or mentoring and preparing leaders of tomorrow.

Collectively the articles in this study have contributed more than I expected. This innovative study filled the gap in the literature regarding the African influence on PIF and professionalism. It challenged the notion of PIF being a single universal construct that is bound to rigid hierarchical identities of traditional teachers. This study added an African voice to this

discourse, affording people from different cultural backgrounds an opportunity to use their own cultural setting. It is important for educators to understand diverse cultural backgrounds in order to be inclusive.

I urge medical educators and researchers to interrogate their own setting, through Wenger's modes of being, *engagement*, *imagination* and *alignment* to strengthen professionalism and PIF.

6.7 Recommendations

6.7.1 Adopting Ubuntu philosophy as part of humanising the curriculum in institutions of higher education in South Africa

As a way of humanising the curriculum, institutions of higher education in SA are encouraged to adopt Ubuntu as a theme that explicates the relationship between educators and students, educators and patients, students and patients, not excluding other healthcare workers. Educators should run a series of workshops where staff members are familiarised with the Ubuntu way of being and encouraging everyone, students, and staff, to be role models that exude humanism. The School of Clinical Medicine should introduce an Ubuntu prize where students and/or patients can vote for an educator, doctor or any healthcare worker who displays Ubuntu.

6.7.2 Letsema Communal Spirit

Letsema, the communal spirit, should be the motto of the University; where both students and staff step in to assist the next person without expecting anything in return. The School of Clinical Medicine should encourage and empower students and staff alike to call out inhumane behaviour, with no repercussions. The University of the Witwatersrand, particularly the Faculty of Health Science, should strive to employ educators who represent the background of their students. This could be achieved through redressing the salary issue that does not cater for groups that carry 'Black tax' (Black people who have to look after everyone in their families because of the legacy of apartheid), where one has to uplift others in the family or community, for example, by paying for their education.[185,186,233] This will open a door for Black academics, affording the Black students a sense of belonging in the space which could in turn enhance PIF. Faculty of Health Science should deal harshly with those who have racist tendencies and not pay lip service to this behaviour.

6.7.3 Making institutions of higher education accessible to all

There are several types of access that should be considered in institutions of higher education. These include epistemological access and monetary access, etc. Institutions of higher education should value students' history as they come in with professional values which medical education devalued and taught them a different thing. Epistemological access could be achieved through medical education incorporating more of Ubuntu, which would make students comfortable with bringing their personal identities and cultural backgrounds into the clinical space. This could transform these clinical spaces in ways that bring more humanity. These clinical spaces could be more inclusive, making students of different backgrounds feel respected, including being called by name instead of identifying them through their clothing. Change in the institutional culture towards more humane interactions with students, patients and staff could also facilitate access to these institutions. Access during the University attendance period is also crucial and this could be achieved through symbolic access, for example, having academic staff that are representative of the student group based on race, gender, different ability, social, etc (a University of the Witwatersrand study awaiting to be published). While waiting for the SA government to honour its free-education promise, I implore the University of the Witwatersrand to raise funds where poor students who are performing well academically could be housed for free and their tuition covered. This money could be raised through research units in the University, where these entities could contribute some money into this pot, particularly the well-established units.

6.7.4 Repeat this study or studies at a national level

Conducting a national study, particularly in neo-colonial former White Universities, might highlight what needs to be done in these institutions nationally. This study offers a perspective which is worth reflecting on at other institutions.

The Universities should conduct studies that concentrate on the experiences of academic, administrative professional staff and cleaners who were all impacted by #FeesMustFall in different ways.

6.7.5 Conducting a longitudinal study

A longitudinal study is best suited for evaluating how PIF is attained. Where there is an opportunity to do so, I would urge researchers to conduct a longitudinal study.

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APPENDICES

Appendix 1: Human Research Ethics (Medical) Clearance Certificate

UNIVERSITY OF THE WITWATERSRAND JOHANNESBURG

R14/49 Dr M Mokhachane

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
CLEARANCE CERTIFICATE NO. M180864

NAME: (Principal Investigator)	Dr M Mokhachane
DEPARTMENT:	Unit for Undergraduate Medical Education Faculty of Health Sciences Medical School University
PROJECT TITLE:	The impact of the 2015-16 "Fees Must Fall" protests on medical students' perceptions of professionalism and their professional development: a case study
DATE CONSIDERED:	31/08/2018
DECISION:	Approved unconditionally
CONDITIONS:	
SUPERVISOR:	Profs L Green-Thompson & A Kuper; Dr A George
APPROVED BY:	Dr CB Penny, Chairperson, HREC (Medical)
DATE OF APPROVAL:	26/11/2019

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Research Office Secretary on the 3rd Floor, Phillip Tobias Building, Parktown, University of the Witwatersrand, Johannesburg.
I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to submit details to the Committee. **I agree to submit a yearly progress report**. When a funder requires annual re-certification, the application date will be one year after the date when the study was initially reviewed. In this case, the study was initially reviewed in **August** and will therefore reports and re-certification will be due early in the month of **August** each year. Unreported changes to the application may invalidate the clearance given by the HREC (Medical).

Mokhachane — Principal Investigator Signature

26/11/2019 — Date

PLEASE QUOTE THE CLEARANCE CERTIFICATE NUMBER IN ALL ENQUIRIES

Appendix 2: University Registrar's approval

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

OFFICE OF THE DEPUTY REGISTRAR

10 October 2019

Mantoa Mokhachane
Student number 09000671
PhD Health Science Education
School of Clinical Medicine

TO WHOM IT MAY CONCERN

"The impact of the 2015 – 2016 Fees Must Fall protests on medical students' perceptions of professionalism and their professional development: A case study"

This letter serves to confirm that the above project has received permission to be conducted on University premises, and/or involving staff and/or students of the University as research participants. In undertaking this research, you agree to abide by all University regulations for conducting research on campus and to respect participants' rights to withdraw from participation at any time.

If you are conducting research on certain student cohorts, year groups or courses within specific Schools and within the teaching term, permission must be sought from Heads of School or individual academics.

No research can commence before ethical clearance has been obtained. Kindly forward a copy of the clearance certificate to this office.

Nicoleen Potgieter
University Deputy Registrar

Private Bag 3, Wits, 2050, South Africa | T +27 11 717 1204/8 | F +27 86 553 2271 | www.wits.ac.za

Appendix 3: Title change approval

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Private Bag 3 Wits, 2050
Fax: 027117172119
Tel: 02711 7172076

Reference: Mrs Sandra Benn
E-mail: sandra.benn@wits.ac.za

23 September 2023
Person No: 8226325
TAA

Dr M Mokhachane
Po Box 6158
Meyersdal
Alberton
1450
South Africa

Dear Dr Mantoa Mokhachane

Doctor of Philosophy: Change of title of research

I am pleased to inform you that the following change in the title of your Thesis for the degree of **Doctor of Philosophy** has been approved:

From:	**The impact of the 2015 - 2016 fees must fall protests on medical students' perceptions of professionalism and their professional development: A case study**
To:	**Medical Students' professional identity formation during a social upheaval: A qualitative study**

Yours sincerely

Mrs Sandra Benn
Faculty Registrar
Faculty of Health Sciences

Appendix 4: Interview Guide

Title	**Medical Students' Professional Identity Formation During a Social Upheaval: A Qualitative Study**		
Reasons (s) why information is required	**Justification for information required**	**Main questions**	**Follow-up situations or probe questions**
Background on participants			
To establish their academic role and background of participants relation to #FeesMustFall	It is important to know whether they are in a leadership or were activists as they may have different take on their responses	In which year of the medical program were you in 2015 were you when #FeesMustFall erupted?	
		What was your role if any during #FeesMustFall protests?	Probe, If class representative/student organisation/activist
Lived experiences prior to and during #FeesMustFall			
To establish what the participants lived experiences.	It is important to obtain unprejudiced everyday lived experiences of the participant's to understand how their lives have been and from which standpoint they are coming from.	1. Tell me your story prior to studying at the University of Witwatersrand? (Your history)	
		2. How was it for you at the University of Witwatersrand prior to #FeesMustFall?	
		3. How was it for you during #FeesMustFall ?	
		4. What is your take on #FeesMustFall ?	
Perceptions on professionalism			
To establish the students' current perception on professionalism	This will assist in their subsequent reflection on students' professionalism during #FeesMustFall.	5. What was/is your understanding of professionalism?	Probe further a. At entry (First and second year)? b. During the pre-clinical years (Third and fourth year)? c. During the clinical years (Fifth and final year)? d. During internship?
		6. What influenced your understanding of professionalism?	Probe based on the response; Teaching? Role models?

		7. Can you comment on the training on professionalism in the context of medical education at the University of Witwatersrand or South Africa?	
Perceptions on professionalism during and post #FeesMustFall			
To establish students' reflections on professionalism during and after #FeesMustFall	Reflection is an important tool in professionalism training	8. Reflecting on #FeesMustFall. Can you share with me what your thoughts were/are on students' professionalism during #FeesMustFall at University of Witwatersrand?	Based on their response, probe further; If participant thinks there was unprofessionalism; Probe further, • What are the behaviours observed that justify the claim?
		9. Can you share with me your thoughts on students' professionalism after #FeesMustFall at University of Witwatersrand ?	

Appendix5: Synthesised themes

		Subthemes	Themes	Synthesised subthemes	Synthesised themes
Paper 1		Values of Ubuntu	Calabash (an image of PIF) worldview	Values of Ubuntu	Ubuntu
		Mosadi ke lejwe la moralla (woman is an igneous rock)	Calabash (an image of PIF) worldview	Mosadi ke lejwe la moralla (woman is an igneous rock)	Ubuntu
		Lebollo- rite of passage	Calabash (an image of PIF) worldview	Lebollo- rite of passage	Ubuntu
		Ugqirha- my body as calabash	Calabash (an image of PIF) worldview	Ugqirha- my body as calabash	Ubuntu
		Transformative and life changing environment	Campus Calabash	Transformative and life changing environment	Ubuntu
		Nurturing	Campus Calabash	Nurturing	Ubuntu
				Respect in conflict with advocacy	Values: tension between inherent and reality
				Lebollo	Ubuntu
				Letsema	Letsema: cultivating a communal spirit of service
				Community shaping identity	Letsema: cultivating a communal spirit of service
				The calabash as a symbol of oneness	Letsema: cultivating a communal spirit of service
		Institution of higher learning are exclusive clubs	Fees Must Fall, a divine interruption	Things fall apart allowing victory to rise	Disrupting traditional constructs of professionalism
Paper 1	My autoethnography of learning during apartheid and attainment of PIF	Things fall apart allowing victory to rise	Fees Must Fall, a divine interruption	Things fall apart allowing victory to rise	Disrupting traditional constructs of professionalism
		Things fall apart allowing victory to rise	Fees Must Fall, a divine interruption	Things fall apart allowing victory to rise	Disrupting traditional constructs of professionalism
		Things fall apart allowing victory to rise	Fees Must Fall, a divine interruption	Things fall apart allowing victory to rise	Disrupting traditional constructs of professionalism
		Things fall apart allowing victory to rise	Fees Must Fall, a divine interruption	Things fall apart allowing victory to rise	Disrupting traditional constructs of professionalism
		Things fall apart allowing victory to rise	Fees Must Fall, a divine interruption	Things fall apart allowing victory to rise	Disrupting traditional constructs of professionalism
		Context influenced PIF	Segregation and discrimination	Home based value and apartheid	Values: tension between inherent and reality
		Higher education an exclusive club	Segregation and discrimination	Intersections of Blackness, womanhood and disability	Intersections of race, gender, colour, social class, disability and identity
		Intersections of Blackness, womanhood and disability	Intersections	Masquerading as a janitor in a whites-only town	Intersections of race, gender, colour, social class, disability and identity
		Masquerading as a janitor in a whites-only town	Intersections	Fees Must Fall echoing my past	Intersections of race, gender, colour, social class, disability and identity
		Fees Must Fall echoing my past	Intersections	Race	Intersections of race, gender, colour, social class, disability and identity
		Respect in conflict with advocacy	Ubuntu	Gender	Intersections of race, gender, colour, social class, disability and identity
Paper 2		Lebollo	Ubuntu	Activism	Intersections of race, gender, colour, social class, disability and identity
		Letsema	Ubuntu	Being policed	Intersections of race, gender, colour, social class, disability and identity
		Community shaping identity	Ubuntu	Everybody has a story	Ubuntu as professionalism
		The calabash as a symbol of oneness	Ubuntu	Knowing that everyone in front of you is a person	Ubuntu as professionalism
		Values of Ubuntu	Ubuntu	Afford everyone dignity by listening to their stories	Ubuntu as professionalism
		Not fitting the appearance norm of an ideal doctor	Transgression to ideal professionalism	Make patients feel human	Ubuntu as professionalism
		Zwonaka, a Black woman with dreadlocks and a nose ring	Transgression to ideal professionalism	Be relatable to patients	Ubuntu as professionalism
		Peter, a White, progressive man with an unconventional hairstyle	Transgression to ideal professionalism	Being empathetic towards patients	Ubuntu as professionalism
		Peter, a White, progressive man with an unconventional hairstyle	Transgression to ideal professionalism	Advocacy- Speaking up on behalf of others	Advocacy for the marginalised
		Nyakallo, a Black man , an activist and a mentor	Transgression to ideal professionalism	Supporting peers and patients	Letsema: cultivating a communal spirit of service
		Moitseki, a Black man , an activist with an African hairstyle	Transgression to ideal professionalism	Professionalism intricately linked to fighting for human rights for others	Advocacy for the marginalised
		Not allowed to embrace activism	Muting of identities	Nyakallo, a Black man , an activist and a mentor	Disrupting traditional constructs of professionalism
		Asinamali, a Black man from the 'missing middle' during #FeesMustFall	Muting of identities	Asinamali, a Black man from the 'missing middle' during #FeesMustFall	Disrupting traditional constructs of professionalism
		Higher education as an alienating space	Muting of identities	Not fitting the appearance norm of an ideal doctor	Disrupting traditional constructs of professionalism
Paper 3		Oppressive training spaces	Muting of identities	Zwonaka, a Black woman with dreadlocks and a nose ring	Disrupting traditional constructs of professionalism
		Race	Intersections	Peter, a White, progressive man with an unconventional hairstyle	Disrupting traditional constructs of professionalism
		Gender	Intersections	Peter, a White, progressive man with an unconventional hairstyle	Disrupting traditional constructs of professionalism
		Activism	Intersections	Nyakallo, a Black man , an activist and a mentor	Disrupting traditional constructs of professionalism
		Being policed	Weaponization of professionalism	Moitseki, a Black man , an activist with an African hairstyle	Disrupting traditional constructs of professionalism
	Clerkship experiences	A western notion of professionalism	Medical clerkship experiences	Hierarchical clinical space	Hidden Curriculum: professionalism as a weapon
		A western notion of professionalism	Medical clerkship experiences	Silencing the students' advocacy towards patients	Hidden Curriculum: professionalism as a weapon
		A western notion of professionalism	Medical clerkship experiences	Observed unprofessional behaviour	Hidden curriculum: professionalism as cover
		A western notion of professionalism	Medical clerkship experiences	Silencing couched as being professional	Hidden Curriculum: professionalism as a weapon
		A western notion of professionalism	Medical clerkship experiences	Silent for fear of being victimised	Hidden Curriculum: professionalism as a weapon
		A western notion of professionalism	Medical clerkship experiences	Peers adopting the unprofessional behaviour of their teachers	Hidden curriculum: professionalism as cover
		A western notion of professionalism	Medical clerkship experiences	Hierarchical behaviour in the next generation of practitioners	Hidden curriculum: professionalism as cover
		A western notion of professionalism	Medical clerkship experiences	Regards professionalism as generational and old fashioned	Hidden curriculum: professionalism as cover
		A western notion of professionalism	Medical clerkship experiences	Judgemental towards patients as per rape victims experiences	Hidden curriculum: professionalism as cover
		A western notion of professionalism	Medical clerkship experiences	Ignores context	Hidden curriculum: professionalism as cover
		A western notion of professionalism	Medical clerkship experiences	Discrimination in the clinical space	Racism
		A western notion of professionalism	Medical clerkship experiences	Experienced racism, structural racism and favouritism	Racism
		A western notion of professionalism	Medical clerkship experiences	Those in position of authority dismissive of those who don't fit the norm	Hidden Curriculum: professionalism as a weapon
		A western notion of professionalism	Medical clerkship experiences	Tattoos frowned upon	Hidden Curriculum: professionalism as a weapon
		A western notion of professionalism	Medical clerkship experiences	Doctors disinterested and disrepectful of patients	Hidden curriculum: professionalism as cover
		A western notion of professionalism	Medical clerkship experiences	Patients dehumanised by those meant to heal them	Hidden curriculum: professionalism as cover
	Lens -Collective Five Finger Theory, Mbigi, 2005.	Respect	Ubuntu	Everybody has a story	Ubuntu as professionalism
		Respect	Ubuntu	Knowing that everyone in front of you is a person	Ubuntu as professionalism
		Dignity	Ubuntu	Afford everyone dignity by listening to their stories	Ubuntu as professionalism
		Dignity	Ubuntu	Make patients feel human	Ubuntu as professionalism
		Dignity	Ubuntu	Be relatable to patients	Ubuntu as professionalism
		Compassion	Ubuntu	Being empathetic towards patients	Ubuntu as professionalism
		Solidarity	Ubuntu	Advocacy- Speaking up on behalf of others	Disrupting traditional constructs of professionalism
		Solidarity	Ubuntu	Supporting peers and patients	Disrupting traditional constructs of professionalism
		Solidarity	Ubuntu	Professionalism intricately linked to fighting for human rights for others	Disrupting traditional constructs of professionalism
		Survival	Ubuntu	Contextual response	Disrupting traditional constructs of professionalism
		Survival	Ubuntu	Using survival tactics such as behaving white.	Intersections of race, gender, colour, social class, disability and identity

Appendix 6: Study information leaflet

Mantoa Mokhachane PhD- Ethics

In-depth Interview

Participant information leaflet for students

Title:

The impact of the 2015 – 2016 Fees Must Fall protests on medical students' perceptions of professionalism and their professional development: A case study

Good day

I am Dr Mantoa Mokhachane with recruiting prospective participants to the above-mentioned study towards her PhD in Health Sciences Education. I would like to **invite you to participate** in this study. **Participation is voluntary** and **refusal to participate will not lead to penalty** or loss of benefits on your part. You **may discontinue** participation in the study at any time without penalty. We will strive to keep this information confidential and pseudonyms will be used when reporting data. If you mention anything that will make you identifiable, efforts will be made to remove or modify identifiers

The aim of this study is to find out what your perceptions are regarding professionalism and the impact of Fees Must Fall on your professional development. We would also like to find out what your experiences were during and post Fees Must Fall. Interviews will be conducted with those willing to take part and the interview will take a duration of one hour. These interviews will be audiotaped and if you agree, I would like to request that you sign a separate consent form for the recordings.

There are **no benefits to you as the participant**. Interviews may bring back to mind the traumatic experiences you encountered during the protests. If that happens, we will refer you to a psychologist for counselling and support.

If you agree to take part in the study, for those students that are under the direct care of Dr Mokhachane, other researchers who are assisting with data collection will interview you. This researcher will not be part of the Unit of Undergraduate Medical Education.

There will be **no payments to take part in the study. Based on the level of lockdown due to Covid-19 pandemic, we may interview you in person or conduct interviews using web-conferencing platforms and you'll therefore be sent R150.00 data voucher to cover the interview costs or time spent.**

For any queries, please contact me at this number …… or email me at …….

Mantoa Mokhachane PhD- Ethics

If you want to contact Dr Mokhachane directly, please e-mail her at this address Mantoa.Mokhacha@wits.ac.za or phone 011 717 2756 or **071 364 2158**.

If you were not happy with the proceedings please contact, Zanele Ndlovu at Zanele.Ndlovu@wits.ac.za, or phone 011 717 2700 or the chairperson, Prof. Penny at Clement.Penny@wits.ac.za

Appendix 7: Consent for the interview

Mantoa Mokhachane /PhD

Interview consent form for students

The impact of the 2015 – 2016 Fees Must Fall protests on medical students' perceptions of professionalism and their professional development: A case study

X	I hereby confirm that I have been informed about the study through an information sheet and discussions
X	All my questions have been answered
X	I understand that I can withdraw from the study at anytime
X	I understand that no identifiers will be used when data is presented
X	I understand that I will not be penalised in any way

I am happy to take part in this study: YES/ NO

I was in MBBCh 1 / 2 / 3 / 4 / in 2015 during fees-must-fall

Research's name _Dr Mokhachane_____

Research's signature _____

Date _14_/_12_/2020

Appendix 8: Consent for audio recording

Consent for audio-recording

The impact of the 2015 – 2016 Fees Must Fall protests on medical students' perceptions of professionalism and their professional development: A case study

	I hereby confirm that I have been informed about the study through an information sheet and discussions
	All my questions have been answered
	I understand that I can withdraw from the study at anytime
	I understand that no identifiers will be used when data is presented
	I understand that I will not be penalised in any way

RECORDING

I am happy for this interview to be recorded: YES/ NO

Participant's signature: _____

Researcher's name: Dr Mokhachane_____ Signatures:

_____

Date ____/____/2020_