PREFACE

This research project arises from the work of the Transformation and Equity Portfolio in the Health Sciences Faculty at the University of Cape Town (UCT). It has been partly funded by a grant from the National Research Foundation (NRF), and has been overseen by a multidisciplinary research team drawn from the Health Science Faculty and experts from other UCT Faculties and outside organisations. Additional funding support for the research came from the Research Committee of the Health Sciences Faculty and from the Portfolio for Transformation and Equity in the Faculty.

Various researchers contributed to different aspects of the work and they are named here in acknowledgement of the tremendous amount of work contributed to this project:

Gonda Perez did the first draft of the historical context (Chapter 2), which was substantively updated by Elizabeth van Heyningen and edited by Leslie London. Nazeema Ahmed did the substantive work on the analysis and write up of interviews with black alumni (Chapter 3). Wahbie Long conducted the analysis and first drafts of the postal survey of alumni (Chapter 4). Sean Field and Felicity Swanson from the Centre for Popular Memory at UCT undertook the field research, analysis and write up of interviews with staff (Chapter 5). Salma Ismail of the Centre for Higher Education Development (CHED) undertook the field research, analysis and write up of interviews with disabled, black and female staff in the Faculty (Chapter 6), and Louis Reynolds is acknowledged for his careful editing of this chapter.

Ayesha Fakie was the researcher who undertook most of the alumni interviews and coordinated the postal questionnaire survey, and assisted generally with analysis, organisation and write up. Carin Masters assisted with coordination of the research team in its second year of work. The full research team, and the advisory committee are detailed on pages 7 and 8 of Chapter 1. Gonda Perez and Leslie London co-managed the research project through the Transformation and Equity Portfolio, overseeing the planning, execution, quality control, analysis, write up and editing of the research.

The Dean of the Faculty of Health Sciences, Professor Nicky Padayachee gave the project his complete support, particularly at critical moments, without which far less would have been achieved than was finally attained.

Leslie London and Gonda Perez
19th March 2003

TRUTH AND RECONCILIATION, A PROCESS OF TRANSFORMATION AT UCT HEALTH SCIENCES FACULTY

NRF Project Report 15/1/3/21/0022

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TRUTH AND RECONCILIATION, A PROCESS OF TRANSFORMATION AT UCT HEALTH SCIENCES FACULTY

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As part of UCT Transformation process, four sub-studies were commissioned to explore the way in which staff and students experienced the UCT environment, both in the past under apartheid, and currently as UCT undergoes significant institutional transformation. These studies included: 1) A survey of black alumni using a semi-structured questionnaire involving both qualitative and quantitative data; 2) A postal questionnaire sent to all alumni from selected graduation years since 1945; 3) A set of in-depth interviews with UCT staff members who served as teaching staff under apartheid; and 4) a set of focus groups and individual interviews with current UCT staff who are disabled, female and black.

Analysis was conducted using a mix of quantitative and qualitative methods appropriate for the methods of data collection and design. Significantly, the different sub-studies converged on a set of common findings that were used to inform Faculty interventions to support institutional transformation.

The main findings to emerge included:

- Black students experienced various levels and manifestations of discrimination while at UCT. By acknowledging this discrimination, UCT will enable recognition of their experiences to take place so that reconciliation may be possible.

- Despite experiencing hurtful discrimination that adversely affected their learning opportunities and careers, black alumni still generally recognised many positive aspects of their training, including the presence of outstanding individuals who acted consistently in the best interests of their students, irrespective of their race. Many black alumni retained a level of loyalty and goodwill toward the institution which enabled them to express strong support for UCT's transformation process.

- Given the historical context, as an institution, UCT could be simultaneously opposed to apartheid as well as reinforcing apartheid's discriminatory practices. This explained many of the ambivalent or contradictory views expressed within and between individuals reflecting on UCT's past.

- An enabling environment, that recognises diversity and that values all members of the University Community is critical to transformation. Exclusion took place not just in the academic field but also in social terms, and the latter was as powerful in replicating disadvantage and discrimination. For this reason, it is critical to build an ethos that values all staff and recognises their human potential into all teaching, research and service in the faculty.

- Human Rights and respect for dignity should become a central part of the Faculty's activities. Moreover, reconciliation will be best acknowledged through concrete actions that promote human rights and diversity and counter discrimination and prejudice. For many alumni, practical progress in this regard will be the most important marker of reconciliation.

As a result of the research, a Special Faculty Assembly was held on 9th May 2002, at which the Faculty acknowledged its history, both of perpetuating discrimination, as well as enabling individuals to resist apartheid, and committed itself to redress of past inequalities through programmes that promote human rights, respect for human dignity and affirm diversity amongst all its staff and students. The Assembly adopted a new Faculty Charter, and a Student Declaration to this effect, and the research recommendations are being fed into the Faculty's ongoing programme for Transformation and Equity. The main challenge facing the Faculty arising from this process is to develop robust indicators of Institutional Transformation that will enable evaluation of the programmes success in the future.

TRUTH AND RECONCILIATION, A PROCESS OF TRANSFORMATION AT UCT HEALTH SCIENCES FACULTY

Chapter 1: Introduction

> *Historians, like their preliterate forebears the praise singers, pass on to generations that follow them the names of their kings and the tales of their brave deeds, as well as the mores, beliefs and prejudices of their society. We are entreated to learn from history if we are not to repeat its mistakes. How are we to learn from our mistakes if we do not acknowledge them, if we falsify and distort history by denying its painful aspects? In this way, long-discredited myths live on, fuelling the prejudice of successive generations.*
> (Rose Zwi, 1997:119)

Although Rose Zwi was writing about her quest to retrace what happened to her ancestors in Eastern Europe under the Nazi invasion 60 years ago, her sentiments are as relevant to the current dilemmas facing South Africa undergoing democratic transition. Indeed, scholars (Chapman, 1999; De Lange, 2000) writing on truth and reconciliation in South Africa make the same point - that to change the future, we need to better understand the past. The imperative to address the past is often mistakenly viewed as a tool for revenge and 'settling of scores' by many who think it best to forget the past, and 'move on.' However, when viewed in the appropriate historical context, understanding the history of discrimination and abuse in South Africa and in our own institutions is not about finger-pointing or blame but quite simply a requisite step to being able to plan and institutionalise a different kind of future.

Post-apartheid South Africa is emerging from decades of systematic discrimination that severely affected every aspect of civil society, including the health sector. Testimonies to the Truth and Reconciliation Commission (TRC) Special Hearings on the Health Sector in June 1997 highlighted the widespread and systematic allegiance of health professionals to apartheid ideology. The Hearings showed how some health professionals turned a blind eye to the plight of vulnerable patients in their care while others deliberately used scientific knowledge to aid the State in its fight against opponents of apartheid (TRC, 1998).

The TRC processes also highlighted the way in which health sector institutions willingly participated in violating the rights of South Africans, particularly black citizens (de Gruchy et al, 1998). Exclusion of black health professionals from membership or leadership roles in the profession, failure to oppose discriminatory conditions of service, and tolerance of racist treatment of patients stemmed from a profound indifference to human rights institutionalised in the health sector (Baldwin-Ragaven et al, 1999). The role of health sector training institutions in reproducing a society in which the violation of rights was normalised was especially highlighted in the Report. Students were trained in racially divided and unequal health facilities, under conditions that were explicitly discriminatory against black students, and in a context where human rights were treated with, at best, suspicion, and at worst, contempt. Unsurprisingly, the TRC considered this milieu to be one which encouraged students to ignore human rights and fostered a tolerance of unethical practices typical of apartheid health care (TRC, 1998).

The University of Cape Town (UCT) was not immune to the racist, sexist, and other discriminatory practices and values that typified society under apartheid. Indeed, it would not be plausible to consider UCT's record without understanding the context in which the

institution operated. What this meant in practice was that training curricula were such that students emerged with technical skills but without a critical understanding or appreciation of human rights challenges for health professionals.

While race was at the core of such discriminatory practices, many other forms of discrimination were operative, such as in relation to gender, a particular problem in hierarchical, sexist health training settings (Eisenberg, 1997). For example, student research in the Health Science Faculty at UCT in 1995 (Rose, 1995) highlighted many problems related to gender discrimination in teaching and the institutional culture.

Today, the university remains with the legacy of these discriminatory practices which is only now beginning to be acknowledged (Baldwin-Ragaven et al, 1999). While student admissions have over the past 5 years come to reflect greater numbers of black students (cite data and refs), staff profiles in the faculty remain overwhelmingly white, and, at senior level, male (see Chapter 2 for more detail). Turnover of black staff remains too high (ref to Empl Equity report, 2001), raising concerns as to how well UCT is succeeding in creating a welcoming academic environment, affirming of all its staff and students. Moreover, issues of diversity and institutional culture remain major challenges to creating an enabling learning climate (London et al, 2002).

It is in order to overcome this legacy, that the Health Sciences Faculty embarked on a Reconciliation Process intended to acknowledge both its part in perpetuating apartheid and in acts of resistance. This process is intended to provide institutional acknowledgement of the experiences of discrimination of alumni and former staff. The purpose is to ensure that: a) humans rights are never again violated in the faculty; b) the experiences are used to build a human rights culture in all the teaching, service and research undertaken in the Faculty; and c) some form of redress can take place through this acknowledgement and ownership. Examination of both the complicity of the Faculty in violations, and its acts of resistance to apartheid will be used as the basis for implementing its transformation processes. In this way, the University and the Faculty aims to situate itself firmly in the mainstream of the national agenda for transformation taking place as part of the democratic transformation in South Africa.

The Transformation Programme at UCT Health Science Faculty

To understand the Reconciliation Process and the place of research in that Process, an elaboration of the Transformation Programme in the Health Science Faculty is needed. In 1998, a Transformation Workgroup was established in the Faculty as part of a process of Faculty restructuring. The major part of the workgroup was to develop contributions to the Faculty's strategic plan, and the first University's Employment Equity plan. Already in this early stage of restructuring, issues of institutional culture and reconciliation were under discussion.

Partly in response to the efforts by WITS University, who implemented an Internal Reconciliation Commission (Internal Reconciliation Commission Summary Report, 1999) following the TRC's health sector hearings, UCT Health Science Faculty Board agreed in May 1998 in principle to the idea that a similar process be undertaken at UCT. The Transformation and Equity Work Group (TEW) was then mandated to explore the idea further and report back to Faculty. Preliminary meetings with black staff supported the notion, as did a survey of Faculty Heads of Department commissioned by the TEW at the end of 1998 (Ijane, 1999). However, at that stage, there was little concrete suggested as to how such a process might best be implemented.

Early in 1999 with the appointment of the new Dean, a Portfolio position on the Faculty Senior Management was created for Transformation and Equity, and this was followed shortly by the appointment of a full-time Transformation Officer for the Faculty. No other Health Science Faculty in South Africa appears to have invested as much human resources into Transformation in this time period and this has been reflected in the level of planning for transformation over the past 3 years (London and Perez, 2001).

The Transformation Programme proposed at the Faculty Board in November 2000 was unanimously adopted, and has formed the basis for subsequent activities. The range of activities undertaken is detailed in appendix 1. In brief, these activities are grouped into three strands - a) Employment Equity and strategies to support attainment of equity objectives; b) Examination and transformation of institutional culture through training, policies, sensitivity to diversity; and c) A Reconciliation Process. Underlying all three is the need to make human rights part of the mainstream business of the Faculty.

Unlike the WITS IRC, the route chosen by UCT to reconciliation has been somewhat different, focusing rather on using a research approach to capture the experiences of all stakeholders in what is a tremendously complex and in some ways, nuanced, moral issue. The reasons for choosing this route over a semi-judicial one were as follows:

- The WITS process was both strengthened and limited by its deliberate choice of a quasi-judicial format. The Commission was chaired by a retired judge and sat for a limited period to hear evidence, in much the same format as the TRC. As a result, it deliberately chose to avoid any questions on individual accountability, limiting submissions to broad systemic issues.
- More importantly, the WITS hearings were very limited in their reach with few submissions, all of which came from people who might be called 'victims' or 'survivors'. No beneficiaries or people who might have been considered to be supportive of discriminatory policies and practices testified to the Commission. The conclusions of the Commission were therefore based on a limited set of respondents.
- Although finally accepted by the official University structures at Faculty and University level, the report suffered a number of setbacks along the way. It was severely criticised for both procedural integrity and scientific validity, reflecting the fact that it was the product of a process driven by a few committed individuals.
- The report was not linked to concrete implementable outcomes, but was rather viewed as a symbolic statement by the Faculty. As such, some critics felt that it had not achieved what might have been possible, given the window of opportunity created by the (Goodman and Price, 1999).

As a result of these insights, and based on feedback from stakeholders on the utility of a Reconciliation Process at UCT, a different approach was devised that was to rely heavily on the use of research methodology to generate a common understanding of UCT's role under apartheid. A multidisciplinary team, including researchers from outside the Health Sciences Faculty convened to develop a proposal that was successfully submitted to the National Research Foundation in 2000. UCT's Research Committee made a small top-up contribution in 2001 to facilitate the work. Support for the research was also provided indirectly from the Portfolio Budget for Transformation and Equity, representing a direct input by the Faculty into the research process.

Thus, while a range of transformation activities (see Appendix 1) were underway in the faculty through 2000 and 2001, the research to support the Reconciliation Process ran concurrently. The official launch of the Reconciliation Process took place on the 5th June at a public function addressed by the Vice-Chancellor, Professor Ndebele, and was marked by the unveiling of a piece of art by Sue Williamson "Nkosinathi Biko - False Medical

Certificate - Dr Benjamin Tucker". The artwork focused on the role of the medical doctors in the abuse of Steve Biko and their failure to maintain ethical standards in the face of political pressure from the security forces, drawing attention to the importance of ethical practice in protecting the human rights of vulnerable patients. In launching the process, a new draft Faculty Oath was tabled for discussion amongst Faculty staff and students, in the form of a workbook based on a series of institutional culture talks held at UCT in 2000 and 2001.

Given this context, it is clear that the research detailed in this report forms part of a bigger programme around Transformation in the Faculty, and is both informed by, and informs such a programme. In particular, what this research sought to support was the processes of Reconciliation to be undertaken.

Motivation for this Research

> *One of the ways in which to start the healing process in South Africa is an honest assessment and diagnosis of the sickness within our society in an attempt to give people, both perpetrators and victims, an opportunity to face the past and its consequences and to start afresh*
> (Boraine as quoted by Stein, 1998).

The TRC's message has consistently been that only by learning from the past, can we promote an order based on respect for human rights in a democratic South Africa (de Lange, 2000). Equally, in order to transform the Health Sciences Faculty at UCT, there is a need to examine the painful history that UCT's Health Sciences Faculty has been through as a microcosm of South African society (de Gruchy et al 1998). Black students at UCT were prevented from entering white wards, were not allowed to be present at case presentations when white patients or at post mortems of white bodies, and were totally excluded from the social life of the university. (Baldwin-Ragaven et al, 1999). Some staff of the-then Medical Faculty spoke out about the exclusion of black students from these important events but those who opposed apartheid often received "little or no support (and often derision and hostility)" from either their colleagues or the management of the faculty (London et al, 1996). Two key histories (Louw, 1969, Kirsch, 1984) written about the Medical Faculty do not mention the difficulties faced by black students at all. Hence a senior academic's speech in 1963 on the ethos of medicine in the Faculty could comment "…I was referring here to extra-curricular activities. What of participation in UCT societies, in sport, going to dances…? By and large the best students have managed all these things..." (Kirsch, 1984: 303) without mention that black students were excluded from these activities.

However, reconciliation as an end in itself is of little meaning without contributing to structural redress, a concept Esterhuyse (2000) has called transformational justice. In developing this research, the team has been mindful of how to ensure that reconciliation occurs at more than just a symbolic level, but directly influences practice. For example, the results of the research will feed into revised modules on human rights and ethics that will be integrated into the new curriculum, and inform the development of new policies and procedures as part of the transformation process that is being undertaken in the faculty.

Aims and Objectives

The project aimed to facilitate and evaluate a Reconciliation Process in the Health Sciences Faculty at the University of Cape Town in order to inform a broader Transformation Initiative. It sought to answer a set of research questions relating to the experience of past and current staff and students in the Faculty:

1. What has been the experience of black and female staff and students at UCT? How has discrimination been experienced and what role did UCT, as an institution, play in relation to this experience?
2. How does this experience impede the realisation of a Transformatory Vision for UCT and the Faculty?
3. Identification of obstacles and faciliatory factors most likely to ensure success of a reconciliation process. What role can a process of acknowledging past and ongoing injustices play in achieving reconciliation within the Faculty and between staff?
4. How can such a reconciliation process contribute to ongoing transformation of institutional culture in teaching, research and service? How do those who benefited from and / or tolerated past abuses get drawn into this process?

To meet this aim, the study objectives sought to:

a) Explore the experiences of current and former black and female staff and students with regard to discrimination in the Faculty and the contribution of this experience to their career paths
b) Assess the attitudes of current and former black and female staff and students towards a Reconciliation Process in the Health Sciences Faculty at UCT with a view to identifying possible steps for redress.
c) Explore the experiences and attitudes of a sample of staff who held Faculty positions under apartheid to questions of reconciliation.
d) Review Faculty documentation for evidence of institutional support for, or resistance to, discriminatory practices.
e) Determine the impact of training on trends in the career paths of black and female graduates and former staff of the Faculty in relation to changes in the environment at the University and the Faculty.

The Research Team

Because of the inherently multidisciplinary approach needed to address questions of transformation and discrimination, the project drew together a diverse group of researchers from a wide variety of disciplines and sectors - health sciences, social sciences, human rights NGO's, human resource practitioners and the law. The full research team is listed in the Table below. The project also appointed a junior trainee researcher, Ms Ayesha Fakie, (already involved in pilot research) who assisted in planning, conducting and analysing different aspects of the research under the supervision of the multidisciplinary team.

Name	Race/Gender	Discipline	Post and affiliation
Dr Gonda Perez	CF	Dentist	UCT HSF Transformation Officer
A/Prof Leslie London	WM	Doctor, Public Health	Portfolio Manager: Transformation and Equity, UCT
Prof. Dumo Baqwa*	AM	Primary Health Care and Family Medicine	Head of Department, Primary Health Care
Dr Shajila Singh	IF	Logopaedics	Lecturer, Speech Therapy
Dr Laurel Baldwin-Ragaven	WF	Doctor, Family Physician	Lecturer, Dept. PHC and formerly Health and Human Rights Research Fellow
Ms Nomfundo Walaza	AF	Psychology	Director: Trauma Centre for Survivors of Violence and Torture

Ms Gubela Mji	AF	Physiotherapy	Physiotherapy Department
A/Prof Andy Dawes	WM	Psychology	Psychology Department
A/Prof. Louis Reynolds	WM	Paediatrician	Paediatrics Department
Ms Miriam Hoosein	IF	Human Resources	University Employment Equity Unit
Ms Ayesha Fakie	IF	Industrial Psychology	Researcher for the Transformation and Equity Portfolio
A/Prof. Howard Phillips	WM	History	History Department

* Tragically, Professor Baqwa died in August 2001.

To facilitate interaction with the rest of the Faculty and alumni, an advisory committee was established to oversee aspects of the research process. The Advisory Committee commented on the questionnaires and provided a letter of support for distribution to alumni to motivate participation in the research. Members of the Advisory Committee included Professors S. Saunders, JC de Villiers, and JP van Niekerk, Doctors N. Matsiliza and A. Aboo and the Dean, Professor Padayachee.

Approach, Assumptions and Methodology

The research approach in this project started from the position of seeking to give voice to those marginalised from positions of power in the academe. It also assumed that in order to achieve change in organisational culture one needs to first understand the past, so as to plan for the future. Simply acknowledging past wrongdoing is only the first step in a process of transformational justice. The centrality of participation of both "victims" and "perpetrators" in the solutions is critical. In any event the exclusive categorisation of perpetrators and victims are not always based on clear-cut or static differences.

Methodology

The methods used in the research were both qualitative and quantitative, and took the form of a range of different sub-studies, as indicated below.

1. Black Alumni
   Snowballing techniques were used to assemble interviews with black alumni who graduated from UCT over the past 6 decades.
2. All Alumni
   Alumni records of the university were used to construct a sampling frame for a postal survey based on a semi-structured questionnaire.
3. Staff who worked at UCT during the apartheid years
   Employment records of the university were used to construct a sampling frame for interviews with staff who taught in the Faculty prior to 1990. These lists included some staff still currently teaching at UCT.
4. Current disabled, female and black staff
   The target group here included both academic and non-academic staff. Staff to participate in these groups were identified by word of mouth and by means of adverts placed on the electronic noticeboard.

Information from university records was used to supplement empirical data. These included minutes of meeting of the Faculty Board and other governance structures, and

archival information held at UCT archives. Human resource data on staff retention and turnover was also reviewed as background information.

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Appendix - Transformation and Equity Portfolio Workplan for 2001

L London
G Perez

Overall Strategic Goals:

- To facilitate a process of Transformation and Employment Equity in the Health Science Faculty at UCT
- To place Transformation and Equity on the agenda of all Faculty Structures so as to ensure its uptake in all Faculty Planning

Specific Areas:

- To promote the application of Employment Equity policies in the Faculty
- To facilitate the transformation of institutional culture
- To promote a process of Institutional Reconciliation
- Communication with internal and external stakeholders

The Faculty Transformation and Equity Workgroup will continue to play an advisory role to the Portfolio.

I. TRANSFORMATION AND EQUITY – PLANNING FOR 2001/2					
EMPLOYMENT EQUITY					
Sub-Objectives	**Strategy and Methods**	**Resources / strucures**	**Timeframe**	**Output/Indicators**	**Other Portfolios**
T/Equity reps on selection committees in the HSF	Establish policy to make TEW members operate effectively on committees Training of T/Equity reps for Academic and Admin/Support Selection Committees Regular feedback from reps, review Audit of T/E reports	Training to be done with HRO and EE Office	Commenced in 1999 – ongoing Admin training by mid 2000 Audit end 200	TEW members enskilled to provide input to selection committees Indicators: Reports on S/Committees Formal audit Increased numbers of blacks and women in new posts	Staffing Human Resrouces
T/Equity training for Chairs of Selection Committees	Identify suitable candidates Conduct training to ensure pool of Chairs Selection Committees for T/Equity	Training to be done with HRO and EE Office	March 2000	Selection Committees for which Dean nominates Chairs; Committee reports	
Departmental Transformation Plans	Line item in Dptml OP plans on Equity; Workshops available to assist departments in Tr/Eq planning	Integrate in Faculty Planning process	Implement for new Departments in 2001	Standard and auditable Equity plans at Dpt level in HSF	Faculty Operations Manager and staff
Policy on recruitment	Continuous review of content of existing and proposed recruitment policies Review of implementation of policies – EE stats	Data and analysis from UCT HR, HSF HR, and PAWC Input from TEW	Ongoing Six monthly review of EE stats	Consistency HSF policies with UCT generally and PAWC EE stats	PM: Staffing PM: P/Grad progs PM: P/Grad studts PAWC
Pro-active recruitment of registrars	Establishment of database of graduates Establish networks through graduates Visits to other centres by senior faculty staff to encourage applications Bridging posts Policy on registrar recruitment UCT input to PAWC adverts	Use of development posts where appropriate; Raise funds ex- private sector for bridging training posts; Travel to other centres for meeting potential applicants;	Faculty HoD meeting mid-2001 Recruitment trip mid-2001 Active contacting of networks Aug+ Other activities ongoing Annual reporting	Improved profile of applicants to UCT; Improve profile of appointees	Staffing HRO PAWC PM: P/Grad progs PM: P/Grad studts

Consonance of PAWC and UCT recruitment policies for joint staff	Workshop with PAWC on joint appraoch Consistent Policy and monitoring of implementation UCT input to PAWC adverts Inclusion of Joint posts in T/Eq for HoD performance appraisal	Data from PAWC	Annaual reporting	Improve profile of joint staff appointees (specialists)	Staffing HRO PAWC
Development of a database on potential candidates	Liaison with Alumnus Office Enlist support of SA Embassies (esp UK, USA and Canada) Identify networks for advertising	Costs of communication (minimal) Piggy back onto other international visits (i.e. minimal extra costs)	Establish contact with embassies mid 2001 Dbase by end August	List of potential candidates by skills, area; contact details	Alumnus Office UCT
Monitoring of progress to EE targets	HRO to summarise appointments Review notes of Chair of Selection Committees; T/Equity reps PM TrEq, TEW, HRO to conduct audits, consider reports;	Requires adequate database function at UCT	6-monthly reports; Faculty databases adequate by end 2001	EE Report to the Dean and the HSF Data for planning TE interventions	HRO HSF Staffing HR UCT HR PAWC
Monitor obstacles to EE	Exit interviews with black staff leaving Interviews with current black and female staff	HR UCT for data on exit interviews Research project for current staff – R 20 000 ex-T/Equity budget	Exit interviews routine (HR); Staff interviews project Apr - Sept 2001	Profile of institutional factors contributing to barriers	HR UCT UCT CHED (project consultant)
Career nurturing of undergraduates	TEW to set up discussions with students;		Ongoing	Identification of career needs	PM: U/Grad students
TRANSFORMATION OF INSTITUTIONAL CULTURE					
Situation Analysis regarding Disability in the HSF	Establishment of Disability sub-group within TEW; Planning of HSF Survey (via Physio students); Liaison with Disability Unit		Dis s/group running by June 2001; Plan for HSF survey in place by June 2001.	Survey in 2000 will be used to develop plans to address disability issues in the HSF	Disability Unit (UCT) Physio and other depts
Public seminars	Regular Public Seminars Development of manual for transformation based on past seminars	Ad-hoc costs of bringing speakers; catering Costs of producing manual - +/- R 10 000 (in budget)	Future seminars at 3 to 4 monthly intervals; Manual by June 2001	Production and distribution of discussion papers, documents, manual	

Exhibition 'Truth Games' – Sue Williamsonb	Regular Public Seminars Development of manual for transformation based on past seminars	Ad-hoc costs of bringing speakers; catering Costs of producing manual - +/- R 10 000 (in budget)	Future seminars at 3 to 4 monthly intervals; Manual by June 2001	Production and distribution of discussion papers, documents, manual	
Departmental level Transformation activities	Encourage T/f activities in deptmts Invite HoDs to T/f activities elsewhere		Ongoing	Greater involvement at dept level in T/f	HoDs SMT
Development of a tool for measuring institutional transformation	Support from Anthropology discipline to develop Social Science Tool Lit review	Research assistance (in budget)	Lit rev 2000; Meet Anthropol. Aug 2000; Pilot in 2001; apply 2002; write up 2003	Publication in the peer-reviewed literature; Raised profile of transformation at UCT;	Raised profile for UCT
Implementation of awards for community based student research	Discuss with Director Research; Ideas from students how to implement	Awards for student projects	System in place by 2nd half 2001	Incentives for students to engage in tranformatory research; Greater profile of tranformatory research in HSF	Director Research
Review way in which Research in the HSF can support transformation	PM Tr Eq to liaise with Director Research; workshop with TEW		Early in 2000	Proposals to be developed with Research Director July 2001	Director Research
Input to Curriculum Reform	TEW to comment on documentation; TEW and PM Tr Eq to participate in relevant curriculum reform opportunities		Ongoing	Transformation issues inserted in curric. Ref. agenda	
Address cultural diversity in the learning environment	TEW to set up discussions with students; Liaison with PM: U/grad recruitment Support existing faculty initiatives	Produce manual from PHC/PH diversity training: R5000	Manual completed by Sept 2001	Identify facilitatory factors for student development Dissemination of manual	CHED EDU
Human Rights Fellowships	Establish one or more HR fellowships in the Faculty	External funding sought - R 80 to 150 000 per year.	Dependent on funding	Appointment of fellow/s Fellowship research	UCT DPR
Faculty Human Rights workshop	Inter-institutional workshop on human rights for Human Rights Day	Venue costs (R11 000)	March 20th 2001	Plan of Action Statement	HoDs Other institutions ? Chancellor

Faculty Constitution	Workshop common oath (Prof Benatar) Develop Faculty statement of values/constitution		June 10th 2001	Adoption of Oath Adoption of Constit.	SMT
RECONCILIATION PROCESS AT UCT					
Establish Advisory Committee	Respected faculty leadership support to assist buy-in by wider faculty	Learn from WITS experience	Early 2001	Letter of support to be disseminated	Dean
Implement Research Process	Interviews with black former students; Interviews with staff Questionnaire mailed to alumni	Budget for full research R 140 000; NRF grant secured for R 62 000; about R 80 000 sought from URC in top-up.	Partly commenced Aim for completion end 2001	Research Report presented to Dean, SMT, Faculty	SMT HoDs
Faculty Assembly	Presentation and adoption of Research Report; Public commitment to fighting discrimination in all its forms in future	Budget for Fac Assembly:	Dec 2001	Faculty Oath/Statement	SMT
Archival and other Research	Review of University documents; Draw on Oral History Project;		Research Ongoing in 2000	Documentation to support reconciliation process	
COMMUNICATION					
External Communication with key stakeholders	Dean, PM TrEq to undertake meetings with key stakeholders; Fundraising; Dissemination of reports	Strategising with Andy Sillen; Budget with DPR	Ongoing Fundraising plan in place	Data for presentation to Parliamentary Portfolio Committee; funding raised	
Internal communication	PM Tr Eq to provide regular feedback to HSF FB, SMT; Availability of documents		Feedback ongoing;	Greater awareness of Tr issues in Faculty	
Internal communication	Establish rubric for transformation on UCT Electronic noticeboard		Email board by June 2001	Greater profile for transformation activities	

HRO = Human Resources Officer in the Health Science Faculty (Louw Toerien)
PM TrEq = Portfolio Manager, Transformation and Equity (Leslie London)
Tf Officer = Transformation Officer (to be appointed)
TEW = Transformation and Equity Workgroup
EE Office = Employment Equity Office (Frank Molteno, Miriam Hoosain)
UCT HR = UCT Human Resources

Chapter 2: The historical context

In South Africa race and gender discrimination have intersected. A Medical Association of South Africa [MASA] submission to the Truth and Reconciliation Commission [TRC] in 1997 examining its past history, described the organisation as 'white, male, elitist, educated, professional'.[1] These words, while none of them derogatory in themselves, in combination sum up some of the issues which this historical background to discrimination at UCT Medical School has attempted to explore. What is at issue is not only the nature of the medical profession but also the kind of medicine inculcated at the Medical School.

This study has attempted to go beyond a simple catalogue of events. The first section makes the point that segregation was entrenched in South Africa, even in the relatively liberal Cape, well before Union. The medical profession at the Cape played its part in this process, calling for segregation on sanitary grounds. The second part of this study explores the intellectual context of racism in medicine, noting the role of anatomy in contributing to notions of scientific racism. It argues that, up to the Second World War, doctors were functioning in a world in which racial differences were taken for granted and such views were part of their mindset, rarely examined and questioned. The cohesiveness of the medical profession in itself tended to reinforce such perspectives.

The following two sections, dealing with the periods before and after the Second World War, provide a brief political and social background. In the section dealing with the interwar period, the ongoing question of black admissions into the Medical School is the main focus. The changes which occurred are noted, as well as UCT's own admissions policy. The part dealing with the apartheid years opens with a brief consideration of the emergence of social medicine in South Africa - a development which arose because of declining health of black people and the urgent need to provide more effective care for Africans in the rural areas especially. UCT's response to this trend is explored. The remaining part of the section examines the tightening grip of apartheid and the Medical School's changing response to repression.

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[1] South Africa. *Truth and Reconciliation Report*, (Pretoria, 1998), vol.4, 146.

There is less consideration of gender issues in this study, mainly because relatively little historical writing has focused on overt discrimination suffered by white women in their undergraduate training. Legal discrimination facing women arose more explicitly once they started work. Although most legal disabilities were removed fairly quickly once the South African Society of Medical Women started a campaign to remedy these deficiencies, postgraduate training for women remained a very difficult experience for women well into the 1990's[2]. The situation was very different for black women whose position is touched on briefly.

One point should be made. A work such as this tends to highlight the inequities, the injustices and the sheer apathy of an institution and its members. This is hardly a fair picture. Although I have tried to indicate, at least in the apartheid period, where opposition to discrimination occurred, the picture is unbalanced. It should be said at the outset, therefore, that I am aware that this is a study of usually dedicated and humane people, shaped by the context of the time, responding to a complex and difficult world.

South Africa before Union

In attempting to place discrimination in the UCT Medical School into an historical context, it is useful to go back as far as the end of the nineteenth century when segregation was more firmly and more formally entrenched in the British colonies. The Boer republics made no bones about the fact that racial segregation was one of the keystones of their societies. Blacks had few legal rights and Indians were excluded entirely from the Orange Free State (and remained so until about 1994). But the situation was more ambiguous in the British colonies, particularly in the Cape where there was a race-free franchise. Although black rights under the franchise had been eroded since it had been introduced in 1872, all black men with the requisite financial or educational qualifications had the vote. In some constituencies in the Eastern Cape the black vote was a real force and even in Cape Town politicians could not ignore it.

This did not mean, however, that blacks were not increasingly subjected to discrimination. By 1900 the public schools were largely closed to blacks who were

[2] Saloojee H, Rothberg AD. (1996). **'**Is registrarship a different experience for women?' S Afr Med J. 1996

usually confined to mission schools with inferior education. The exceptions were the handful of mission colleges in the Eastern Cape, such as Lovedale and Healdtown, where the standard of education was comparable with many white schools. The quality of education was important since it was an additional obstacle to the acquisition of medical training for blacks, of whom there were four or five on the Cape medical register before 1910.[3]

Other institutions, particularly medical institutions, were also becoming segregated by 1900. This was true of most hospitals, although in overcrowded and underfunded institutions like the Old Somerset Hospital for the chronic sick poor this discrimination was often ignored. The newly-built Valkenburg Hospital, on the other hand, was intended entirely for whites, confining black 'lunatics' to Robben Island. The trend, in other words, was towards increasing segregation and the medical profession concurred in this process.

In fact, doctors did more. Medical officials in colonial and local government were active in promoting segregation. In his seminal article on 'The sanitation syndrome' Maynard Swanson has drawn attention to the way in which the colonial medical authorities seized the opportunity of the outbreak of plague in 1901 to establish locations and remove Africans, identified as the source of infection because of their living conditions, from the cities in Cape Town, Port Elizabeth and East London.[4] Other historians have developed this point further.[5] In acting in this way colonial practitioners had the support of the best imperial authorities. A man like Sir William Simpson, Professor of Hygiene at King's College, London, whose plague experience had been gained in India, would gladly have seen segregation carried to far greater lengths if it had been economically practicable.[6] Political rights then, did little to save blacks from a discrimination which was sanctioned

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[3] E. van Heyningen, (1989). 'Agents of empire: the medical profession in the Cape Colony, 1880-1910', *Medical History*, 33 (1989), 450-71.

[4] M.W. Swanson, 'The sanitation syndrome: bubonic plague and urban native policy in the Cape Colony, 1900-1909', *Journal of African History*, 18(3), (1977), 387-410.

[5] C. Saunders, 'The creation of Ndabeni. Urban segregation and African resistance in Cape Town', *Studies in the History of Cape Town*, 1, (1984) 165-93; E. van Heyningen, 'Public health and society in Cape Town, 1880-1901', (unpublished Ph.D. thesis, University of Cape Town), 1989, 286-349.

[6] M. Sutphen, 'Striving to be separate? Civilian and military doctors in Cape Town during the Anglo-Boer War', in R. Cooter et al, *War, Medicine and Modernity* (Stroud, Sutton Publishing, 1998), 50.

by apparent scientific advance. Segregation and the forces of modernism went hand in hand.

The situation in Natal was far less liberal. Although, in theory, Natal also had a race-free franchise, colonial settlers were almost completely successful in excluding blacks from the vote. Given this attitude, blacks were even more likely to be stigmatised as a source of infection, a threat to the health of white settlers. Segregation was nearly as intractable as it was in the Boer republics - the main difference was that it was sometimes a matter for debate.

When South Africa entered Union in 1910 the position of blacks was further weakened. Although black men retained the franchise in the Cape, Africans were soon confined to voting for 'native representatives' rather than participating in the common vote. When white women were enfranchised in 1930 it was partly because their vote helped to outweigh the influence of the coloured vote in the Cape. Politically the Cape continued to differ from the other provinces in that coloured people and Indians could, and did, sit on municipal councils. The redoubtable Dr Abdurahman was an outstanding figure in Cape Town local politics - a status which he acquired partly by virtue of his medical qualifications[7].

A world of unstated assumptions: racism and medical science

In seeking to understand why humane doctors were so slow to resist apartheid practice in medicine, one needs to look beyond the march of events; to explore the *mentalité* of the profession.

> Discrimination is an infinitely more subtle process than the crude practice of apartheid. Discrimination and racism have often operated within a context of what Philip Curtin has called the 'world of unstated assumptions', ideas which have become so culturally embedded that they are rarely discussed or critically examined. Writing of the racism of

[7] Dr Abdurahman was the founder of the African People's Organisation (APO) in 1902, one of the first black political organisations in South Africa. He was also the first black city councillor in Cape Town and remained on the council for several decades. He obtained his medical qualifications in Glasgow. See: G. Lewis, Between the Wire and the Wall. A History of South African 'Coloured' Politics, (Cape Town, David Philip, 1987).

> British colonial officials he notes that: 'The more cohesive the society, the less need to bring these unstated assumptions into the open'.[8]

South Africa in the twentieth century was one such world. Medical practitioners, as products of their society, often shared racial assumptions. More than this, their medical culture reinforced such premises, giving them scientific credibility.

By the twentieth century the South African medical world was, in many respects as cohesive as that of the British ruling establishment. This was even more true of the Cape. Before colonial doctors could train locally the great majority, as is well known, trained in Scotland, notably in Edinburgh. Moreover, since overseas training was financially unattainable for many colonials, most doctors were British-born, with Scottish doctors predominating.[9] When the UCT Medical School was established, the teaching staff was largely recruited from Scotland, particularly in the early years, and the model of the curriculum was also Scottish.[10] The result, at least up to about 1939, was 'an unanticipated coherence which was reflected in the general approach to the medicine of its graduates. Typically, he or she became a safe, Scottish-style general practitioner, able to perform satisfactorily in all branches of medicine.'[11] Nor was this influence confined to Cape Town. The Wits Medical School was similarly endowed at first.[12] The schools shared a Scottish tradition of comparative anatomy, a heritage that helped to stimulate ongoing interest in the subject.[13]

In other respects, too, the South African medical profession was relatively cohesive. By 1940 there was an infrastructure of medical organisations and institutions which set standards and promoted the interests of practitioners. These included the Medical Association of South Africa [MASA], the South African Medical and Dental Council [SAMDC] and a variety of journals, amongst them the *South African Medical Journal*

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[8] P. Curtin, *Images of Africa*. British Ideas and Action, 1780-1850 (Madison, University of Wisconsin Press, 1964), vii.

[9] H. Phillips et al, *The Cape Doctor. The Cape Medical Profession in the Nineteenth Century* (Amsterdam, Radopi, 2003-4 *In press*).

[10] H. Phillips, *The University of Cape Town 1818-1948. The Formative Years* (Cape Town, University of Cape Town Press, 1993), 85.

[11] Ibid., 102.

[12] B.K. Murray, *The Early Years. The University of Witwatersrand Johannesburg and its Precursors, 1896-1939* (Johannesburg, Witwatersrand University Press, 1982), 177; S. Dubow, *Scientific Racism*, 23.

[SAMJ], dating back to the nineteenth century in various forms. The process of professionalisation itself reinforced the cohesiveness of medical practitioners. There is a considerable sociological literature on professionalisation which emphasises, for instance, the ways in which a profession excludes, and how it accumulates and mystifies knowledge to ensure the continued need for professionalisation. Liz Walker has argued that medical professionalisation has also been a gendered process, entrenching institutionalised male power.[14] The point is that medical professionalisation was a powerful and conservative process which not only excluded competitors but reinforced bonds within the profession, leaving limited space for opposition and conflict.

This coherence was partially dissolved when medical schools were established at the Afrikaans-speaking universities. The effect was to train doctors who were exposed mainly to the values of emergent Afrikaner nationalism. By 1948, when Malan's Afrikaner Nationalist government took power, Afrikaner doctors had a dominating place in many of the regulatory medical institutions. The result was that MASA, especially, had become politically conservative, unwilling to challenge the injustices of apartheid, even when they ran counter to ethical medical practice. But English-speaking doctors were often equally reluctant to question government actions. There were a number of reasons for this, some of which will be explored later, but a sense of solidarity with their fellow doctors, a reluctance to cause controversy within their professional institutions, and racist thinking itself, undoubtedly played a part.

It was against this background that Curtin's 'world of unstated assumptions' functioned. The role of scientific racism in shaping apartheid has been admirably explored by Philip Curtin, Saul Dubow and Leonard Thompson, amongst others.[15] There is no place here to examine the influence of scientific racism on medicine in any detail, but several points can be made.

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[13] Dubow, *Scientific Racism in Modern South Africa* (Cambridge, Cambridge University Press, 1995), 39.

[14] E. Walker, 'The South African Society of Medical Women, 1951-1992: its origins, nature and impact on white women doctors' (unpublished Ph.D. thesis, University of the Witwatersrand, 1999), 7-9, 26-33; See also F.R. Ames, *Mothering in an Apartheid Society*, 2d ed. (Cape Town, The Author, 2002)

[15] Curtin, *Images of Africa*; Dubow, *Scientific Racism*, L. Thompson, *The Political Mythology of Apartheid* (New Haven and London, Yale University Press, 1986).

The emergence of modern medicine was closely linked to the emergence of modern scientific thinking. Systems of classification, the use of statistics, and the critical study of the human body were all elements of modern science by the nineteenth century. But these developments took a racial turn fairly early. Anatomists, particularly, began to classify human 'types' and to establish a hierarchy in which Europeans were regarded as the most advanced and Africans, especially 'Hottentots' and 'Bushmen' were at the bottom of what was to become an evolutionary scale. Such ideas soon went well beyond the scientific and educated world, to become part of popular discourse. The notorious Edinburgh anatomist, Robert Knox[16], played a particularly significant role in promoting early physical anthropology and in popularising it. Curtin describes him as 'the first real founder of British racism and one of the key figures in the general Western movement towards a dogmatic pseudo-scientific racism'[17]

The relationship between trained scientific thought and popular notions is not a simple case of dissemination downward, distorted or otherwise. Scientists themselves imbibe cultural norms which may serve in turn to shape their training and research. An obvious example in the nineteenth century is the way in which the beliefs that women were naturally passive creatures, prone to hysteria, unfitted for a public role, were confirmed, reinforced and promoted by the medical profession of the day.[18] Ideas about race were equally vulnerable to cultural misconceptions.[19] They proved, moreover, extraordinarily flexible in the face of fresh scientific thought. Emerging forty years before Darwin's *The Origin of Species* in 1859, scientific racism took evolutionary theory on board readily, giving rise by 1900 to eugenics - the belief that races were engaged in a struggle for

[16] Dr Knox was an Edinburgh surgeon in the early 1800's who employed the dubious services of a pair of grave robbers, William Burke and William Hare, to find corpses for his anatomy classes. Burke and Hare began to murder victims for money in order to supply Knox with cadavers for dissection. After being caught, Hare turned state witness, and William Burke was found guilty, sentenced to hang and his body to be publicly dissected. Dr Knox was never charged with a crime but the Edinburgh citizens were angry at his involvement and there was a riot outside his house shortly after the trial. He eventually left Edinburgh due to dwindling uptake of his classes and his general unpopularity, and moved to Glasgow and later London where he eventually died in 1862. Accessed at http://www.edinburgh.gov.uk/libraries/historysphere/burkeandhare/burkeandhare.html

[17] Curtin, *Images of Africa*, 377.

[18] E. and E. Showalter, 'Victorian women and menstruation', 38-44, J. Conway, 'Stereotypes of femininity in a theory of sexual evolution', 140-54, and P.T. Cominos, 'Innocent femina sensualis in unconscious conflict', 155-72 all in M. Vicinus (ed.), *Suffer and Be Still. Women in the Victorian Age* (London, Methuen, 1972).

[19] Dubow, *Scientific Racism*, 6-7.

survival and that the unfit should be eliminated lest the race become degraded, unfit also in the political struggle for survival between nations.

It was not surprising that teachers in South African medical schools, like their peers abroad, should hold views on the superiority or inferiority of races. At Wits H.B Fantham, professor of zoology, for instance 'interested himself in questions of human heredity and "race admixture" and warned against mixing the races in South Africa'.[20] Better known was Raymond Dart, professor of anatomy, who was also, for many years, external examiner in anatomy at UCT. A controversial figure in his day, Dart remains contentious now. Dubow has drawn attention to the racism which infused his views on physical anthropology. Dart's story, he suggests, must be told with reference 'to the wider assumptions about the nature of race, within which he operated and did so much to sustain.'[21] Assumptions of intrinsic racial difference and notions of superiority and inferiority were so embedded in Dart's lifework, he suggests, that it is impossible to assess his contribution to anthropological knowledge in isolation from this fact.[22]

The professor of anatomy at UCT, Matthew Drennan, another Edinburgh graduate, shared similar views. Drennan was a successful and influential teacher, whom Christiaan Barnard described as his ideal.[23] Much of Drennan's research was devoted to the investigation of the 'Boskop man' which hypothesised that modern 'Hottentots' and 'Bushmen' were degenerate lineal descendents of an earlier physical type. He was, Dubow suggests, contemptuous of modern 'Bushmen' whom he regarded as the human equivalent of the dodo. He 'reinforced the racist conception that they were not fully human. His dismissive references to them as "morphological Peter Pans' encouraged the view that they were "the race that never grew up".'[24]

South African physical anthropologists did not exist in an ivory tower. Dart, particularly, was a vigorous populariser of his own views and they had a wide influence beyond

[20] Murray, *The Early Years*, 157.
[21] S. Dubow, 'Human origins, racial typology and the other Raymond Dart' in A.F. Alexander et al, *Africa Today. A Multi-Disciplinary Snapshot of the Continent in 1995* (Canberra, Australian National University, 1996), 255.
[22] Ibid., 257.
[23] C. Barnard and C.B. Curtis, *One Life* (Cape Town, Howard Timmins, 1969), 60.

academe. Scientific thinking of this kind infused the speeches of intellectual South African politicians like Smuts and J.H. Hofmeyr. Thus Smuts, giving the keynote address to the South African Association for the Advancement of Science in 1932 could say:

> 'We see in the one the leading race of the world, while the other, though still living, has become a mere human fossil, verging on distinction. We see the one crowned with all intellectual and spiritual glory of the race, while the other still occupies the lowest scale in human existence. If race has not made the difference, what has?'[25]

Moreover, in South Africa science was closely identified with rational progress. Dubow has pointed out that as racial segregation came to dominate the political agenda from the early 1920s, intellectuals and social reformers embodied scientific findings in their rationalisation of segregation. The intellectual politician, J.H. Hofmeyr, declared in 1929 that the challenge of science in Africa was to help determine 'the lines along which white and coloured races can best live together in harmony and to their common advantage'.[26]

It was influences such as these that led Leonard Thompson to conclude that before 1948 'there were no fundamental, generic differences' between the racial assumptions of Afrikaners and of other white South Africans. Such differences as existed, he suggests, 'were more a matter of occupation, class and regional milieu than of ethnicity'. Most simply assumed that they were members of a race that was superior to that of other races in Africa.[27]

After the Second World War racist physical anthropology became discredited. The terrible racist logic of the Nazi Holocaust did much to turn minds against such ideologies. The development of genetics also gave new directions to scientific thinking

> 'Strongly informed by the 1952 UNESCO statements on race, the new discourse embraced keywords such as gene "pools", "clusters", "flows" and "breeding populations". This vocabulary indicated a departure from the static associations of typological analysis, and a new emphasis on the dynamic plasticity of human populations. The "races of man" paradigm was openly disavowed and replaced by

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[24] Dubow, *Scientific Racism*, 51; D.J. Coetzee, *Living with the Dead. Impressions of Some Years with Professor M.R. Drennan in the Anatomy Department, Medical School, Mowbray, Cape* (Observatory, The Author, 1954), 49.
[25] Dubow, *Scientific Racism*, 42, 51.
[26] Ibid., 14-17.
[27] Thompson, *Political Mythology*, 100.

> "populations" and "ethnic groups". These were said to "grade into one another to such an extent that races or sub-species as normally defined in zoology", were "meaningless when applied to anthropology".'[28]

Men like Drennan, Dubow suggests, struggled to adjust to these trends, still clinging to notions of racial diversity, where genetics now emphasised unity. And these ideas about racial typology and consequent racial hierarchy lingered on into the 1960s. Colleagues were often slow to disavow the work of their eminent mentors. Dubow has pointed to the ambiguity in Phillip Tobias's statements about Dart.[29] At UCT, J.H. Louw's history of the UCT Medical School gives no hint that Drennan's researches had become discredited.[30]

The above discussion is not to suggest that racist physical anthropology formed part of the undergraduate medical curriculum. Indeed, one student noted that when he was examined by Dart in anatomy, he knew nothing of the Taung skull and the 'missing link problem'.[31] Medical students were educated at home, in school and at university in a context in which differences between the races was taken for granted and the inherent superiority of 'Europeans' assumed. The road to change was long and slow.

Between the wars

The first half of the twentieth century saw the rapid consolidation of mining as the predominant force in the economy of the country, predicated on the super-exploitation of black labour. While racial discrimination was the official policy of successive governments, , the implementation of racial discrimination was widespread and systemic under apartheid. Political resistance to racial oppression was manifested mainly in non-violent appeals to the white ruling authorities, premised on liberal notions of fairness and justice for the indigenous population that had formed part of the rhetoric of justification for British colonial expansion. Not surprisingly, such efforts were ineffective in halting

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[28] Dubow, *Scientific Racism*, 65.
[29] Dubow, 'Human origins', 262, 273-274.
[30] J.H. Louw, *In the Shadow of Table Mountain. A History of the University of Cape Town Medical School and its Associated Teaching Hospitals up to 1950, with Glimpses into the Future* (Cape Town, Struik, 1969), 261.
[31] R.E. Kirsch and C. Knox, *UCT Medical School at 75* (Cape Town, Department of Medicine, University of Cape Town, 1987), 207.

the growth of white exclusionary politics that was manifested in the subsequent ascent to power of the National Party in 1948, and its apartheid policies.

Initially Union in 1910 did little for the advance of medicine. The early Union governments, dominated by ex-Republicans who had placed relatively little store by a well-developed medical bureaucracy, failed to establish medical practice on a national footing before the First World War. Only after the scandalous mortality of the 1918 Spanish influenza epidemic revealed how poor the health status of the Union was, did the government establish a national Department of Health.[32] The gradual realisation that the migrant labour system, combined with viciously unhealthy conditions on the mines, was undermining the economic security of the country, led to the establishment of research institutions to investigate industrial health. Even so, tuberculosis especially, took an increasing toll of South Africa's workers, not only on the mines but more and more in the rural areas as well as a result of desperate conditions under which the rural population were increasingly forced to live.[33]

Tuberculosis was not the only reason for the poor health of South African blacks. During the interwar years a symbiotic process occurred in which poor whites were empowered while blacks lost most of the little access they had to wealth and power. The 1913 Land Act was crucial in removing Africans from land outside the designated reserves and forcing them into the overcrowded black territories. The right to work in the towns was circumscribed by the Urban Areas legislation which was based on the premise that Africans should only be allowed into the towns to provide labour for white industry and business. The pass system has an ancient history in South Africa, but it was more strictly enforced now and Africans were largely confined to designated townships. It is true that some inner city areas like Sophiatown survived but, as segregation tightened its grip, this became less common. Africans remained in the towns largely because state structures were not yet sufficiently well funded to enforce the law rigorously.

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[32] H. Phillips, ' "Black October": the impact of the Spanish influenza epidemic of 1918 on South Africa', *Archives Year Book for South African History*, I, (1990).

[33] R.M. Packard, 'Industrialization, rural poverty and tuberculosis in South Africa, 1850-1950', 104-30 and S. Marks and N. Andersson, 'Industrialization, rural health, and the 1944 National Health Services Commission in South Africa', 131-162, both in S. Feierman and J.M. Janzen (eds), *The Social Basis of Healing in Africa* (Berkeley, University of California Press, 1992), 104-130.

Coloured people and Indians were particularly affected by government programmes to uplift poor whites during the interwar years. Sub-economic housing was usually built for whites while coloured people were left to the increasingly depressed inner-city slums, especially in areas like District Six in Cape Town. More serious was the institution of job reservation. Young coloured boys found it almost impossible to get apprenticeships; white women replaced coloured in the factories. The result was unemployment and impoverishment which was reaching crisis proportions by 1939. During the 1930s, in the wake of the Great Depression, which had hit South Africa particularly hard, both social services (mainly for whites) and social science as a discipline had evolved. At the Universities of Cape Town and Stellenbosch departments of sociology were established (that at Stellenbosch under the young academic, Dr Verwoerd). At UCT Professor Edward Batson instituted a social survey of Cape Town which was published during the Second World War and which revealed starkly the terrible poverty which now existed amongst Cape Town's coloured population. Even those in employment usually earned pitiful incomes, while young men had little hope of finding jobs. Their plight contributed to growing social problems in Cape Town, long before the apartheid removals tore communities apart.

It was against this background that the UCT Medical School was established, first in the opening of the anatomical and physiological laboratories at UCT in 1912[34] and later in the formal founding of the Medical School in 1920. There is no need here to trace its origins.[35] Other aspects of the Medical School will be discussed later. The academic life of the School was dissociated from the broader political developments occurring in South Africa. Reading the Faculty Board minutes, for instance, there is little to indicate that the diseases of poverty were the primary health concerns of the country; that tuberculosis was rife in Cape Town and that infant mortality rates were unacceptably high. To put it bluntly, the doctors being trained at UCT were better fitted for general practice in Europe than South Africa.[36] This is not to say that the Medical School was ignorant of the poverty and deprivation that existed in Cape Town. Of course it was not - staff and

[34] Ncayiyana D. (1999). Medical education challenges in South Africa. Medical Education 33:713-715
[35] Louw, *In the Shadow of Table Mountain*; Phillips, *The University of Cape Town*, 84-6.
[36] See the section dealing with medical training. UCT medical students expected to work amongst whites in the towns, not amongst blacks in the rural areas.

students encountered these problems daily in the city's hospitals - but medical training was not, in the first instance, directed to coping with them.

There was one political issue which was, however, beginning to impinge on the consciousness of the Medical School. This was the growth of Afrikaner nationalism. Afrikaner nationalists were particularly sensitive to the fact that, although South Africans could now obtain their medical training in South Africa, they received it in English, despite the fact that, by 1938, 20% of students at WITS and 33% of students at UCT were Afrikaners[37].

Demands for medical schools at the Universities of Pretoria and later Stellenbosch, had as much to do with the feeling that, in a modern South Africa, Afrikaners had the right to an Afrikaans medical education, as it had to do with the need to increase the number of practitioners in the country. The Botha Commission of 1939 argued that the State had a constitutional duty to provide an Afrikaans medical education.

> 'For broadly national (in the sense of doing justice to both sections of the people in the matter of language), cultural and educational reasons, therefore, it is the duty of the State through its medical schools to provide Afrikaans medium medical training. If this premise is accepted - and we cannot imagine anybody questioning it - then it becomes a question of how this provision is to be made.'[38]

Both the Federal Council of MASA and the *SAMJ* agreed that the University of Pretoria was the suitable institution for an Afrikaans medical school[39] UCT made a bid to preserve its turf by offering first-year classes in Afrikaans. At first, despite their numbers, Afrikaans medical students were slow to opt for first-year classes in Afrikaans since it was felt to be a hindrance when the rest of the training was in English.[40] Nevertheless, even after the Pretoria medical school was established in 1938, the number of Afrikaans medical students increased during the war years and by 1948 first-year parallel-medium classes had become more popular.[41]

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[37] UG 25-1939, *Report of the Committee on Medical Training in South Africa*, 49.
[38] Ibid., 31.
[39] Murray, *The Early Years*, 324-5.
[40] UCT Administration Archives [AA], Medical Faculty Board minutes, 15 March 1933.
[41] Phillips, *The University of Cape Town*, 323.

Quite apart from the political issue, by the 1930s it was obvious that UCT and Wits could not produce enough graduates to satisfy South Africa's needs. The issue was spelt out in two commissions in the interwar years, the Loram Commission of 1928 which investigated black medical training, and the Botha Commission of 1939, inquiring into all medical education.[42] The situation was, in fact, not very different from that which existed at the end of the twentieth century.

The 1939 Botha Commission estimated that there was a doctor-patient ratio of about 1:5000 for the whole population and 1:1000 for whites only. However, since doctors were largely confined to the towns, the situation in the rural areas, particularly in the African territories, was very different. Here it was calculated that the doctor-patient ratio stood at about 1:60-70,000 people. Both humanity and self-interest were involved. Many Africans died without treatment. 'They are left in the hands of the Native herbalist who too often combines with his rude art the practices of the Witch doctor.' As a result the mortality rate was unacceptably high. 'Indeed, it was stated by the magistrate in one district that the general death rate had actually overtaken the birth rate.'[43]

Both Commissions concluded that the only remedy was a state-sponsored medical scheme for blacks.

> 'In considering the availability of medical practitioners to the population we must again point to the economic factor which in the last resort determines these ratios. We have no reason to believe that the doctors are influenced in their opinion by selfish and commercial motives. The medical profession is no longer the Eldorado which it was once upon a time. Medical training is an expensive business and the doctor must live. There is a comparatively small number of doctors who work above their capacity and earn thousands of pounds every year, but the income of the great majority is not such as can be considered attractive to people with money-making intentions. Unless, therefore, the State can initiate a scheme by which medical men can obtain full-time government employment, we must reluctantly conclude that the country cannot under present conditions absorb a material increase in the number of medical practitioners.'[44]

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[42] UG 35-1928, *Report of the Committee Appointed to Inquire into the Training of Natives in Medicine and Public Health*; UG 25-1939.
[43] UG 35-1928, 5.
[44] UG 25-1939, 5.

What was really at issue was the training and employment of black health care workers. Some of the racial questions had already been confronted by the nursing profession. Was it appropriate for white nurses to tend black patients? Natal particularly had been strongly opposed to this practice but in the early 1900s it was too expensive to keep hospitals completely segregated and the nurses themselves did not usually object to black charges.[45] The attitude of the nurses was very different when it came to black doctors, however. When Dr Silas Molema admitted white patients into the Victoria Hospital in Mafeking in 1927, the entire nursing body, including the matron, resigned. They refused either to be ordered by a black doctor or to assist him in treating white patients - the patients themselves did not apparently object.[46] This episode became the benchmark against which the issue of black doctors in white wards was measured. Provincial Administrations seized the opportunity to introduce legislation which gave hospital boards the authority to refuse admission to doctors who were not on the hospital staff. This proved to be a convenient tool to keep out black medical students as well as black doctors.[47]

In the Cape the matter became further politicised since Afrikaner nationalists dominated in the provincial bodies which governed hospitals. In 1938 the Provincial Council instructed the Cape hospitals to use black servants where there were no black nurses to tend black patients. Both the Trained Nurses' Association and the medical profession were outraged. Louis Leipoldt, then editor of the *SAMJ*, declared it 'a monstrous suggestion that decency and humanity must disappear when confronted with colour. One stands aghast at a mentality apparently unable to regard non-Europeans in human terms and that projects its own obsessions on members of an honourable profession.'[48] To some, the obvious solution was to train black nurses, but for years the various authorities jibbed at the financial investment involved. Ironically it was Afrikaners rather than blacks who were recruited into the nursing profession in the interwar years. As with black

[45] S. Marks, *Divided Sisterhood: the Nursing Profession and the Making of Apartheid in South Africa* (London, Macmillan, 1994), 49-56.
[46] Ibid., 59-60.
[47] Murray, *The Early Years*, 302.
[48] Marks, *Divided Sisterhood*, 60-61.

doctors, black nurses only began to be trained on a substantial scale after the Second World War.

The Botha Commission, the members of whom were all medical men, is a study in moderate, 'rational' racism. The language is judicious, steering its way carefully between extremes of right and left. The classification of Europeans as negrophiles or negrophobes vitiated serious discussion and stifled action, the Commission believed.[49] But South African racism was not to be challenged. 'This social colour bar is as stubborn a fact as any that can be imagined and must simply be accepted without argument', the Commissioners considered. All the discussion which followed was based on this premise. Not surprisingly, it led to contradictions in their thinking on black medical training. On the one hand they recognised the need to train black medical students, who, at the time, could only obtain their qualifications abroad, an undesirable situation on a number of counts, the Commissioners felt. It was expensive and black students were exposed to influences which fitted them ill for life in racist South Africa. 'Without going into the question of the sociological dangers which may be attached to a five or six years sojourn in a country which does not know and cannot appreciate social segregation on the ground of colour and all that it implies, it would be safe to say that for medical reasons it would be better if non-Europeans could be trained in South Africa."[50] Overseas medical students would not encounter the diseases of poverty which were so rife in South Africa. Moreover it was difficult to find places in European medical schools and the Commissioners recognised that they had not right to expect concessions from European schools which they were not willing to make themselves.

The harsh reality, however, was that the poor black schooling system ensured that only a handful of blacks ever obtained matriculation, let alone gained the marks they needed to enter Wits or UCT. In 1928 the Loram Commission anticipated that there would be no more than five students a year available for the next five years.[51] The situation had improved little in the 1930s. Between 1933 and 1937 a total of 465 blacks matriculated -

[49] UG 25-1939, 38.
[50] Ibid.
[51] UG 35-1928, 9.

213 Africans, 156 coloured students and 96 Indians.[52] The numbers were too small to make a black medical school viable. UCT and Wits both expressed a willingness to train black students provided that they were taught in separate classes (funded by the state). Unfortunately there was another obstacle in that the provincial administrations, mindful of the Mafeking débacle, refused to allow black students to have anything to do with white patients. Until the hospitals were willing to make facilities available, clinical training was impossible. Given their view that colour prejudice must simply be accepted, neither the Commission members nor the universities were willing to press the matter further.

The result was that the members of both Commissions were forced to rationalise other options. There was no point in training doctors to treat blacks since the great majority of Africans did not useWestern Medicine, they claimed. Africans still believed in their diviners and herbalists and were not willing to submit to scientific medical treatment, the Botha Commission argued. Moreover, most could not afford medical treatment. It was up to the State, the Commission concluded, to educate Africans into the meaning of health and to provide health services for them. As with the nurses, much of the debate centred on the training of health care assistants rather than fully-qualified doctors. Their role would be to teach Africans clean and healthy living, the Botha Commission argued; to prepare them to accept Western medical care. Underlying the discussion, however, was the feeling that Africans, suitably acculturated into accepting Western medicine, would provide useful livings for white practitioners. To the Loram Commission such work was 'honourable to the European and advantageous to the Native.[53] The Botha Commission was more direct:

> 'The contention that non-Europeans are more capable or serving their own people in any capacity than are Europeans, is disputed by many who are not only friendly disposed towards, but also have intimate experience of them. It has been contended, on the contrary, that the christianised Native is less acceptable to the mass of his people than the European, and that he often has less sympathy with their primitive habits and customs. For essentially the difference between the tribal Native and the European is not so much one of race, language and colour, but rather of what we vaguely call civilisation or

[52] UG 25-1939, 39.
[53] UG 35-1928, 16.

> culture. The point we wish to make here is that the medical interests of non-Europeans need not be neglected on the ground of the lack of medical practitioners of their own race.'[54]

Conversely, although this was not mentioned in the Commission reports, there was a very real fear that white practitioners might lose white patients to black doctors.[55] The logical conclusion was that it was better to create an Afrikaans medical school in Pretoria than to train black doctors.

UCT's stance in the debate was ambiguous. The University had been advised that its constitution did not give it the right to exclude students on grounds of race. From 1921 the policy was, rather, to persuade black applicants that the University could not offer them appropriate facilities to complete their training. In 1921 an Indian applicant was turned away, as were Africans consistently for years, even after coloured and Indian students were admitted. At a special meeting in 1927 the UCT Medical Faculty had recommended that 'it was not desirable that natives be admitted to the existing medical classes at the University'. The Medical School preferred, in fact, that a separate medical school be established for black students and that the standard should be the same as that at existing medical schools.[56] It was essentially these resolutions which were incorporated into the report of the Loram Commission. The Commission noted that UCT had formally resolved that Africans should be trained in South Africa rather than overseas, to the same standards as whites, but that an African medical school was inadvisable since it could not offer the facilities of the existing schools. UCT was willing to offer parallel classes for the pre-clinical years but it had no suggestions to get round the problem of clinical teaching. The Loram Commission, however, thought that blacks were more appropriately located at Wits, where more clinical material was available and which was closer to the black reserves.[57] In the event UCT continued to refuse admission to black medical students in the 1930s. In 1931 A. Minikulu, for instance, was advised that, although his son, who had completed his first year, could be admitted for the second

[54] UG 25-1939, 38.
[55] Murray, *The Early Years*, 301.
[56] AA, Medical Faculty Board minutes, 12 May 1927.
[57] UG 35-1928, 15-16.

and third years, there was no point since he could not complete his clinical training at UCT because of the shortage of clinical beds.[58]

It is probable that the Medical School had not given the matter very serious attention before the 1930s, for it was only after a series of applications from black students in the early 1930s that the question was raised about the willingness of the hospital authorities to allow black students into the wards. Prior to that the excuse had always been that there was insufficient clinical material. This was true enough but it was not given as an excuse in the 1940s when black students were admitted and the problem of enough clinical beds was once again acute. In the event, when UCT did inquire in the 1930s, the Cape Hospital Board refused admission to black students, a situation which UCT accepted without protest.[59] Murray suggests that, prior to the war, UCT, rather than Wits, had led the way in taking in black students although Wits accepted its first coloured medical student in 1926. In 1937 there were forty black students at UCT, mainly coloured, and only ten at Wits, five coloured and five Indian.[60] This 'openness' was very limited, however. In the first place no African was admitted to either medical school. Secondly, black students were still not allowed to undertake their clinical training in the Cape hospitals.

J.H. Louw's treatment of admissions policy is indicative of the denial which still existed in the Medical School of the 1960s. By this time the University had taken a stand as an 'open' university, and Louw treats the whole question as though UCT had had an open admissions policy since the 1920s. 'Since 1921 many non-White students have been admitted to all faculties of the university, including the medical faculty', he claims. Later on he wrote, 'It should be noted that since its inception the University of Cape Town admitted non-White as well as White students and subscribed in the strongest terms to the system of university autonomy, under which it is free to choose its own staff, to decide the nature of its curricula and to select its own students from among those who are

[58] AA, Medical Faculty Board minutes, 11 March 1931.
[59] Ibid., 7 October 1931, 5 April 1932, 9 May 1932, 5 October 1932, 15 March 1932.
[60] Murray, *The Early Years* , 298-9, 302, 316-7.

academically qualified, irrespective of race, colour and creed.'[61] This was far from the case.

By 1939 little had changed. Before the Second World War a handful of black medical students entered UCT Medical School. In 1939 six coloured and six Indian students were admitted although at the time they still had to complete their clinical training abroad.[62] Other medical institutions varied in their response to the question. Leipoldt, as editor of the *SAMJ*, was consistently liberal in his attitude to black education, even questioning the need for separate classes but MASA itself was much more reactionary, supporting a second-grade black medical education.[63]

Murray notes that the Second World War transformed the situation for black medical students. During the war it was impossible for them to obtain their training abroad. Both UCT and Wits were forced, to some extent, to revise their policies. Black students themselves no longer took the prohibition lying down. By the 1940s they were becoming more militant, with a Non-European Medical Students Vigilance Committee, led by B.M. Kies, to campaign actively for students to be admitted to the clinical years.[64]

Things changed when the new hospital was opened at Groote Schuur. From 1943 Coloured and Indian students were allowed into the 'non-European' hospital wards, on condition that they had no contact in any way with white patients, even post mortem.[65] Given the large number of Afrikaans students at the Medical School in the 1940s, this proviso was easily and closely monitored and the Medical School went to 'grotesque lengths', Phillips notes, to ensure that the rule was kept. Even staff members of markedly left-wing views complied unquestioningly. There was reason for being careful. In 1944 there was a public outcry, with letters in *Die Burger* and a question in parliament, regarding the presence of black students during an operation on a white child. The furore died down when the students concerned explained that they had not realised the child was white, but it was a warning of which the University took heed.[66]

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[61] Louw, *In the Shadow of Table Mountain*, 300.
[62] Ibid., 145.
[63] Murray, *The Early Years*, 307.
[64] AA, Principal's Office, Admission of students, F2/1, B.M. Kies to the Registrar, 2 February 1943.
[65] AA, Medical Faculty Board minutes, 8 October 1942, 9 March 1943
[66] AA, Medical Faculty Board minutes, 29 February 1944, 13 March 1943.

In 1947 the Medical School had believed that this arrangement would be temporary but segregated teaching continued through to the 1960s.[67] The students admitted in 1939 were able, however, to complete their training at UCT. By 1944 there were ninety-four black students registered at UCT, of whom twenty-four were in the Medical Faculty. In December 1945 M. Samy-Padiachy, RAAR. Lawrence and C.H. Saib were the first to obtain the M.B., Ch.B.[68]

The apartheid years

The Second World War had a significant impact on the political environment in South Africa, temporarily suspending the increasingly powerful moves towards the institutionalisation of racial discrimination. National patriotism in the effort against the Nazis briefly united the country with the result that the political groupings such as the Communist Party, fighting for the rights of black people, were accepted into the dominant political discourse of the time. As we have seen, the changed political and economic environment meant that some opportunities previously denied on the basis of race were opened for black South Africans as a result of the exigencies of the war economy.

However, the brief period of the loosening of racial discrimination came to a rapid end with the ascendancy to power of the National Party government in 1948, and the introduction of a host of racially discriminatory laws in the decades to follow. The ushering in of the apartheid state was to have the most profound impact on the training of health professionals, both black and white, for the coming decades.

The Population Registration Act of 1950 formed the bedrock of the apartheid state in providing for the classification of every South African into one of four racial categories. Access to societal resources (housing, education, health care, etc.) was then defined by race group. In terms of the 1950 Group Areas Act the entire country was demarcated into zones for exclusive occupation by designated racial groups. Implemented from 1954, the result was mass population transfers involving the uprooting mainly of black citizens and

[67] AA, Principal's Office, Admission of students F2/1, Registrar to Town Clerk, East London, 16 April 1947; Phillips, *The University of Cape Town*, 323.
[68] Louw, *In the Shadow of Table Mountain*, 300.

the resulting destruction of communities.[69] For medical students, this Act further restricted opportunities for training through limiting where and how students could live, make use of public transport or gain access to health facilities. Other legislation included the 1950 Immorality Amendment Act; the 1949 Prohibition of Mixed Marriages Act; the 1953 Separate Amenities Act; and the 1953 Bantu Education Act[70].

Perhaps the most noteworthy apartheid legislation which affected students in this period was the 1959 Extension of University Education Act which denied black students the right to attend their university of choice. It therefore became illegal for white universities to admit black students except with ministerial permission.[71]

During this period, resistant to apartheid rule shifted from the strategies of negotiation and reasoning to that of mass mobilisation and protest politics. In 1943 the ANC's Youth League was formed and by 1949 they had adopted a programme of action relying on the strategy of mass mobilisation.[72] In 1952 a defiance campaign was launched led by Nelson Mandela and others. This was followed by major school boycotts in 1955 and an anti-pass campaign in 1959. These civil disobedience actions resulted in an increase in support of the ANC and the Youth League. In 1955 there were many bannings and the Congress of the People was held, where the ANC aligned itself with representatives from all the race groups and the Freedom Charter was adopted.[73]

The war years had done more than open the medical schools to black students. They had also seen great changes in the attitude to social welfare. In an age of total war, when the entire population is committed to the war effort, it has been common for governments to promote war as a means of change. The old inequalities will be swept away and better things will follow. The Second World War was no exception and in Britain, particularly, plans for the welfare state were publicised. Most famous was the Beveridge Report which promised 'cradle to the grave' welfare, including a national health system. South Africa was by no means immune to these influences. After the German invasion of Russia in 1941 and the alliance with Soviet Russia, South African communists were free to

[69] TRC, *Report*, Vol.1, chap. 2.
[70] Ibid.
[71] Ibid.
[72] Marx, 1992.

promote their ideas more publicly. All this hastened the slow shifts in thought which had been occurring in some quarters long before, particularly in relation to socialised medicine. Both the Loram and Botha Commissions had accepted that only a state health system could remedy the deficiencies in medical care for blacks. At UCT men like Batson were also promoting the idea of some form of social security. But it was on the Rand that new ideas about the management of health in South Africa came. Amongst the pioneers were Sidney and Emily Kark who had established the first health centre at Pholela in Natal just before the war. In the Department of Health men like Eustace Cluver, Secretary of Health, 1938-1940, Harry Gear, Deputy Chief Medical Officer from 1939, and George Gale, Chief Medical Officer and Secretary for Health in 1946, were all key figures. Smuts's Minister for Health, Dr Henry Gluckman, described by Shula Marks as South Africa's only progressive Minister of Health before 1994, was another crucial figure.[74] Yet another factor was the visit of Henry Sigerist in 1937-1938, as a guest of the South African Students' Visiting Lecturers' Trust Fund. Described by the *Cape Argus* as the 'foremost apostle of socialised medicine', he did much to inspire younger doctors at UCT and Wits. Social medicine, Marks suggests, 'had within it a liberatory potential which inspired and excited the younger, more radical members of the medical community, surrounded as they were by the disease consequences of rapid industrialisation and rural impoverishment'.[75]

Marks argues that, in the field of social medicine, 'for just over a decade in the mid-century, South Africa was widely acknowledged as being in the forefront of international progressive thought, its distinctive social conditions and developed medical practice making possible an experiment in social medicine with far-reaching implications'.[76] It was in the context of the rising tide of African ill health that a health clinic was established at Pholela by the Karks as an experiment in social medicine. The health

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[73] Ibid.
[74] S. Marks, 'Doctors and the state: George Gale and South Africa's experiment in social medicine' in S. Dubow (ed.), *Science and Society in Southern Africa* (Manchester, Manchester University Press, 2000), 189.
[75] Marks, 'Doctors and the state', 198.
[76] Ibid., 188.

clinics were initially promoted by Cluver and Gale as an inexpensive way of treating Africans, rather than hospitalising them.[77]

The war years also saw some radicalisation of the medical profession. The Federal Council of MASA set up a planning committee to consider a future national health policy for the Union, the *SAMJ* ran a series of articles on the same subject, MASA published a pamphlet advocating a national health service controlled by the medical practitioners. Then, in 1942 the government set up the 'National Health Services Commission on the Provision of an Organized National Health Service for all Sections of the People of the Union of South Africa' under the chairmanship of Dr Henry Gluckman.[78] The report of the Gluckman Commission offered a vision of health care based on about 400 health centres throughout South Africa - in effect a system of primary health care very different from the hospital-based system which then existed.

The vision of the Commission was never implemented although about fifty health clinics were established in the post-war years, including one at Grassy Park in Cape Town. In Durban the Karks set up an Institute of Family and Community Health, intended to establish a comprehensive system of health care for the entire Durban community, and to train health workers.[79] But Smuts was never wholly behind the report and he allowed the conservative provinces to retain control of the hospital services.[80] The Nationalist government which came into power in 1948 had little interest in social medicine and the clinics were slowly closed down or absorbed into the existing system.

This brief experiment in social medicine had one other outcome. In 1951 the long-discussed medical school for blacks was established at the University of Natal. The Brebner Commission of 1948, which inquired into the conduct of teaching hospitals and medical schools, had stressed the inclusion of preventive and social medicine in the curriculum. Students were encouraged to establish and maintain health centres like SHAWCO.[81] The Natal Medical School was to follow these guidelines; it was not to be a 'feeble replica' of the existing schools. Instead it was to move away from the curative,

[77] Ibid., 196.
[78] UG 30-1944.
[79] Marks, '1944 Health Commission' 157.
[80] Marks, 'Doctors and the state', 201-2; Marks, '1944 Health Commission', 156.

hospital-based approach to promote social medicine, 'the medicine of the future'.[82] George Gale became the new Dean and it was his vision which permeated the school in its early days. But Gale did not last long in Natal, his tenure foundering on financial rocks. The establishment of the Durban Medical School did, however, let UCT off the hook as far as African students were concerned. It was no longer necessary to make embarrassed refusals to Africans wishing to study medicine at UCT. The first African medical student was only admitted to UCT in 1985.[83]

UCT Medical School did not escape these winds of change in medicine entirely although they left remarkably little mark on the teaching curriculum. During the war years blacks had migrated into Cape Town in unprecedented numbers in response to the wartime demand for labour. Many had settled on the Cape Flats, in the Kensington-Windemere area, where a large mixed population of squatters built their shanties. Badly flooded in winter, living conditions were dire and Cape Town Municipality was forced to absorb the area into the municipality in order to provide some basic services. UCT medical students also responded to the crisis, setting up a medical clinic in Kensington-Windermere in 1943. The clinic expanded rapidly although neither the UCT Principal nor the Dean of the Medical Faculty was prepared, at first, to acknowledge it as a legitimate activity of the medical students. Subsequently social work students also became involved, the organisation eventually expanding into the Students' Health and Welfare Centres Organisation [SHAWCO].[84]

One other change at UCT Medical School had some limited impact. This was the appointment of J.R. Brock as Professor of Medicine in 1938. Brock had been an assistant of John Ryle in Cambridge, the latter holding the first chair in social medicine in Oxford. Ironically, an influence on Ryle's thinking, as with a number of other contemporary social reformers, was Smuts's philosophy of holism.[85] For a brief moment it was hoped that the Rockefeller Foundation, which funded the Durban Medical School, might subsidise a social medicine unit at UCT, but the proposal was abandoned because of the relatively

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[81] Louw, *In the Shadow of Table Mountain*, 302.
[82] Marks, 'Doctors and the state', 204.
[83] L. London et al, *Truth and Reconciliation, a Process of Transformation at UCT Health Sciences Faculty* (Cape Town, University of Cape Town, 2003), 19.
[84] E. van Heyningen, *The History of SHAWCO 1943-1975* (Cape Town, SHAWCO, 1975.

small number of Africans in Cape Town.[86] Nor was UCT generous in research funding. However, Brock was able to embark on a major project on nutrition with funding from the Union Department of Public Health.[87] In 1949 he headed a Clinical Nutrition Research Unit and in 1950 he was commissioned by the WHO to investigate kwashiorkor in Africa. Despite its remoteness from the rest of Africa, Brock considered Cape Town well placed for such work. Scurvy was rife in the town and Cape Town was 'one of the meeting places of old and new cultures' which displayed 'differences of dietary habit and nutrient availability'.[88]

For years Brock urged UCT to make social medicine a more prominent part of the medical curriculum. In 1948 he put forward a strong memo on the teaching of social medicine at UCT. 'One of our basic proposals is that throughout undergraduate and postgraduate education, emphasis must be placed on the acquisition of a sound knowledge of all measures that may make and preserve a healthy nation; that these measures must be regarded as part of the concept of Medicine, and that they should be the subject of wide and intensive research', he urged. Mindful of financial constraints (and perhaps the views of his colleagues), Brock did not advocate the establishment of a new Department. More important, he considered, was a new philosophy which should permeate the teaching of medicine. At this stage he envisaged a 'People's Centre' in Goodwood, to be funded by the National War Memorial Health Foundation, along the lines of the Pholela Clinic. The People's Centre would be 'a pilot centre to demonstrate how disease prevention and health promotion can be forwarded by voluntary survey and service, guided by technical experts'. Although the Faculty approved the proposal, little came of Brock's proposals or the Goodwood Centre.[89]

A few years later Brock turned to the SHAWCO clinic as a suitable health centre to play a much larger role in University teaching.[90] A medical officer was appointed with the

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[85] Marks, 'Doctors and the state', 189, 204.
[86] Ibid., 204.
[87] Phillips, 324.
[88] Ibid., 335-6.
[89] AA, Medical Faculty Board minutes, 3 May 1948, 3 June 1948.
[90] Ibid., 24 October 1952, Recommendations . . . arising out of the report of the committee appointed to consider the teaching of public health, preventive and social medicine.

special duty of developing social medicine work and teaching.[91] At SHAWCO Dr H.T. Phillips took up the baton for a number of years. Although a UCT graduate, Phillips had worked in Durban with the family health centre movement, whose principles he promoted at SHAWCO. In 1955, for instance, he planned to initiate a scheme which would familiarise more students with social medicine.[92] Like so many health centre advocates, he emigrated in the 1950s and, after his departure the scheme was gradually abandoned. The Grassy Park Health Clinic, one of the Pholela-type health clinics, attracted almost no attention from UCT despite its innovatory services. Batson took a few students there but the Medical School seem never to have taken any interest in its existence.[93]

By the late 1950s none of these schemes had attained any prominence in the medical curriculum and even the teaching of public health was struggling to survive. In the anti-socialist atmosphere of the 1960s the term 'social medicine' fell away, to be replaced by 'comprehensive medicine'. The change in name did little to alter the situation and comprehensive medicine also had limited support.[94] UCT's reluctance to embrace social medicine may, perhaps, be summed up in an early Faculty Board resolution to the effect that 'all departments were emphasising the importance of the preventive aspects of their subjects'.[95] This was enough. UCT's focus in teaching remained firmly curative, based on the hospital. Although standards were high and UCT work was internationally recognised, it was not yet grappling with the major health issues of South Africa. Admittedly, this was becoming increasingly difficult. As the homelands policy got under way, and power was devolved to the corrupt and incompetent governments of the Bantustans, health care in South Africa was fragmented more and more. Census data and vital statistics for much of South Africa's population was lean at best, entirely absent for large areas since 1910 or before. The management of a disease such as tuberculosis was rendered almost impossible by this fragmentation.

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[91] Ibid., 18 December 1952, 27 April 1954.
[92] E.J.Salber, *The Mind is Not the Heart. Recollections of a Woman Physician* (Durham and London, Duke University Press, 1989), 82-121; AA, Medical Faculty Board minutes, 28 October 1954.
[93] H. Phillips, 'The Grassy Park Health Centre: a peri-urban Pholela' (unpublished paper, 2003). I should like to thank Professor Phillips for making this paper available to me.
[94] AA, Medical Faculty Board minutes, 7 March 1967.
[95] Ibid., 9 September 1924.

The 1950s were quiet years when the status quo in the Medical School went virtually unchallenged. The small number of black students admitted into the Medical School could be accommodated without difficulty. Such students were accepted in the face of stiff competition, when about half UCT's applicants for first year were turned away, the Medical School explained to J.G. Meiring, head of the newly-established University College of the Western Cape in 1964.[96] But numbers were increasing. By 1962 there were 157 black students enrolled in the Medical Faculty, at least three times as many as in any other faculty.[97] As a result new problems regarding admission were arising as black graduates sought to specialise. UCT medical staff were usually sympathetic to these requests but their approaches were couched in the discourse of apartheid, still assuming that separate facilities were right and proper. Thus, when one graduate wanted to specialise in psychiatry, the professor of the day explained:

> 'There is a great deal of mental illness amongst Coloureds - in fact tens of thousands of cases are dealt with annually in Cape Town alone, and there are many more, including alcoholics, who exist in the community without specialist psychiatric attention. However, there is not one trained Coloured psychiatrist in the entire country, and there is an urgent need to recruit and train Coloured medical practitioners for this speciality, especially as there is an acute shortage of psychiatrists in South Africa (there being less than 70 to cope with the needs of the whole country.)'[98]

In 1968 UCT pointed out to yet another commission on medical education that there was an urgent need for facilities for black post-graduate training. The problem was a shortage of clinical beds. The establishment of a medical school at Stellenbosch had already created difficulties; the possibility of a third medical school in the Western Cape filled the Medical School with dismay.[99] Above all the Medical School urged, black and white medical education should be considered together.

> 'The University of Cape Town has for many years trained Coloured and Asiatic medical students and is convinced the training offered these medical graduates is second to none. In spite of the difficulties encountered in conducting a medical curriculum attended by

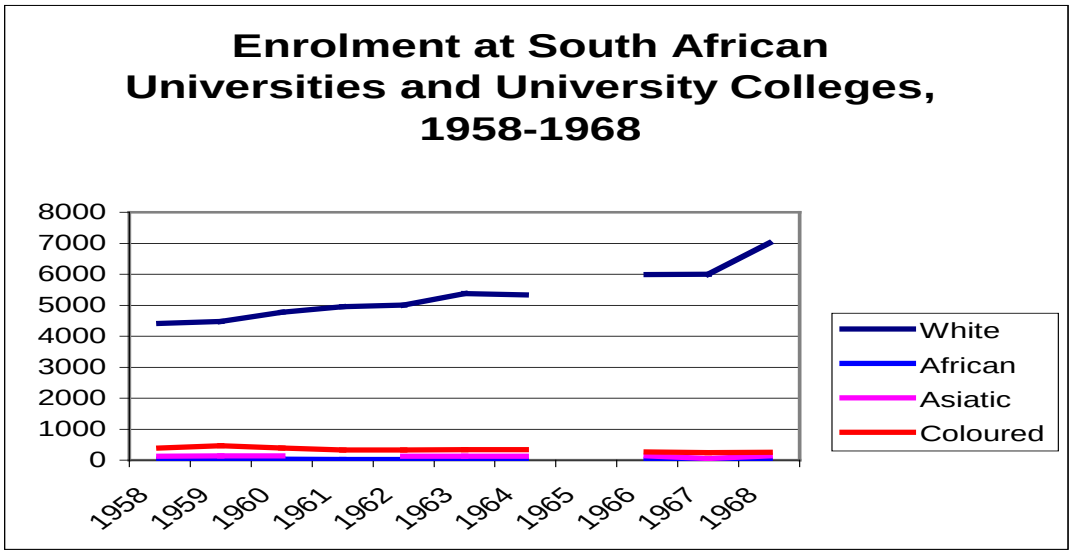
[96] Ibid., 25 August 1964.
[97] AA, Principal's Office, Admission of students F2/1, Vol 2, Registrar to Adv. A.H. Broeksma, 4 December 1962.
[98] AA, Medical Faculty Board minutes, 3 August 1965. 8; 22 April 1968, Memo of UCT Committee on the Commission on Medical Education.
[99] Ibid., 22 April 1968.

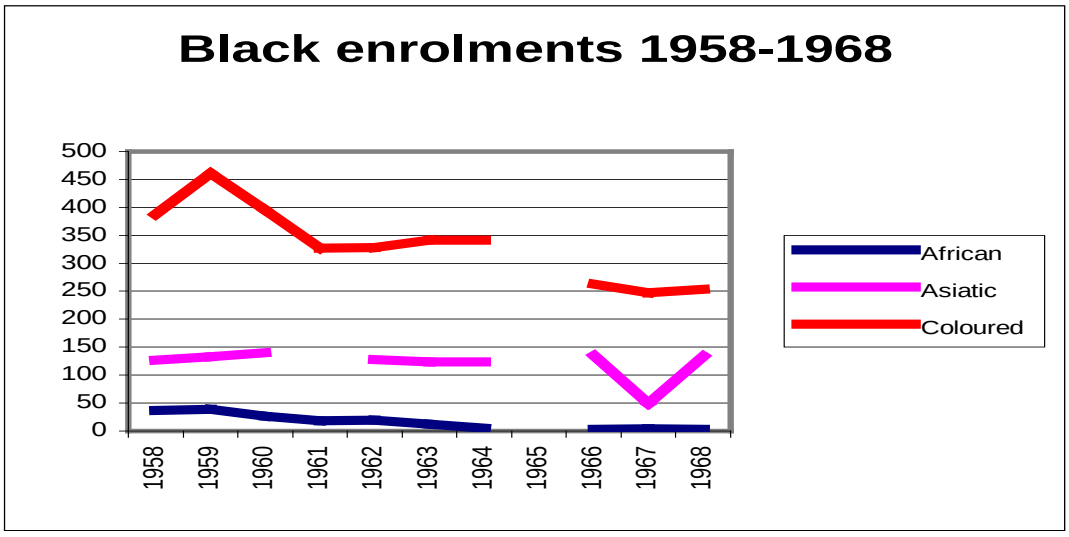
> mixed racial groups the University is convinced that the results justify the inconveniences and would urge the Committee give very careful consideration to the full implications of the establishment of yet another Medical School in the Western Cape.'

There would appear to have been another consideration at work, however - the fear that standards might be lowered. Coloured students entering UCT Medical School did so in competition with whites, who benefited from a far better educational system. That this resulted in only a handful entering the School was not considered an issue. Between 1959 and 1964 about twenty-five coloured students were admitted each year, with only about six graduating (ten in 1963). 'The university regards it as desirable, in order that standards should be maintained, that these relatively well-qualified applicants should continue to face the stiff competition of UCT First Medical Year.'[100]

Exact figures of the numbers of black medical students at UCT are difficult to find. The proportion of black university students in South Africa as a whole, although greater than it had been in the 1940s, was in reality diminishing in comparison with whites. The number of black doctors was still very small and that of black medical students remained a tiny percentage of the whole. [101] In 1959, of 7789 medical practitioners in South Africa, only 67 were African and 93 Indian and coloured. Of 1371 medical students, 108 were African.[102]

[100] Ibid., 25 August 1964, draft reply to J.G. Meiring, Rector, University College of the Western Cape.
[101] AA, Principal's Office, Admission of students, F2, NUSAS Memo on the enrolment at South African Universities and University Colleges, 12 April 1969. These figures are problematic since the numbers of black enrolments seems very small indeed.
[102] Ibid., Association leaflet.


Enrolment at South African Universities and University Colleges, 1958-1968
8000
7000
6000
5000
4000
3000
2000
1000
0
1958
1959
1960
1961
1962
1963
1964
1965
1966
1967
1968
White
African
Asiatic
Coloured


Black enrolments 1958-1968
500
450
400
350
300
250
200
150
100
50
0
1958
1959
1960
1961
1962
1963
1964
1965
1966
1967
1968
African
Asiatic
Coloured

The issue of black post-graduate training remained unresolved until 1971, when Stuart Saunders invited Bryan Kies to be the registrar in neurology at Groote Schuur Hospital.Discrimination still existed, however, because Kies was not entitled to eat or sleep with his white colleagues. As more black students undertook their postgraduate training they began, nonetheless, to use such facilities as the doctors' bungalow. When the housekeeper objected, she was told she could resign and from this point most facilities were open to all. A crucial figure in desegregation at Groote Schuur was the medical superintendent, Dr J.G. Burger. Appointed as a Nationalist, he, nevertheless, supported Saunders and others in their efforts to end discrimination.[103]

By the end of the 1950s most of the key apartheid legislation had been put in place - the Population Registration Act (1950}, Group Areas zoning (1950), the Reservation of Separate Amenities Act (1953), the Bantu Education Act (1953) which destroyed the mission schools. In 1951 Africans lost their remnants of parliamentary registration, as did Indians. From 1952 coloureds were also disenfranchised. The communist party was banned in 1950. The 1955 Natives (Urban Areas) Amendment Act restricted even further the right of Africans to remain in the cities. The result was an upsurge in popular protest and state repression. The ANC and the PAC were both banned, driving resistance underground and abroad. Many of the leaders who remained in the country were arrested and imprisoned on Robben Island. During this period, also, a number of segregated black universities opened, removing most black students from the white institutions. The opening of the University College of the Western Cape [UWC] affected UCT most directly. Many of the new institutions were plagued with student unrest; some were closed down for varying periods of time.

This era also saw the mushrooming of today's Historically Black Universities: Fort Hare (in Xhosa territory) had been in existence since the early years of the century; now followed Turfloop (for the Sotho, Tswana), Zululand (for the Zulu), Durban-Westville (for the Indians), Western Cape (for the Coloureds).

[103] S. Saunders, *Vice-Chancellor on a Tightrope. A Personal Account of Climatic Years in South Africa* (Cape Town, David Philip, 2000), 66, 95.

At the end of the 1950s the 'liberal' universities were confronted directly by apartheid planning when the Extension of the University Education Act of 1958 was passed, prohibiting black students from admission into white universities and providing for racially-based black institutions.[104] For the first time, the University really confronted the implications of its claim to be an 'open' university. Led by the principal, T.B. Davie, UCT put up a sustained protest against the Act. Representatives of UCT and Wits met in Cape Town to discuss the Bill, the proceedings of which were recorded in *The Open Universities of South Africa*. In this document was presented carefully reasoned arguments in defence of the four essential freedoms formulated by the late Dr T.B. Davie: 'Freedom (of a university) to determine for itself on academic grounds who may teach, what may be taught, how it shall be taught and who may be admitted to study.'

In another act of demonstrated opposition to the Bill, on 7 June 1953 UCT marched through the streets of Cape Town, after the Bill was read a second time in Parliament in the same month. The procession of about 3 000 graduates, undergraduates, members of the staff and of Council moved up Adderley Street into Wale Street and Government Avenue to Hiddingh Hall. At its head marched the Chancellor, the Vice-Chancellor and Acting Principal, and the Chairman of the University Council. Subsequently other forms to protest against the Bill were held. Despite such resistance, the Bill was enacted.

Medical students were often at the forefront of these protests, Ralph Kirsch remembering that 'Many of our class took our turn at holding these [banners outside parliament] while others attended the debate wearing black arm bands mourning the death of academic freedom. I remember my anger at being asked to leave the Gallery and not return until I had removed the band from my jacket sleeve.'[105]

However, an upshot of the Separate University Education Bill was that, two years later, on 29 July 1959, the University of Cape Town formally dedicated itself to academic freedom. The dedication was signed by the Chancellor, the Chairman of Council, the Vice-Chancellor and the President of Convocation. This dedication, which was amended in 1973, is affirmed annually at the T.B. Davie Memorial Lecture.

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[104] London, *Truth and Reconciliation*, 22.

[105] R.E. Kirsch (ed), *The Forman Years* (Cape Town, University of Cape Town Department of Medicine, 1984), 226.

But the university authorities apparently felt that they had gone far enough in resisting apartheid by encouraging an open academic environment. After T.B. Davie's death they were extremely reluctant to challenge social conventions. The Principal explained to the President of the SRC in 1958, 'Council has declared that it considers that in all non-academic or social affairs the University should abide by the customs and conventions of the community in which it exists.' The student leaders, however, were unwilling to accept this ruling. The following year the SRC expressed its dismay and refused to police student gatherings as the authorities considered that it should.

> Since its inception the University of Cape Town has on no previous occasion resolved to treat students differentially on racial grounds in matters which have been within its jurisdiction and we find this acceptance of the "customs and conventions of this community" strangely in contrast with the spirit of a university and contrary to the policy and tradition which we have considered to have been accepted by the University of Cape Town. During the short history of this University, changes in the relationship between students have come about by a natural evolutionary process, and it is this same evolutionary process, neither impeded nor enforced by external agencies, which we wish to see continued in the University of Cape Town.[106]

How far was this ban to go, the students demanded. To Chess Club meetings? To meals in the Union cafés? To student committees? Nevertheless, black graduates had been prohibited from attending the Graduation Ball in 1959 and in the following year the Principal disallowed a mixed final-year Medical Students' Dinner. As a result an increasingly radical SRC passed a resolution protesting that the banning of the Medical Dinner was 'a seriously retrogressive step in student social relations' which was 'contrary to the principles for which the University claims it has been fighting.'[107] But the ban still held in 1962 when the students were again warned that mixing in sport as well as social functions was forbidden.[108]

The 1960s were dominated by increasing political and economic repression for the majority of South Africans. Heightened political campaigns were met with severe responses by the apartheid state. During this period the campaign against the passes

[106] AA, Principal's Office, Admission of students, F2/1, vol. 2, D. Clain, President, SRC to the Principal, 9 March 1960.
[107] Ibid., Memo on social practice, 6 July 1960.
[108] Ibid., H. van Huyssteen, Acting Secretary of Council to Mr Callie, President, SRC, 22 June 1962.

which Africans were required to carry gained widespread support and resulted in the rally in Sharpeville on 21 March 1960, where 69 unarmed men, women and children were killed by the police. The international response to these killings was met with the banning of the ANC and PAC by the Nationalist government. The Rivonia Trial which followed the arrest of the leadership of the ANC's armed wing in 1963, effectively led to the jailing of much of the resistance movement's leadership and shifted the focus of political resistance into exile. It also marked the phase of urban sabotage organised by the ANC, begun from 1964.

By the late 1960s the economic climate in the country had improved. In the 1970s several leaders of the liberation movement were in exile or imprisoned and opposition in South Africa was halted by brutal police force and by the forced removals of individuals from urban areas to separate homelands.[109] The result was substantial fear and little active resistance. However, underneath the surface of what appeared to be a silencing of the opposition, discussions for future resistance were taking place, particularly amongst the black students in the segregated universities.[110] The overcrowded schools and growing universities created opportunities for students to discuss the discrimination they suffered. Black Consciousness Organisations were formed and student organisations such as the National Union of South Africa Students (NUSAS) began to be radicalised in a decade marked by significant political events, including the independence of Portuguese colonies, Angola and Mozambique, after protracted liberation wars, an outburst of labour strikes in response, and the subsequent growth of the independent trade union movement. On June 16, 1976, the Soweto uprising took place which was a protest against the imposition of Afrikaans as a medium of instruction. The harsh response of the police to the protest resulted in 25 students being killed. Six days after the initial uprising, 130 people were officially listed as having been killed.[111]

In recent years some of those writing about the UCT Medical School have noted the lack of political protest from leading members of the Faculty. Given the cautiousness of the University environment when J.P. Duminy was Principal, this is not difficult to

[109] Marx, 1992.
[110] Ibid.
[111] Ibid.

understand but individual responses also played their part. Professor Frank Forman was a case in point. A loved and respected teacher, clearly a humane man, whose wife, Golda Selzer, had played a prominent role in the founding of SHAWCO, Forman almost never expressed public opposition to apartheid.[112]

One must also ask why some members of the Medical School adopted a stronger stance than this against apartheid. Neither political allegiance nor personality is always adequate explanations; certainly abhorrence of apartheid is not. A younger generation was probably more militant. In some cases, a personal experience changed perspective. Stuart Saunders admits that it was the arrest of his wife in the late 1960s, while she was dispensing soup in the townships, that led him to part company from more conservative members of the Medical School staff. 'I made a firm resolve then and there never to allow any consideration of my reputation, or the way in which people might see me, to interfere with the response that I would give publicly to matters of public concern. Principle and values should rule, not expediency. '[113]

> If the Medical School could ignore protest at home, staff travelling abroad encountered opposition and outright hostility to an extent which they had not done before.

Medical staff on leave were forced to examine their own political views. Most probably regarded such issues as irrelevant to medical practice but a few considered it sufficiently important to comment in their leave reports. Some were defensive, others anxious to explain the good things which were nevertheless being achieved, while a few commented critically on government policy. The Professor of Obstetrics and Gynaecology admitted that he found it difficult to defend South Africa's policies. 'What a pity it is that so fair a country in all its many natural aspects is so seemingly unfair in its basic human concepts,' he wrote.[114] Another seized the opportunity to correct 'wrong impressions' about South Africa which could, if not watched, 'do considerable harm to this country'.[115] Hoffenberg, soon to be banned, reacted somewhat differently, responding optimistically to the civil rights movement, then at its height in the United States. 'It is apparent', he noted, 'that the integrationists have gained in respectability and I found Deans of Medical

[112] Kirsch, *The Forman Years*, 194-8, 203.
[113] Saunders, *Vice-Chancellor on a Tightrope*, 46-7.
[114] AA, Medical Faculty Board minutes, 17 August 1960, Professor James Louw's leave report.

Schools, factory-owners, and people from many walks of life who have accepted integration now not only as a necessary, but as a desirable aspect of their lives'.[116]

Perhaps the most sustained discussion came from the Professor of Orthopaedic Surgery, commenting on a report on 'Rehabilitation in Africa'. His remarks are at once conservative and enlightened - typical, perhaps of the confused thinking of humane and liberally-minded white South Africans who had not yet come to terms with the implications of racism. He was clearly irritated by the attitudes of some anti-apartheid activists.

> 'I find it of interest that many countries who in the past have had dealings with Africa and some who have been enriched by their association with Africa, should suddenly at this period in history become aware of the need of uplift of the African. This is the more interesting if it is assumed that such countries did not take steps to uplift the African in the past at times when they were so associated with him'.

He wrote of Africans as alien people - the other - but with sympathy and some insight. There was a tendency to write of all dark-skinned Africans as if they were the same, he complained, but tribes differed materially.

> 'Very important in any consideration of assistance that may be given to the African are the host of curious beliefs, African folk-lore and ways of life. One must be prepared to accept that the African may not welcome assistance; he may prove very disappointing from some points of view; he may, in fact, even be hostile. There are many matters about which it is very hard for the so-called civilised European mind to comprehend in the viewpoint of the black people of Africa . . . From my own meagre knowledge of the African I cannot help but feel that, by and large, they are a wonderful people. Their way of looking at life is different from ours and may, in fact, never come into line with ours. It is my impression that they may be as correct in what we call a primitive outlook as we are in our so-called educated and civilised outlook.'

By the late 1960s the Medical School could no longer avoid confrontation with the forces of apartheid. In July 1967 Dr R. Hoffenberg was banned, ostensibly because of his involvement in the Defense and Aid Fund. The event tested the moral fibre of the Medical School staff. Brock led the protest against the banning, drafting a protest letter to

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[115] Ibid., 14 August 1961, leave report of Professor C.W. Lewer Allen.
[116] Ibid., Dean's Circular No 10, 25 April 1966, 5.

the South African Medical Journal that was never published[117], and the Medical School passed a resolution deploring it.[118] Other University staff and students joined the protest, as did UCT's Chancellor and the Vice-Chancellors of Wits and Rhodes. Leadership from the UCT Principal, still Duminy, was weak, however, and by no means all senior medical staff supported the movement, some suggesting that there was no smoke without fire. The Cape Western branch of MASA, dominated by government supporters, took no action. The difficulty was the form that protest should take. Petitions and protest marches were all very well, but had little effect. The suggestion that all Medical School and hospital staff should resign was turned down by Brock since patients' lives would be put at risk. Saunders commented of their dilemma: ' It raises the crucial issue of what the appropriate form of protest should be against a thoroughly evil regime. We said a lot but did very little. Should we have done more on this and other occasions when we protested against apartheid? We probably should have done so, and I regret what could have been shortcomings. We could have put ourselves at greater risk, but I could not have resorted to violence.'[119] Unable to practise, Hoffenberg was forced into exile.

In the international medical world Hoffenberg's banning produced a very negative response. Taken with growing protests from black health care workers about the inequity of differential salaries for the same work, there was a strengthening of the academic boycott against South Africa. 'The system of differential remuneration to medical and academic staff at South African Institutions according to race and colour has become better known overseas and is doing a tremendous amount of unnecessary harm and damage to South Africa's image in overseas academic circles', one academic noted.[120]

Dating perhaps from the attack on university freedom and the banning of Hoffenberg, but particularly from the 1970s, there was a palpable change in the Medical School in its response to apartheid. Less and less were health care professionals willing to collaborate in the existing system. This was not, of course, true of everyone, but objections, protest and resistance became a regular pattern in the next two decades. An important factor in

[117] F Ames. (1991). Biko revisited. S Afr Med J 80: 107-108.
[118] Ibid., 8 August 1967.
[119] Saunders, *Vice-Chancellor on a Tightrope*, 39-42; Kirsch, *Forman Years*, 246.
[120] AA Medical Faculty Board minutes, Dean's Circular No 24, 22 February 1968, Dr H. de V. Heese's leave report, 2.

this change was the quality of leadership in the Medical School and in the University as a whole. Duminy retired in 1967, to be replaced by Sir Richard Luyt, providing a much more congenial context for protest - conservative though he seemed to some. At the Medical School itself stronger leadership emerged when men like Stuart Saunders, who had succeeded Brock as Professor of Medicine, took a more determined stand. Saunders' later appointment as principal of UCT also strengthened leadership in the University's opposition to apartheid. In the Medical School a Professional Standards Committee [PSC] provided a forum in which staff and students could debate political issues as they related to the practice of medicine.

One issue on which the UCT took a more explicit stand was that of separate training institutions for the different race groups. When UCT made a submission to the Commission of Inquiry Relating to the Coloured Population Group, the Medical School made its views explicit. If the different population groups had to rely on their own practitioners, trained in their own institutions, the position of coloured people, let alone Africans, was unacceptable. Only 32 (7%) of students at Natal Medical School were coloured; Wits trained only a handful. By contrast an average of 90 coloured students a year had been registered at UCT over the past 12 years. A medical school for coloureds would do little to relieve the situation. It made no sense to debar them from UCT.

> 'Quite apart from the above practical considerations, there is the fundamental principle that a university, including a medical school, should have the right to admit anybody who is academically qualified for the course and should not be forced to select students with any relationship to their ethnic origin. The young Coloured man should be able to compete on equal grounds with people of other race groups to try to go to the Medical school which he thinks is the best for him and should not be forced, for ethnic reasons, to accept what he thinks is second-best. . . . '[121]

If UCT had made progress in its understanding of the implications of racial discrimination, there was little advance in gender sensitivity.

The issue of differential salary scales became the major problem confronting the Medical School in the 1970s. This was a form of discrimination which could not be justified as unchangeable convention. As the Anti-Apartheid Movement gained strength, the problem

[121] Faculty of Health Sciences [FHS], Medical Faculty, Dean's Circular, No 61, 10 September 1973.

raised its head repeatedly during international visits. Professor Stuart Saunders was vigorously attacked at a workshop of the CIBA Foundation in London in 1974. Even more daunting was the confrontation with Professor M.D. Bowie in Bristol in 1978. 'I have little doubt that there is an organised campaign in Great Britain against academic medicine in South Africa', Saunders concluded, 'and can only hope that such issues as the inequality of pay will be corrected in the very near future because whenever one discusses the many positive contributions to health care in the country existing gross professional inequalities cut the ground from under one's feet and are in themselves basically wrong and indefensible.'[122]

The Medical School could do little itself to rectify the disparities as, in terms of the Joint Agreement with Province, the staff were paid by the Province but they protested repeatedly all through the 1970s. It was prodded to do so in the first instance by the Medical Graduates Association and by the Junior Hospital Staff Association at Groote Schuur Hospital.[123]. The matter was raised in Faculty in 1977 and again in 1978 when it was acknowledged that the gap was widening. Finally in 1979 the inequalities began to be addressed.

Differential salaries were not the only issue which affected the hospitals. The practice of excluding black students from access to white patients was also gradually eroded, again, largely in response to dissatisfaction from students, who found the lack of progress in repealing this colour bar unacceptable.[124] . There were also practical considerations. The cost of separate ICUs led to the first integration of black and white patients but segregation in the wards remained offical policy into the 1980s. By that time student interns were playing an active role in pressing for change. Both a UCT Declaration and the Geneva Declaration, which formed the basis of the oaths taken by the student interns, were flouted in the wards where students were sometimes prevented from treating the victims of political violence, and where they felt that black patients still received inferior

[122] FHS, Medical Faculty, Dean's Circular No 64, 11 January 1974; Medical Faculty Board minutes, 18 July 1878.
[123] Ibid., 1 October 1968
[124] 'One of Many' (anonymous), 1977. Letter to Pulse 3(1):8

treatment.[125] Fearing a government backlash, the Professional Standards Committee [PSC] of the Medical School responded more cautiously to student demands than the students liked, agreeing that the UCT Declaration should be rewritten to accommodate the students' concerns. To the discontent of the students little else changed in the next year and members of the PSC were aware that more urgent action was needed, resolving 'to recommend and obtain the removal of all prejudicial racial considerations in our patient management at the UCT's teaching hospitals forthwith'.[126] It is probably fair to say that these events hastened moves to integrate the old hospital. From this point black patients were allowed to overflow into white wards, while some departments integrated their wards more actively.[127]

When a new hospital was planned at Groote Schuur, the Medical School was determined that these gains should not be lost. As a result the University was led into outright confrontation with the Provincial authorities and was forced to abandon its policy of quiet desegregation. Dr Niklaas Louw, the Director of Hospital Services, had made it clear that the new Groote Schuur Hospital was to be segregated but the Planning and Commissioning Unit at UCT had ignored this intention in planning the new wards. However, when Louw stated his position in the press, UCT was forced to declare its determination to provide medical care free from all discrimination. Students were informed of this at a Faculty Assembly on 7 May 1987[128] and a letter to the *SAMJ* reaffirmed this stance.

> 'Tradition and international ethical codes of medical practice make it clear that there is no place for discrimination on racial, social or other such irrelevant grounds in the care of patients. Health care professionals throughout the world agree that no-one may direct them to practise otherwise.
>
> In our society, where racial discrimination has been imposed by statute, medical practitioners, nurses and the other professions allied to medicine have endeavoured despite these unacceptable restrictions to provide the best possible care in state-controlled

[125] FHS, Professional Standards Committee [PSC], Memo submitted to the PSC by the Intern Committee of GSH on 'Racial discrimination in the medical management of patients in the Univeristy's teaching hospitals, 8 August 1984.
[126] Ibid., November 1985. For student views see also PSC, MSC student poster, 17 April 1987.
[127] FHS, PSC, Chronological recapitulation of events leading towards the integration of patients of different colour in Groote Schuur Hospital, Faculty Assembly, 7 May 1987.
[128] Ibid.

> medical institutions. Over recent years the segregation of facilities has progressively been reduced in a number of private and public hospitals, on the basis of convictions that are explicitly enjoined by our professional codes.
>
> Considerable progress has been achieved at Groote Schuur Hospital, to the point that integration has occurred at many (although not all) levels. This has reflected a determination of the staff to practise according to the professional principles to which they are committed, and to make optimum use of limited resources.
>
> It has recently officially been state that the new Groote Schuur Hospital, into which we are about to move, will be segregated according to race. We reject this proposal on ethical grounds and we must therefore oppose it with determination, in order to protect the professional, clinical and teaching standards in which we firmly believe and to preserve the dignity of our patients. We cannot agree to the imposition of racially segregated facilities in the old Groote Schuur Hospital or in the new hospital.'[129]

Louw argued that patients were segregated in accordance with the spirit of the International Code of Medical Ethics, whereby all patients had the right to decide where they should be treated: 'This does not imply that patients must be confronted with the question as to whether or not they would be prepared to be hospitalised in a mixed ward. Thus, to avoid any embarrassment to patients they should be accommodated with their own population group from the outset.' He was incensed that patients continued to be mixed 'and this despite the official and announced policy on the hospitalisation of in-patients at the new hospital and particularly after I had arranged a compromise at the highest possible level and had conveyed the later to you'. [130] He threatened the Medical School with disciplinary steps but the University had by now discovered that hospital segregation had no standing in law. Since it had inherited *de facto* segregation in hospitals from the beginning of the century, the government had failed to put the necessary legislation in place.[131] Thus, by the mid-1980s Groote Schuur could claim that it was the only hospital in South Africa which was not segregated by race, although this was far from the case at its peripheral draining hospitals.

[129] FHS, Medical Faculty, Board minutes, 5 May 1987
[130] FHS, PSC, Dr N.S. Louw to Dr J.D.L. Kane-Berman, 30 June 1987.
[131] FHS. PSC, Prof P. Folb to Prof. G. Dall, 3 February 1986.

However, the role of the Faculty as driving desegregation was not uniformly accepted by many stakeholders. Students, in particular, felt that the Faculty too easily resorted to 'sitting on the fence'[132]. Indeed, correspondence between the Dean and students in 1988 indicated his view that 'immediate racial desegregation [of peripheral hospitals in the teaching complex was] not feasible and [was] not practically attainable"[133]" and he cautioned one protesting student "against … precipitate action which might result in curious consequences … harmful to your medical career."[134] Thus, while recognising the need to address the harmful consequences of race segregation, the Faculty was also limited in the kinds of measures it was prepared to take, and the support it gave its students in their protests.

Nonetheless, in the Professional Standards Committee it was recognised that the issues related to segregation in medicine went far beyond that of separation of the races in the wards. Moreover, the introduction of a new constitution which created 'own' and 'general' affairs, in which health became an 'own' affair, to be administered by three different racial administrations, threatened to fragment health care even further. The effect would be intolerable.

> 'We are very concerned that under the new Constitution hospitals and health services may be divided and become fragmented and urge that the deleterious consequences of such a move be very seriously considered. We believe that only a unitary health service can meet the needs of the Republic of South Africa and that a division of health services into own affairs and general affairs cannot achieve this. The health of all South Africa is at stake and we urge that this fragmentation should not occur.'[135]

Backed by UCT the College of Medicine also issued a credo, stating its opposition to discrimination and to violence.[136]

The desegregation of Groote Schuur took place against a background of deepening disaffection both on and off the campus. By this time the entire pass law system and Urban Areas legislation was breaking down as increasing numbers of Africans poured from the desperately impoverished black 'homelands' into the almost as impoverished

[132] Anonymous, 1987. Apartheid: Sitting on the fence. Pulse (undated).
[133] Correspondence cited in Mindel, 2003: 164.
[134] Ibid, 164.
[135] FHS, Medical Faculty, Professional Standards Committee, 7 December 1987.

squatter settlements on the outskirts of Cape Town The government, however, had not yet accepted the change and persisted in demolishing the squatter camps - Modderdam and Werkgenot in 1977, Unibel in 1978.

The changing social context persuaded the Medical School, in theory if not entirely in practice, that the practice of medicine itself needed to be approached differently. As early as 1977 they spelt this out in a letter to the *SAMJ*.

> We have firmly turned our backs on treating diseases only and emphasize instead diagnosis and therapy for the patient as a whole. Students are taught to pay attention to the total background of the patient - his home circumstances, economic considerations and cultural and hereditary factors. We teach that tuberculosis is rife when there is malnutrition and overcrowding; the rheumatic fever is common in those who live below the breadline; that typhoid is associated with poor sanitation and inadequate water supplies; that kwashiorkor and infantile gastro enteritis flourish as unemployment rises; that alcoholism, prostitution and venereal disease are promoted in societies where there is no stable family life and that failure to recognize this comprehensive approach results in inadequate health care and human misery. Comprehensive medicine is taught in every medical school in the Republic of South Africa, and community care, with its emphasis on preventive medicine, is highlighted. Surely it is time for members of the medical profession to use their influence collectively to promote a healthier community life throughout South Africa.
>
> Our responsibility for human welfare insists that we draw attention to the dangers of social disorganisation, inadequate housing and disruption of the family unit. The mater is urgent and deserves out immediate attention.[137]

This shift in thought contributed to the greater standing of the SHAWCO clinics, many of which were, moreover, located in the squatter camps. This often took staff and students into the most disaffected areas. When SHAWCO took the decision to offer its services to the rapidly-expanding illegal black squatter settlements the Medical School encountered the demoralising effects of apartheid policy more directly. When Unibel was threatened some members of the Medical School went beyond delegations and petitions, to monitor events on the ground and to report on the medical aspects of the demolition. Later in the year, when Crossroads erupted in internal conflict, both SHAWCO and some medical

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[136] FHC, PSC, 5 August 1986.
[137] FHS, PSC file, *SAMJ*, 15 October 1977.

staff were on hand to treat those who had been assaulted. The Dean, however, was unhappy at this turn of events and some members of the Faculty were openly hostile.[138]

Then, in 1976, the Soweto uprisings marked the spread of political unrest to Cape Town and onto the UCT campus. Even in the hospitals the medical staff was confronted by the effects of civil unrest, treating gunshot wound victims from the townships. When the police demanded the names of the victims, the staff refused, with the result that police were placed in the wards. Rising indignation led to objections from the Medical School, with the result that one of the leaders of these protests, Dr Louis van der Poel, was arrested and his contract terminated by the Province. Only after the Somerset Hospital staff, where van der Poel was training as a registrar, threatened to go on strike in conjunction with hospitals in Port Elizabeth and Durban, and members of the Medical School staff met L.A.P.A. Munnik, then Minister of Health, was he released and reinstated.[139]

For the medical profession in South Africa the real turning point was the death of Steve Biko in detention in 1977. The two state district surgeons who attended to Biko prior to his death were shown to have colluded in his torture by allowing the security police to dictate their management of the brain-injured detainee[140]. National and international outrage urged that disciplinary action be taken against the two doctors, Lang and Tucker, for their failure to maintain ethical standards. The Biko case was an acid test for the profession's ability to adhere to ethical standards and to accord respect to, and recognise the dignity of a black person.

For UCT the issues were particularly acute since the district surgeons responsible for Biko had been UCT graduates. The ethical considerations related to Biko's death have been widely discussed[141]. An extended submission was made to the TRC on the

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[138] Ibid., 56-8.

[139] Saunders, *Vice-Chancellor on a Tightrope*, 68-9.

[140] Baldwin-Ragaven L, de Gruchy J, London L. (1999). An ambulance of the wrong colour. Health professionals, human rights and ethics in South Africa. UCT Press, Cape Town, 91-100.

[141] See, for example, McLean GR, Jenkins T. (2003). Developing World Bioeth. The Steve Biko affair: a case study in medical ethics 3(1):77-95; Berat L. (1989). Doctors, detainees and torture: medical ethics v. the law in South Africa. Stanford J Int Law 25(2):499-542; Kandela P. (1985). South Africa: medical care of detainees. Lancet 2(8462): 1000-1; EM Barker. (1983). The Steve Biko case. S Afr Med J. 1983 May 21;63(21):796; Hoffenberg R. (1984). The Biko case: an appeal. Lancet 2(8412):1158; Johnson E. (1984). The continuing South African controversy. Can Med Assoc J. 130: 1623-4.; Rayner M. (1987). Turning a

circumstances of Biko's death[142] and Saunders has related at some length the actions of himself and other staff at UCT and Wits University in this regard[143]. One the one hand, Saunders, then Vice-Chancellor designate at UCT, offered outstanding leadership. Together with a number of other doctors, he resigned publicly from the MASA because of disquiet at the way in which the medical institutions had handled the matter. MASA 'had behaved intolerably in its response to Biko's death, Saunders declared. Similarly, Frances Ames, a consultant neurologist at UCT was one of a handful of committed health professionals who mounted a legal challenge to the South African Medical and Dental Council's failure to discipline the 'Biko' doctors. Their actions, at considerable risk to their own security, were successful in the Supreme Court, and forced the SAMDC to take action in 1985, when it reversed its initial finding that Drs Tucker and Lang had not been guilty of misconduct. The Biko case, and its treatment by the MASA and the SAMDC prompted significant organization amongst medical students at UCT, and served as seminal years for the development of a student leadership committed to social justice[144].

However, Ames' actions, now recognized for their courage and principle[145] did not at the time enjoy the wholehearted support of her colleagues who feared retribution from government should UCT be seen to speak out. She found to her 'dismay and surprise that senior colleagues could … refuse to pursue the fight because of reluctance to crucify their colleagues and their feeling that they should close ranks.'[146] Student petitions calling for action on the Biko doctors found only a minority of senior staff willing to sign up and

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blind eye? Medical accountability and the prevention of torture in South Africa. Washtington DC: American Association for the Advancement of Science.

[142] Submission to the Truth and Reconciliation Comission regarding medical involvement in torture and death of Stephen Bantu Biko: Sept/Oct 1977. Professor Peter Folb, TRC Health Sector Hearing, June 17-18th 1997.

[143] Saunders, *Vice-Chancellor on a Tightrope*, pp 85-91.

[144] Anonymous. Biko: The case continues. Pulse Magazine, September 1984: 14-15. See also Mindel M. (2003). The construction of medical education in an unequal society: A study of the University of Cape Town Medical School, 1904-1907. Thesis submitted for the degree of Doctor of Philosophy (PhD), University of London: 151-153.

[145] See Ncayiyana, 1997

[146] F Ames. Verbal submission to the TRC Health Sector Hearings, Cape Town, 17 June 1997. See also Mindel, 2003: 146 for a description of Faculty ambivalence regarding openly speaking out.

few professors were willing to follow Saunder's example of resigning publicly from MASA[147].

Nonetheless, in the years that followed Biko's death, the UCT Medical School began to take a firmer stand in defying the security forces. Dr Neil Aggett's death in detention in 1982 prompted a Faculty protest assembly[148] and a letter to the Medical Journal urging the profession to support the protection of the rights of detainees[149]. The Professional Standards Committee, set up in the Faculty in response to the Biko case, publicized six ethical criteria that should govern the delivery of health care to detainees, and called for strict adherence to the Tokyo Declaration and the protection of rights of detainees[150]. UCT staff (including Frances Ames) helped diagnose thallium intoxication in an Eastern Cape youth who was poisoned with the heavy metal during his detention[151]. Later, in 1985, the Dean called for medical panels to provide better care of detainees and for support for district surgeons when the police ignored their instructions[152] and the Faculty publicly congratulated Wendy Orr for the stand which she had taken against police maltreatement of detainees.[153] In the late 1980s and 1990s, UCT staff were increasingly engaged in the activities of anti-apartheid health groups providing services to victims of political repression[154], and in engaging in public debates on the ethical issues involved[155]. Like colleagues elsewhere in the country, UCT clinicians were having to grapple with the ethics of managing hunger strikers in detention or who were campaigning for the release of political prisoners, and developing appropriate ethical guidelines[156].

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[147] Mindel, 2003: 145.
[148] Folb P. See Statement on Aggett. Pulse April 1982: 13; Saunders, Vice-Chancellor on a Tightrope, 126-127.
[149] Benatar SR. (1982). *The death of Neil Aggett*. S Afr Med J 82: 300.
[150] McKenzie D. (1982). *Medical treatment of prisoners and detainees*. S Afr Med J 72: 688.
[151] Majoos FL, Marais AD, Ames FR. (1983). Thallium poisoning. A case report. S Afr Med J 64: 328-30
[152] *SAMJ*, 68, 3 August 1985, 133, in PSC file.
[153] FHS, Medical Faculty, Board minutes, 1 October 1985.
[154] Baldwin-Ragaven et al, 1999: 185-207.
[155] Benatar SR. (1988). Ethical responsibilities of health professionals in caring for detainees and prisoners. S Afr Med J 74: 453-456; L London. (1991). Ethical Issues in the Management of Civil Unrest Injuries. SA Family Practice 12: 277-283
[156] Keeton GR. (1993). Hunger strikers--ethical and management problems. S Afr Med J 83: 380-1.

With regard to civil unrest, the Faculty adopted a public position in 1985 that its staff would be governed by the principles of medical ethics alone in treating the victims of civil conflict: 'Members of the medical profession who are called upon to supply their services in armed conflicts, including civil unrest, should refuse to give their assistance to measures of reprisal against persons in their care or under their protection and should attempt to oppose acts of reprisal by all means at their disposal', the Faculty stated.[157] Indeed, it would appear that staff members working at Groote Schuur and UCT-linked hospitals were relatively successful in preventing police from routinely arresting injured patients under their care, in contrast to other local hospitals[158]. As a result, security forces appeared more likely to route detainees in need of health care away from hospitals which were seen to be resistant to their control[159]. In the following year, amid an environment of escalating repression, staff at UCT also issued public statements against the effects of political violence and detention on mental health[160] and on the consequences of detention for the health of children[161]. These actions on the part of some of the medical fraternity at UCT helped to prevent the government from sweeping the effects of its repressive actions under the carpet.

Yet at the same time as Faculty members spoke out on human rights abuses, medical students at UCT were warned against public protest and/or threatened with sanction by senior Faculty and University leadership when protesting apartheid [162]. One black alumnus recounted how, when he approached the Dean as an undergraduate student for assistance with dealing with the accommodation difficulties posed by the Group Areas Act, the Dean "shrugged his shoulders and said it was not UCT's problem, and they had to abide by the Group Areas Act."[163] Similarly, despite strident protests by the University

[157] *SAMJ*, 68, 3 August 1985, 133, in PSC file.
[158] Information contained in NAMDA W Cape Newsletter, October 1985.
[159] Baldwin-Ragaven et al, 1999: 58.
[160] Ben-Arie et al. (1986). *Disaster, detention and mental health.* S Afr Med J 70: 370.
[161] Beighton et al, (1986). *Children in detention*. S Afr Med J 70: 235.
[162] See Mindel (2003): 146, 151, 153.
[163] Personal communication, Dr Maart, February 2nd 2004.

against proposed legislation to restrict the intake of black students, UCT's actual admissions of black students were woefully limited[164].

This ambivalence also appears in the Faculty's increasing criticisms of the apartheid government's race-based policies in health during this period. For example, at the 1984 Graduation Ceremony, the Dean was reported as voicing the University's opposition to racial discrimination, on the basis that race separation under apartheid led to 'dissimilar standards of medical treatment for different population groups.'[165]. By the end of the 1980's, other faculty staff were raising concerns in the Medical Journal about the impact of apartheid separation on health care for black people[166]. Yet, students who pressured the Faculty to more active in ending hospital apartheid, found the Faculty reluctant to take concrete action, and to make overt mention of racism in its public statements[167]. For example, one student response to the failure of the Faculty to follow through on a Mass Meeting's resolution on desegregating the teaching hospital bemoaned the lack of progress: "… one of the few incidents whereby this medical school establishment have recognised their role in this strange, unequal society in which we live, has just disappeared – gone into the wastepaper bin. … Is it possible that the powers that be are actually inhibiting the recognition and action that that Mass Meeting's position called for?"[168] Indeed, much of the criticism of apartheid health care emanating from UCT staff was fed by and, in return, fed into growing discontent amongst students with race segregation in the health services, discontent that finally drove the de facto desegregation of health facilities at UCT some years prior to the official dismantling of apartheid.

However, it should also be noted that the strongest voices campaigning against apartheid inequalities and the effects of political repression on health in South Africa did so much earlier than did the University and from institutional bases outside the University, such as

[164] Mindel (2003): 153-155.
[165] Staff reporter. Stand on Medical Ethics. Cape Times 13th Dec 1984.
[166] Benatar SR. (1989). Apartheid and medical care. S Afr Med J 75: 559-560; Klein M. (1989). Effects of apartheid on health care. S Afr Med J 76: 172.
[167] Mindel (2003): 160.
[168] Edwards B. (1982). Letter to Pulse, p4.

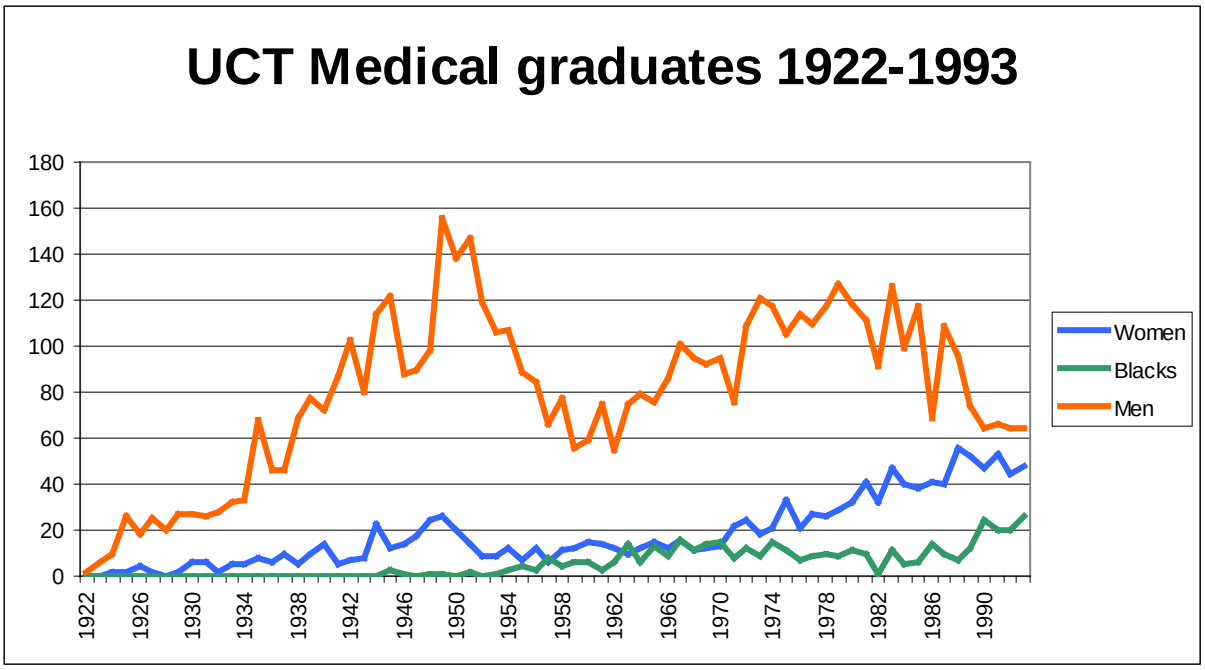
non-governmental organizations or progressive professional organizations[169]. In that sense, while individual UCT staff members were active in making public stands against apartheid, they were also instrumental in leading the Faculty on a path that was evolving for the health sector as a whole in South Africa during the period of political transition.

By the 1990s, then, both the structures of the medical profession and the character of the student body at the Medical School had altered considerably. If transformation had not been fully achieved, especially in the ethnic makeup of the teaching staff, the School was significantly more Africa-centred than it had been twenty years before.

The graph below gives some indication of the changes occurring in the student body of the Medical School. It should be noted, however, that UCT seems not to have kept an analysis of the students.[170] Women and black students have been identified by name. This means that the number black students is undercounted. Black and white women have not been distinguished and black women are included in both categories.

[169] Submission to the Truth and Reconciliation Comission on behalf of the Progressive Doctors's Group (PDG) in respect of the National Medical and Dental Association (NAMDA), May 1997, TRC, Cape Town; Baldwin-Ragaven et al, 1999, 185-207; see also Mindel (2003): 156.

[170] Walker seems to have encountered the same difficulty. See her graph at the end.



Women in the Medical School

The literature on the history of gender discrimination in South Africa is far more slender than that on racism. In particular, the position of white women has attracted little interest, partly because they may have been seen as collaborators in racism, achieving the vote at the expense, in different ways, both of black men and black women. The doctoral thesis of Liz Walker, examined the experiences of early white women doctors at UCT[171], while Mindel (2003) analysed a set of documentary interviews with female graduates of the Faculty from the second half of the 20th century.

Bruce Murray, in his history of Wits, has argued that women students were not discriminated against in the Medical School, although women staff were. 'They were paid less, retired earlier, and were liable to have their service terminated when they married.'[172] However, in terms of women's experiences at the University of Cape Town, the data on whether white women encountered overt discrimination as medical students is equivocal. Eva Salber comments on the 'ease and casualness' with which she entered

[171] Walker, 'The South African Society of Medical Women'.
[172] Murray, *The Early Years*, 327.

Medical School, a situation she believed to be very different from the situation in America.[173] Indeed, the University of Cape Town and its medical school had never excluded women and two women, Edith Paterson and Norah McCullough, graduated from the Medical School within two years of the first two men, in 1924. However, although there was always a sprinkling of women in every year, as a percentage of the class they increased very slowly. In 1982 women still formed only 18.5% of the class, the same as they had done 50 years before, although as a proportion of the graduates their numbers were increasing by then.[174]

Nonetheless, the extent of discrimination or harassment encountered by female medical students in Medical School emerges in later narratives. Although the Medical Faculty Board minutes never suggest that this was an issue at all, the Dean of the Faculty, in correspondence regarding need for UCT to make a submission for the TRC Health Sector Hearings in 1997, acknowledged that 'Women were very much in the minority for much of the existence of the Medical Faculty and they frequently talk of being disadvantaged as medical students and subsequently in their careers.'[175] For example, anatomy classes were segregated, not only by race, but also by gender, a situation that was apparently accepted without question. Walker notes that separate anatomy classes continued into the 1960s[176] confirmed by accounts of female graduates from that period[177].

The strongest evidence of hostile and patronising attitudes towards women emerges in relation to accounts of treatment of female patients, particularly black women. For example, numerous accounts from the early 50s through to the 1980s[178] emerge of female patients, particularly in obstetrics and gynaecology, being treated with lack of respect -

[173] Salber, *The Mind is Not the Heart*, 4. It should be noted, however, that the USA opened its doors to women doctors far earlier than Britain.
[174] Kirsch, *UCT Medical School*, 85.
[175] Van Niekerk JP. Correspondence with Dr Wendy Orr, 28 May 1997, TRC, Cape Town.
[176] Phillips, *The University of Cape Town*, 91; Louw, *In the Shadow of Table Mountain*, opp. p.138; Kirsch, *UCT Medical School*; Salber, *The Mind is Not the Heart*, 7; Walker, 'The South African Society of Women Doctors' 91.
[177] Mindel, 133-138.
[178] Ibid, 134, 140, 170-177.

being examined without being covered by large numbers of students, being called by patronising terms (e.g. 'meisie' or 'girlie')[179], it being assumed that women always lie about their pregnancy, and patients generally being there to be practiced upon. Most notoriously, the concept of 'the black pelvis' taught to students represented a particular confluence of racial stereotyping with mysogenous science[180].

Some evidence also highlights offensive treatment of women by both staff and male colleagues. For example, on female student recalled being addressed by a registrars in sexist and patronising terms – "come, come my girlie. Be a good girlie[181]." Walker notes the subtle ways in which women were excluded or patronised.[182] Entry into the medical school, she suggests, did not guarantee acceptance into the profoundly male culture of the profession.[183] Most women seem to have ignored such attitudes. Some, Walker argues, responded by adopting a masculine stance. 'In a masculine discourse of science, to be feminised is to be trivialised . . . Maintaining femininity renders women doctors, at worst irrelevant, and at best marginal.'[184] Given that research decades later into institutional culture in the Medical Faculty suggested that, well into the 1990s, sexist and misogynist comments from lecturers and gender-biased assumptions in teaching materials and method were common, and widely accepted as the norm[185], it confirms that the experience of women undergraduates in the Faculty through earlier decades was significantly gendered. Thus, while access as an undergraduate was not barred to women, the experience was probably one which was highly discriminatory

The situation with regard to access to career development after women qualified was more explicit in its discrimination. Until, perhaps, the 1960s, the norm was that the work of women who qualified as doctors would take second place to that of their husbands, a

[179] "Concerned', letter to the editor, Pulse, March 1981.
[180] Mindel, 2003: 137.
[181] Ibid, 138.
[182] See also Salber's comments on Creighton's lectures. *The Mind is Not the Heart*, 9-10.
[183] Walker, 'The South African Society of Women Doctors', 88-93.
[184] Ibid., 93.
[185] Rose P. Report on Institutional Culture. A Review of experiences of the Institutional Culture of the Medical Faculty, University of Cape Town. Students' Representative Council, UCT, 1995.

view accepted by most women graduates themselves. Eva Salber notes that her daughter, as an undergraduate, was the first to speak of her mother's job as a 'career'.

> 'In my time and country a women who chose to follow a profession did so knowing that her husband's career came before her own, that she would have to go with him when and wherever his work necessitated, and that the care of children would remain primarily her obligation whether she worked or not.'[186]

This may be one reason why the career paths of women doctors tended to be different from that of men - they looked for work which could accommodate the demands of marriage and children. However, the institutions of medicine discouraged career progress of women into specialities other than those few in which women's roles as mother and wife could be accommodated[187]. For example, a 1918 advertisement for a lecturer post at UCT Medical School stated quite clearly "Women eligible, men preferred."[188] In the period prior to the Second World War, because women found it difficult to get work when their training was completed, they tended to enter public health services, one of the least valued areas of medicine. Certainly relatively few found employment in the Medical School although, by the 1930s some were working as temporary or part-time assistants[189]. In 1932 the position of laboratory assistant was created for women B.Sc. graduates.[190]. Those women who remained in employment for any length of time rarely obtained positions beyond that of lecturer.[191] This situation was not for lack of ability. Women regularly won prizes and distinctions in the School [192] but this did not translate into increasing number of women staff in the Faculty. It was true, however, that few

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[186] Salber, *The Mind is Not the Heart,* x.

[187] Typically, these would be general practice or specialties such as radiology or dermatology, which could provide a work schedule approximating closer to 'office hours.'

[188] Phillips, 139.

[189] The few exceptions included the botanist, Edith Stephen, who was a senior lecturer long before most women achieved such a position and Dr Deborah Morrison, who was appointed senior lecturer in physiology as early as 1921 – see Louw, *In the Shadow of Table Mountain:* 157 and AA, Medical Faculty Board minutes, 14 June 1921. Bacteriology attracted a number of women who carried the burden of their department in the face of the drinking problem of their head – see Phillips, *The University of Cape Town*, 329. Almost all these appointments were in the pre-clinical years or for non-medical posts, however.

[190] Louw, *In the Shadow of Table Mountain,* 233.

[191] Phillips, *The University of Cape Town*, 329. There were exceptions, however. Botanist, Edith Stephen, was a senior lecturer long before most women achieved such a position. Another was Dr Deborah Morrison, who was appointed senior lecturer in physiology as early as 1921 – see Louw, 157; AA, Medical Faculty Board minutes, 14 June 1921

women who were appointed remained in their posts for many years and the University complained that women rarely stayed the full five years of the laboratory assistants' course or left shortly after to marry. However, many reasons other than marriage may have been responsible, particularly the institutional culture and the fact that salaries were too low to be attractive.[193]

Other, more subtle, explanations may also be found. Frances Ames traced the obstacles which confronted her when she was offered the opportunity to specialise. She was pregnant at the time but she could not work part time since the SAMDC did not accept part-time work for registration as a specialist. With so few women doctors in the hospitals, there was no provision for maternity leave or crèche facilities.

> 'The thought of women demanding such help never occurred to us. It would have entailed contesting male authority. The threat of being considered unfeminine and thus sexually undesirable was far too great. The hierarchical structure of the medical school and hospital was also never questioned.'[194]

After she was appointed to the Medical School staff, she was limited by her unfamiliarity with male structures of advancement. It never occurred to her to ask for a contract at work or to look actively for promotion. 'I waited humbly for things to be bestowed upon me'.[195]

The South African Society of Medical Women was formed in 1951 to lobby for the abolition of inequities in the employment of women doctors. The two issues which most concerned them was the age of retirement and the bar against permanent employment after marriage. As with women in other occupations, the Second World War had provided spaces for women in medicine in the public sector. Although some were forced to move out after the war, others noted that the positions they gained then were

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[192] For example AA, Medical Faculty Board minutes, 14 December 1922, 13 December 1923, 7 December 1926.

[193] AA, Medical Faculty Board minutes, 29 May 1956, Draft reply to questionnaire on medical auxiliaries.

[194] F.R. Ames, *Mothering in an Apartheid Society*, 2d ed. (Cape Town, The Author, 2002), 54. See also Eva Salber' comment on the view of professional women as unfeminine. Salber, *The Mind is Not the Heart*, 5.

[195] Ames, *Mothering in an Apartheid Society*, 55.

retained.[196] This meant that the discrimination existing in the public service was now more irksome. In 1950 women in the public sector retired at 55 rather than 60 and their pension payments were commensurately higher, while married women were employed only in a temporary capacity. The Society developed a low-key campaign of letters, petitions and deputations. Its struggles, Walker notes, were 'genteel, polite, and lady-like'.[197] They were able to take advantage of their status as educated, white, middle-class women to gain access to senior public officials. The result was that their goals were achieved fairly rapidly and without much difficulty. 'What was conceived as a large stumbling block to women's position was in effect handed to them on a plate.'[198] At UCT, however, a ceiling existed and it was not for years before a women was appointed as full professor. Frances Ames seems to have been the first, appointed as Professor of Neurology in 1976.

It is evident that the gender discrimination suffered by black women in the Medical School was compounded by hurdles of race in ways that accentuated hierarchies both in access and in career opportunities. Using names as a very unsatisfactory guide, it would appear that the first black women only graduated with M.B. Ch.B. in 1961, with about 7 women qualifying in the 1960s and about 12 in the. 1970s. Ironically, the first African graduate of the faculty in 1990 was female. But opportunities for black graduates for post-graduate training, already limited by race bars, were further compounded by gender prejudice. One black female doctor recalled being actively discouraged by a white male Head of Department from specializing in a particular field because her family and personal life should come first.[199]

Conclusion

[196] Walker, 'The South African Society of Medical Women', 103-4.
[197] Ibid., 108.
[198] Ibid., 121.

In reading the memoirs of male and female doctors, one is left with the sense that the practise of medicine sometimes had different meanings for the two genders. Eva Salber commented on how detached she felt during her medical training. Disease did not interest her deeply. 'I could appreciate the hard work and often brilliance that went into the diagnosis of disease . . . but this predominantly intellectual task didn't excite me.' The teaching at UCT was good but it stressed 'the biological and bacteriological causes of disease and the acquisition of diagnostic and prognostic skills'; therapy was little emphasised. Still less were students shown the importance of social, economic and political factors in disease.

> 'Later, when I got away from the academic setting with its emphasis on individual patients, I began to think in terms of groups of people and the relationship between their living conditions and their illnesses. Only then did it dawn on me that I'd chosen a profession in which I could express my values through my work.'[200]

Frances Ames chose a different career path, but her extraordinary memoir, *Mothering in Apartheid Society*, describes a life which was very different from her male counterparts. It is a journey of discovery of her relationship with a black domestic worker, Rosalina, who gave her the support she needed to carry on her career after the death of her husband, while her sons were still young. It is also a study in the process of understanding, over many years, a mother from a very different culture. Through this work she explores the meaning of feminism for herself, as a woman doctor. For her the male hierarchy of the medical profession and the male routes to power appear to go hand in hand with the authoritarian practice of medicine, which characterised the South African profession. She has little to say, explicitly, about her own well-recognised and well-respected stand against apartheid but the reasons are implicit throughout. Ames's personal experience as a woman doctor and mother, and her actions in opposing apartheid were indivisible. This is not to suggest that women doctors were uniquely humane and sensitive to apartheid. However, the experience of women doctors may have encouraged them to practice a form of medicine with a larger social commitment than that which had traditionally been

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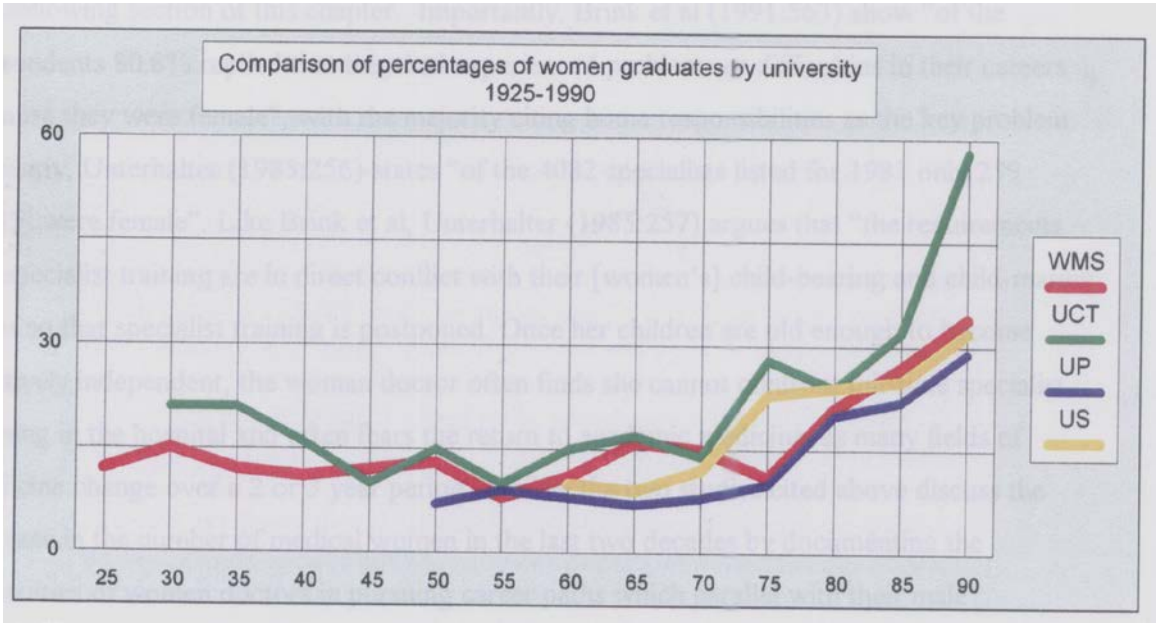
[199] Mindel, 2003: 175.
[200] Salber, *The Mind is Not the Heart*, 7.

taught in the Scottish-based medical schools which had characterised the first eighty years of South African medical education.



CHAPTER 3 - ANALYSIS OF RESPONSES OF BLACK ALUMNI

1. INTRODUCTION

One of the many sequels of South Africa's history of racial discrimination was the impact it had on the training of black doctors, the consequences of which are still with us today. For instance, in 1967 South Africa had produced 92 to 98 doctors per million whites and only 0.9 to 0.5 African doctors per million blacks (Tobias, 1980). Not only were blacks excluded from training opportunities but the conditions under which black doctors trained were extremely onerous (Tobias, 1980). The findings of the Truth and Reconciliation Commission's (TRC) investigations into the Health Sector has shown how the discrimination inherent in medical training reproduced broader societal patterns of discrimination and was responsible for the acquiescence of many health professionals to the systematic human rights abuses that characterised apartheid and the racial discrimination practised in the health services (TRC, 1998).

Although policies in the training of health professionals in South Africa have changed radically over the last decade, research has shown how important it is for the health professions, and institutions of the health professions to understand their role in complicity with human rights abuses. This is the case both internationally and in South Africa (Baldwin-Ragaven et al, 1999). By understanding how the training of health professionals in discriminated against blacks and other groups in the past, health training institutions can work to create learning environments more receptive to diversity and the nurturing of black professionals, thereby contributing to redress of past inequality.

The need for reflection on past experiences in order to assist transformation in health sciences education has been manifest in submissions by Medical Schools to the TRC, initiatives of human rights training and in the Wits University Internal Reconciliation Commission (IRC).

It is this understanding that has prompted the Transformation Portfolio in the Health Sciences Faculty at UCT to undertake a Reconciliation Project aimed at facilitating

institutional redress. A central part of this project has been a research project investigating the experience of former students and staff, with a view to understanding better how the faculty was both complicit in, and able to resist racial discrimination. What follows is an attempt to raise a debate about how best our health science institutions can understand the experiences of discrimination in order to effect transformation.

A HISTORY OF RACIAL DISCRIMINATION

From the time of the arrival of the first Europeans in South Africa (up to the first democratic elections in 1994), racial discrimination was the foundation of life in this country (Girvin, 1987). The South Africa Act, which paved the way for the formation of the Union of South Africa in 1910, provided that parliamentary representatives from all provinces had to be of "European descent" (Boulle, 1987). The process of racial segregation was given a legal framework in 1948 with the coming to power of the Nationalist Party.

While no formal legislation existed prior to 1948 to restrict the admission of blacks into "white" universities, these universities adopted policies that effectively barred blacks from studying there. In 1923 UCT's Council believed that it would not be the university's interest to admit native or coloured students (Phillips, 1993). When blacks were admitted into universities, they were restricted from participating in sports and social activities.

Prior to 1929, UCT had a policy of barring or restricting access to black students in its medical course because it could lead to mixed classes and "white patients being examined by black medical students" (Phillips, 1993).

By 1937 UCT had admitted a total 40 Coloured and Indian students in the faculties of Arts, Science, Education and Medicine. However, Black students in the Medical Faculty were not allowed to complete the whole course at UCT as local hospitals did not allow blacks access to white wards for the clinical part of their training. They were therefore expected to travel overseas for the second part of their training (Ralph Lawrence, Paper presented to NUSAS conference, 1941).

During the period covered by the Extension of University Education Act individual black students were required to obtain Ministerial consent from the relevant Minister, according to their race classification (Roux, 1964, Tobias, 1980) to attend a "white" university.

It was only when the Second World War started and it became more difficult for students to travel overseas that a decision was made to admit black (ie students classified as "coloured" or "Indian"), students for the first time. However, African students were excluded and Coloured and Indian students were only admitted on condition that they signed a declaration that entrenched self-imposition of racist practices.

"I understand that my registration in the Faculty of Medicine is conditional on the following:

a) That I understand that the University cannot guarantee clinical training for non-European students in the Faculty of Medicine.
b) That if I am admitted to clinical training at any hospital or institution used for teaching in the Faculty of Medicine, such admission is subject to the understanding that I at once leave any class or clinic where a European patient is present. I understand that class includes clinics, clinical lectures, demonstrations, operations and post mortem examinations."

Letter from Dean of Medical School, 1963; cited in Perez and London, 2003

Introduction of the Bantu Education Act (1953) placed the control of education for Africans in the hands of the Department of Native Affairs. The Minister of this Department, Dr Verwoerd, outlined his plans for the education of Africans as: "My department's policy is that education should stand with both feet in the reserves and have its roots in the spirit and being of Bantu society…There is no place for him (the Bantu) in European community above the level of a certain form of labour" (Roux,

1964). This set the scene for the introduction of an inferior form of education for African people, the consequences of which are still seen today.

African students were not admitted into UCT's Faculty of Medicine until 1985. In 1983 the University Amendment Act was passed by Parliament. This Act was envisaged to replace the 1959 Extension of University Education Act by which persons of colour had to apply for a special permit to attend "white" universities, with a racially determined quota system that universities would be required to administer (Saunders, 2000). This legislation was not enforced. However, UCT was informed that African students would not be allowed to enter the Department of Land Surveying and the Faculty of Medicine (Saunders, 2000).

2. METHODS

2.1 Sampling

Alumni were chosen through a “snowballing” method. We asked an alumnus for the names of people whom she remembered studied at UCT Medical School. We used this list to contact alumni and asked each person interviewed to give us the names of others. We stopped the process when we were no longer receiving new information.

Black alumni were contacted and asked to participate in the study. Where possible interviews were conducted face to face. Where this was not possible, questionnaires were mailed or faxed to participants or participants were interviewed by telephone. Through these methods we obtained 73 completed questionnaires. The response rate is shown in the table below.

Table 1

No. contacted	**No. Interviewed**	**Response by phone, mail or fax**	**No refused to participate**	**Total participants**
84	52 (62%)	21 (25%)	11 (13%)	73 (87%)

The following report includes the results of the analysis conducted on the semi-structured questionnaires that formed part of the Faculty Reconciliation Research Project. The report includes both qualitative and quantitative results of the research.

2.2 Method of Analysis

A total of 75 typed transcribed questionnaires were analysed, the average length of the completed questionnaires being two pages of typed text. Analysis was conducted in the following periods: 1945-1959; 1960-1985; and 1986-1994. These periods were chosen as they represented the period prior to the introduction of the Extension of University Education Act (1959), post the introduction of the Act (1960 to 1985) and the period following the dropping of the Act (1985 onwards).

The 'open coding' method as described by Strauss and Corbin (1990) formed the basis of the analysis. The process of open coding involves a line-by-line analysis of the transcripts in order to label phenomena, identify concepts, and finally group concepts into categories. The concepts and categories that were identified were reviewed on several occasions in order to ensure that the concepts that pertained to the same phenomena were placed in the appropriate category. This was applied to each decade with similar concepts and categories developed across the decades. The structure and nature of the questionnaire items did not lend itself to in-depth qualitative analysis. In general the responses were brief and fairly succinct in response to the questionnaire items.

In terms of the analysis of the data, reliability of the analytic procedure was enhanced by a code-recode procedure that was conducted by one researcher. This involves coding a selected part of the data, re-coding the data two weeks later and comparing the results (Krefting, 1991). No discrepancies were found in the code-recode procedure, with the data being clearly suggestive of the codes previously identified. Two members of the research team independently coded 10 pages of the transcribed data and compared the results in order to check for the reliability of the analytic coding process.

Reliability of qualitative data takes on a different meaning to that of quantitative research, where the "uniqueness of the human situation" is emphasised (Krefting, 1991). Since experiences of individuals are inevitably expected to vary, qualitative research defines reliability in terms of the dependability of the data. This refers to whether the findings of a study would be consistent if replicated with the same participants or in a similar setting (Krefting, 1991).

The concept of validity in qualitative research concerns to gaining of knowledge and the understanding of the true essence and meaning of the phenomenon being studied (Deatrick & Faux, 1991). Validity is dependent on the extent to which researchers have confidence in the truth of their findings (Krefting, 1991). In order to check the validity of the questionnaire data analysed a focus group discussion was held. This enabled the researchers to determine the recurrence of themes and to verify the data obtained in the questionnaires. The term triangulation is often referred to in qualitative research and implies the combination of multiple methods, in order to accurately depict the phenomenon under investigation (Knafl & Breitmayer, 1991). Methodological triangulation was achieved by utilising more than one method of data collection and allowed for data to be verified and hence validity of the data to be improved.

3. RESULTS

The analysis of the data arising from the open coding method is presented as well as tables which outline data that lent itself to quantitative analysis. Table 2 provides a breakdown of the gender of the sample of respondents within the three periods. A predominance of male students is evident.

Table 2: Sample of Respondents (*n*=75)

Period	**Number of students**	**Male**	**Female**
1945-1959	4	4	-
1960-1985	58	47	11
1986 – 1994	13	8	5
Total	**75**	**59 (78,6%)**	**16 (21,3%)**

The analysis of the data resulted in several categories being identified, each of which will be outlined below. Since the outcome of the present research is integrally linked to the political history of South Africa, a brief synopsis of the political context in which students resided is important to take into account. Italicised phrases and sentences are direct quotations from the questionnaire transcripts that serve to highlight the experiences of the respondents.

The term 'Black' has been used to refer to individuals previously classified as 'Coloured' and 'Indian/Asian', while the term 'African' has been used to refer to individuals previously classified as 'Bantu'.

3.1. 1945-1959

In order to fully comprehend the experience of medical students in this era, it is important to be cognisant of the fact that it was this period in history which marked

the beginning of the legislation of the apartheid government that was to have a profound impact on the citizens of South Africa. The Population Registration Act of 1950 formed the bedrock of the apartheid state in providing for the classification of every South African into one of four racial categories. In terms of the 1950 Group Areas Act the entire country was demarcated into zones for exclusive occupation by designated racial groups. Implemented from 1954 the result was mass population transfers involving uprooting mostly black citizens and the resulting destruction of communities (TRC Report, 1998, Vol 1, chap 2). Other legislation included the 1950 Immorality Amendment Act; the 1949 Prohibition of Mixed Marriages; the 1953 Separate Amenities Act; and the 1953 Bantu Education Act (TRC Report, 1998, Vol 1, chap 2).

Perhaps the most noteworthy apartheid legislation that affected students in this period was the 1959 Extension of University Education Act that denied black students the right to attend their university of choice. It therefore became illegal for white universities to admit black students except with ministerial permission (TRC Report, 1998, Vol 1, chap 2).

While the government of the day focused on regulating its citizens, the masses began mobilising themselves. In 1943 the ANC's Youth League was formed and by 1949 they had adopted a programme of action where the strategy of mass mobilisation was opted for (Marx, 1992). In 1952 a defiance campaign was launched led by Nelson Mandela. This was followed by major school boycotts in 1955, an anti-pass campaign in 1959 and these civil disobedience actions resulted in an increase in support of the ANC and the Youth League. In 1955 the Congress of the People was held where the Freedom Charter was adopted (Marx, 1992).

The analysis of the data from this era reflect the responses of merely four respondents. This is a function of the minimal number of black students studying at UCT's Medical School during this period. Two broad categories were identified.

3.1.1. Discriminatory medical education

Inequality in terms of medical education and facilities came in the form of students being mailed information regarding UCT's segregation regulations. This came in the form of being denied access to white health care facilities such as white wards and exposure to clinical teaching of white patients, which they believed impacted on their medical training.

All black students were required to sign a document stating that they understood that their registration in the Faculty of Medicine was conditional on the following:

- the University not being able to guarantee clinical training for them in the Faculty of Medicine; and.

- if admitted to clinical training at any hospital or institution used for teaching in the Faculty of Medicine, such admission would be subject to the understanding that they would excuse themselves from any class or clinic where a White patient is present. The term 'class' included clinics, clinical lectures, demonstrations, operations and post mortem examinations.

"In 1944… It then became a condition for our annual registration that we sign an undertaking that we would not attend a white patient or be present when a white patient was being demonstrated to the class or being attended to in the outpatients department. Additionally, we were debarred from being present when an autopsy was done on a white patient."

The segregation was upheld even in outpatient departments that comprised all race groups.

"In outpatients, where whites and non-whites were seen in the same clinics (entering by separate doors), we were required to stand outside when a white patient was being seen. Many a day we hurried to the 9am clinical demonstration only to turn back at the door because the patient's case folder was pink. Yes, pink was used for white and green for non-white."

Other forms of discrimination came in the form of being barred from participating in university extra-mural activities and social events, as well as university residence.

Compulsory hospital internships implemented in 1948 implied that they were forced to seek internships at black hospitals since they were barred from working at Groote Schuur Hospital (GSH). Post-graduate options for black students at UCT were minimal and resulted in some doctors relocating in order to further their studies.

3.1.2. Perceived position of white staff members and white students

The feeling amongst the respondents of this era was that the UCT academic staff upheld the apartheid policies and little was done to oppose it.

"All the academic teaching staff in the clinical years tacitly observed the apartheid policies of the University. I don't think that the academic staff were prepared openly to oppose the University apartheid policies."

"Extremely sad that intelligent people could have been intellectually so complacent about apartheid in the medical profession."

During this period black students had no access to white academic staff outside of teaching hours. Mention was made of the few exceptional staff members who assisted black students.

"During my clinical years there was one medical clinic tutor who recognised the academic handicaps under which we worked and in my final year he invited me and my three other non-white colleagues to come to his house for tutorials once weekly."

White students were perceived as not being opposed to the University's apartheid policies, although some privately appreciated the injustice that was directed at the black students. The most significant incident for one respondent was of being suspended from university pending a disciplinary hearing as a result of white students

laying a complaint to the authorities that he was present at a clinical tutorial which included white patients.

3.2. 1960-1985

The 1960's were dominated by economic repression and survival was foremost in the minds of many. It was during this period that the campaign against the passes which Africans were required to carry gained widespread support and resulted in the rally in Sharpeville on 21 March 1960, where 69 unarmed men, women and children were killed by police. The international response to these killings was met with the banning of the ANC and PAC by the Nationalist apartheid government. Urban sabotage organised by the ANC began from 1964.

By the late 1960's the economic climate in the country had improved. By the 1970's several leaders of the liberation movement were in exile or imprisoned and opposition in South Africa was halted by brutal police force and by the 'forced removals' of individuals from urban areas to separate homelands (Marx, 1992). The result was substantial fear and little active resistance. However, underneath the surface of what appeared to be a silencing of the opposition, discussions for future resistance was taking place particularly amongst the black students in the segregated universities (Marx, 1992). The overcrowded schools and growing universities created opportunities for students to discuss the discrimination they suffered. This decade was marked by significant political events. On June 16, 1976, the Soweto uprising took place. The harsh response of the police to the protest resulted in 25 students being killed. Six days after the initial uprising, 130 people were officially listed as having been killed (Marx, 1992). This period was also marked by the death of the black consciousness leader, Steve Biko in 1977 who was fatally injured after police brutality. This decade saw the first black student hold a post-graduate position.

A total of 58 respondents formed the sample for this period. The broad categories are outlined below.

3.2.1. Impact of and resistance to political climate

The prevailing political climate that dominated South African society had a significant impact on the lives of the black medical school student population at UCT. One respondent noted that his involvement with the Congress Alliance resulted in his detention and solitary confinement in 1964 when charged with "subversive" activities, working for the ANC. Another respondent commented on the PAC march in 1960/1 led by Philip Khosana, adding that there was uncertainty about whether UCT committed to an official response or not as well as the position which the majority of white students held.

"We had little contact with white students. We didn't mix, so we didn't know how they reacted to the march."

A few noted that within the medical faculty there was uncertainty and suspicion about staff members' alliance with the apartheid government.

"There were rumours that many superintendents were police reservists."

"You were always looking over your shoulder… is there anyone who is a member of Special Branch?"

The importance of politics in the lives of students during this era is highlighted. One respondent who qualified during this period comments on the police presence during his first year at UCT that had a significant impact on him.

"My first year was in 1972. The police came onto Jamieson steps ordering the clearing of the whole campus. The effect it had on us as junior first years students ***was huge****. We were under threat on our own campus because of the police".*

The late 1960's saw the beginning of student resistance with boycotts of post-mortems, graduation, class photographs and of final year celebrations. It was an era where formal complaints were laid with UCT authorities. Black students began defying the 'rules' and entered white wards and other 'forbidden' areas such as the

cafeteria and student union. Generally students were requested to leave when defying the rules. Respondents cite numerous examples of resistance. A march was held at the time of the 1976 Soweto uprising and the killing of Steve Biko, and one black student who was actively involved in petitioning was arrested, spent two weeks in solitary confinement and prior to the specialist exams was dismissed and then reinstated shortly afterwards. A few respondents comment on the passive role that UCT adopted in these instances.

"the 1976 Soweto riots, when a lot of children were killed. We put together a statement, but I think because of the whole atmosphere at UCT no-one wanted to stand up and state it at a mass meeting. The other was the death of Steve Biko and UCT's response was poor. …. I refused to become a member of MASA. They did nothing about the people who were implicated in the death of Steve Biko. It made us see that UCT paid lipservice and it wasn't interested in doing anything active".

A white doctor was arrested for leading a protest march in 1976 and in 1980 black students decided to not attend classes in support of the protesting and rioting that was taking place. Protests came in the form of boycotting classes, boycotting the final year dinner, having a separate class photograph and boycotting the graduation ceremony.

"Graduation – we didn't feel like being part of it. Most didn't go. I went for my parents. We had separate photographs – it was our way of protesting".

One respondent commented on his challenging the norm of separate tea-rooms as well as approaching the Dean regarding the quota system, which he was reluctant to discuss. Protests came in the form of black students not accepting awards that were racially defined.

"I qualified and got good marks in Paediatrics. The prize I got said I was the best coloured student. I gave it back. I wanted to be recognised as a student, not on colour".

Black students who attended the final year dinner were outspoken about the injustices at medical school and as a result of this were ostracised by one lecturer. Attempts were also made to resist regulations that denied access to white post-mortems. Some white students protested that lecturers include black students in their groups.

In 1968 students participated in a nation-wide go-slow in protest against the unequal salaries since white interns were paid more than black interns. The strikes resulted in black students obtaining an increase but the salaries were still not equal. The majority of white students did not participate in the strike. Some students were active in attempting to redress imbalances. For example, there was a suggestion that white interns contribute part of their salaries to black interns in order to address racial inequities in remuneration. Admission policies were challenged with black students arguing to admit African individuals to the Faculty. Some respondents comment on the fact that some white students spoke about the injustices and were sensitive to their needs. However, the general impression was that these white students were a minority and few were willing to participate in active protesting or support of black students

"I also tried to get onto student council to use it as some form of influence. I got no support from white students. Also no support from white academics."

"We tried to get white students to boycott with us. One or two tried, but they said that it was not their fault."

Not only did the political climate result in tensions between black and white students, but the black students themselves appeared to differ in their approach and views on the political stance to be adopted at university. There appeared to little tolerance for freedom of association and interaction with white students was considered as collusion.

"The early '70's was the period of black consciousness, …. A lot of meetings and interpersonal discussions were held at the time. Many guys said we musn't talk to white students. The idea of ostracisation/ isolation evoked debate and feeling. There

was an active campaign to isolate two coloured students who associated with white students a lot. …. It was a pivotal era, not only at UCT but countrywide".

3.2.2. Institutional changes

From 1959 black students were barred from white universities unless they produced a permit. All non-white students were therefore required to obtain a permit to study at UCT, and this was renewable on an annual basis. Besides the humiliation at having to apply for a permit, respondents comment on the anxiety at the end of each year, being uncertain of whether they would be granted a permit. Some however do not recall applying for a permit. Study permits were abolished around 1977. During the course of this decade a quota system was also implemented which implied that some suitable candidates were denied access to the medical faculty.

"Prior to 1964, many potential good doctors weren't allowed into medical school, and they were lost to society. I know several who were never accepted."

"Applying for permits was a big issue for me. Having to be confined to a certain part of the hospital was another. The indignity was there all the time".

"All first year students meet the Dean on main campus …. He would greet you and let you know that all black students should be very grateful to be at this illustrious institution".

"The humiliation and stigma attached to studying under a permit system. Certain sectors of ones community took a dim view of someone willing to study under these circumstances"

"you never felt accepted, or that you belonged there. It was also used as a control measure. The Dean or a Faculty member would remind you that could be kicked out".

"We were told we were different and inferior or weren't empowered to get up"

The latter part of this period marked the beginning of important changes within the medical faculty. However, respondents comments suggest that black students continued to be subjected to similar inequalities as their counterparts in earlier years. Some of the most noteworthy include the following: black interns being allowed access to GSH and Red Cross Hospital and able to attend all ward rounds; being allowed to dissect white bodies; the racial mixing of tutorial groups; registrars being allowed access to the white wards, although interns and housemen were still denied access. These changes occurred during the course of this decade and responses from the questionnaires vary depending on the period when changes were implemented. One respondent noted that black students were made to feel fortunate to attend UCT, especially when considering the minimal number of blacks in higher academic positions

"The lack of blacks in academic positions (registrars and consultants) left one with the impression that you should not aspire much higher than MBChB".

Black interns were initially paid less than white interns but this had equalised by the end of the 1980's. There a few discrepancies with some reporting that facilities and sporting clubs were available to black students but remained segregated, while others comment that they were open to all.

It is important to note that while there appeared to be a slight move towards equal treatment of students, in reality changes took place over a protracted period of time. One respondent recalls that black students were allowed to work in the ambulance service but were always paired with black drivers. They were not allowed to fetch white and black patients in the same ambulance

"if you had a patient in Guguletu and had to pick up a patient in Rondebosch, you couldn't pick them up. I quit after three weeks – on principle".

One respondent noted that Valkenberg Hospital continued with the policy of segregation for a longer period of time than other hospitals.

"At Valkenberg they sustained the segregation of health services which had changed so many years ago at GSH".

3.2.3. Disadvantaged backgrounds

The transition from schools where there were not adequate facilities and teaching to an institution such as UCT was considered as challenging for many of the black respondents who felt that they had to work harder to succeed. Their under-privileged background and education resulted in transition difficulties and UCT did not accommodate or acknowledge the educational differences that existed for these students. The limited financial support was commented on as well as the travelling difficulties that in some instances was a result of access to medical residence being denied to black students. There was a lack of sensitivity to the demands placed on students as a result of transportation and accommodation restrictions. Some comment on the inadequate studying facilities provided.

"*It was quite a jump, in particular to non-white students. We didn't have the facilities at our schools that the whites schools had. Their level of teaching was far higher*".

3.2.4. Discriminatory medical education

The most consistent and recurring theme questionnaires concerns black students being denied access to the following: university residence, university facilities, white wards, white patients, white autopsies, certain hospitals such as GSH and Red Cross Children's Hospital, academic and clinical training, contact with staff (outside of university hours), university events, and extra-mural activities, and social functions. Each of these posed as important restrictions on black students.

Racism at medical school appeared to be entrenched, with numerous unwritten rules adhered to by most. There were clear instructions with regard to access to white wards and white patients, and apartheid legislation was actively upheld by many UCT staff members. One respondent noted that the segregation at UCT medical school was implicit. This suggests an institutional culture with powerful unwritten rules that facilitated discrimination in a significant manner.

"There were unspoken rules".

"In anatomy there was an unwritten rule that you'll never work on white bodies".

"There was never a law that said you cannot examine a white patient. But they made an internal decision. It must have been a departmental directive or decision of their own".

"There was never overt racism, except for white wards, white post-mortem's issue".

"It was just the system. It was understood that you couldn't apply to GSH as an intern"

One respondent describes the manner in which a "guard" was positioned at the door ensuring that black students do not enter when white patients were presented. Hospital staff too would actively prevent access to white wards.

Respondents comment on the humiliation of attending university given the numerous restrictions imposed on them, especially when barred from white post-mortems and ward rounds.

"Being humiliated in front of your white colleagues when barred from white post-mortems and ward rounds in white wards at GSH".

"*With post-mortems in 3rd year is where you felt the prejudice and the discrimination. When they had a white body you had to walk out. It was a practice that was accepted, that was done over the years. It was one of those unspoken, unwritten laws*".

"Had to acknowledge a 'gentleman's' agreement to abide by certain conditions … including respecting apartheid after death in the pathology post-mortem facility at the medical school".

"There was no major incident, just a daily feeling of humiliation".

Tutorial groups were also segregated on racial lines, with the perception from black students that the best tutors were assigned to the white groups.

"Through the tutorial system, whites had better guidance, a better system of support, better 'spotters'".

As a result of black students being denied access to university residence, some incurred higher costs when seeking alternative accommodation. This often implied additional travelling expenses that required additional income being sought after university hours. There were also inequities with regard to salaries for black and white interns.

The limited prospects for post-graduate studies at UCT resulted in some not furthering their studies. After qualifying, black doctors were faced with limited work opportunities as they were denied access to hospitals such as GSH and Red Cross and were only accommodated at Somerset Hospital. One respondent said he resigned after being denied access to Red Cross Hospital while completing his post-graduating training in Paediatrics in 1976.

In terms of the training, respondents generally acknowledge that they were exposed to medical training of a high standard, despite the racist underpinnings and numerous limitations.

"We got a very good education. I can't say we missed out on anything."

"Training was excellent, despite negative factors".

"I am proud of having been at UCT, despite all the problems".

"Very good training was received".

"In retrospect it was good training, but it could have been much better."

"Qualitatively, in spite on the shortcomings, we came out as good doctors".

Only one respondent was of the opinion that the training was of poor quality.

"*There is absolutely no question that it [i.e. UCT training] was inadequate and incomplete compared to our counterparts, because of narrow constraints"*.

A minority of respondents noted that the training was inadequate since they were denied access to the full range of pathology and there were missed teaching opportunities.

"We didn't see a spectrum of disease that the white students saw. We never got personal attention that white students got. … we were definitely affected. We weren't even taught how to read an ECG".

"*the whole spectrum of your patient population was never presented to you. You missed out on certain things and only got them in theory but never saw them*".

Many comment that they were denied the experience of an all-round education.

"Cheated! There were so many ordinary things we were denied because of our colour. We could have excelled academically as well (in) as any other spheres, viz, debates, sports, community activities, etc."

Table 3 demonstrates that more than half of the respondents believe that their training was affected as a result of the racial discrimination.

Table 3: Was the quality of your training affected by your being a black student?

Period	Number of students	Affected training	Did not affect training
1945-1959	4	4	-
1960-1985	58	37 2 maybe	15 5 unsure
1986-1994	13	7	6
Total	**75**	**48 (64%)**	**26 (34,6%)**

3.2.5. Perceived position of white staff members and white students

A wide of range of comments were obtained with regard to black students perceptions of white staff members and white students. Some commented on the limited social contact with staff members and the lack of personal attention that they received compared to their white counterparts. Several respondents commented on the minimal support they received from staff and their passivity. Some were of the opinion that white staff members formed part of the system and ensured that the apartheid regulations were upheld and that the medical faculty rules were enforced. Of interest is the explicit racism on the one hand and the role of silence amongst both the students and staff on the other hand. Few respondents comment on white staff members who expressed a willingness to assist them and resist the racist university policies. Generally respondents commented on the implicit racism and apathy of white staff members who were perceived as upholding apartheid.

The table below reflects the views of black alumni to the questions: “Were there people at UCT responsible for upholding apartheid legislation?” and “Were there people at UCT who put patients and students above upholding apartheid legislation?”

Table 4: Were there people at UCT responsible for upholding apartheid legislation? / Were there people at UCT who put patients and students above upholding apartheid legislation?

Period	Number of students	People at UCT upheld apartheid		People at UCT put students first	
		Yes	No	Yes	No
1945-1959	4	2*		2	
1960-1985	58	50*	6	46*	9
1986-1994	13	10	3	9 1 unsure	3
Total	**75**	**62 (82,6%)**	**9 (12%)**	**58 (77,3%)**	**12 (16%)**

* some respondents did not answer this question

Students responded to this with the following quotes:
"their biggest crime was silence"

"*Their silence was what was common to most. Physicians never raised any objections. Some could have done better*".

"All the lecturers and professors never expressed to us their feelings on apartheid. It was just part of life"

"We all felt that the staff were part of the system. They would say their hands are tied. The professors, the academic staff could have done more".

"Certain professors and consultants definitely entrenched the apartheid policies be it overt or subtle"

"*The academic staff was protected from being overtly racist. The onus was on students of colour to 'voluntarily' not attend white patients and white autopsies. None protested nor did express regret at what was known to them*".

"*There are several who promoted the concept of superiority of the white race. It would be worth naming them because they had double standards as far as the international medical community was concerned. They contributed to international journals and medical contributions. These bigots were brilliant in academic medicine*".

Some were of the opinion that lecturers were employed at UCT because of their political affiliations and were clearly racist in their interactions with black students, although these were not always explicit.

"To some extents, lecturers were there because they were pro-Nat or Broederbond".

"During clinical years there was nothing overt, but silent co-operation with the government".

"UCT has been riding on this liberal label when this was not the case".

A few respondents mentioned the names of staff members who were supportive and oppose to the discrimination within the faculty. One staff member in particular was caught placing posters up calling on people to boycott the upcoming elections. He was banned from working for the hospital system and was forced into exile. Other staff members chose jest as a way of communicating with black students about the political context in which they had to live.

"By far the majority of staff were unbiased and really tried to help us. Some even went out of their way to help and encourage us".

"*there were few who were genuinely concerned by our circumstances. They offered more than moral support. ….. He gave us financial assistance and extra tutorial*

classes after hours in whatever categories of academic medicine we had missed out on".

"A fellow called … he would make jokes in class – 'are there any Special Branch people under the desk?'"

There was acknowledgement by one respondent that broad generalisations were made about white staff members that were unjust.

"There may have been people with different views. We thought white professors were automatically racist. This was not so, but that was the problem we face".

One respondent was of the opinion that the medical school staff was dedicated to teaching but chose to ignore the larger system within which they functioned. Another believed that staff members were not racist in their treatment of black students.

"*Most cared about teaching. It's just that they turned a blind eye to the system. They were totally oblivious".*

"we had very good teachers that taught without regard to race".

"Despite not being accepted as first class students, we weren't openly discriminated against by lecturers".

Of interest are the comments of a few respondents who express uncertainty about the nature of interactions that existed between students and staff members. They report feeling uncertain as to whether lecturers' harshness was as result of their personality or whether it could be attributed to racism.

"Lecturers gave a hard time – did they because they were that type of person or because of the colour of your skin. It is difficult to attribute";

"I feel that often it is so difficult to divide the cultural from the racial at UCT. As a student you felt belittled and oppressed… Maybe it didn't relate to racial undertones;

it could have been the way they taught. … I think that there is a fine line between the way our teachers almost found themselves in positions where they were in oppressive attitudes to students (as a whole) and racism. It is a complex issue to differentiate between. Is it discriminated to a group or superiority as teachers. I don't know".

Another respondent was of the opinion that ones racial origins did not impact on the training they received, arguing that there was equal treatment and that the political context is important to take into account.

"*During the '60's, the people who taught us were genuine people. They wanted to teach us regardless. All of us got the same punishment, no matter what our race*".

"*they were only teachers. They lived in the apartheid context. We were scared because of academic fear. … We submitted to the tyranny if we weren't up to scratch. We never interpreted it as discriminatory. We felt it was equal treatment*".

Some commented on the feeling of having to work harder than their counterparts in order to achieve given the enormous restrictions imposed on them.

"We had to prove ourselves more. We came here with the attitude that we were equal. Professors treated us as inferior"

"I remember always feeling that I had not just to be good. I had to be better than good. I wanted to show them that I was equal and better".

One respondent related an incident where a physician sarcastically reprimanded a group of black students who arrived late.

"He said, 'You people should be lucky to be here, LUCKY TO BE HERE'. Ostensibly, he was asking us why are you late. But that was not the tone; the tone was racial".

One respondent believes that the marking system was biased against blacks especially in oral examinations and added that medals were often allocated to white students.

At times white patients protested about being examined by black students. These types of situations were dealt with in different ways with some staff members considering the objections of patients while others were intolerant of their racist attitudes.

Some mention the personal attacks on students.

"They reprimanded people for having long hair".

"During obstetrics and gynaecology, I had been on the whole night. I had gone to get something to eat. I walked in wearing a pair of sandals. The consultant was appallingly rude about this".

Comment is also made of white students' passive acceptance of the situation with little attempt to engage in the reality of the political context in which they resided. It was noted that they were generally complacent with only a minority expressing their opposition to the apartheid system. They failed to actively assert themselves and interact with other race groups, hence the feeling that they colluded with the system.

"*White students also accepted the situation for what it was – a privilege. They went out of their way to fraternise. They were good, genuine fellows, but never talked about the political liberation of the country*";

"white students whose attitude was one of tolerance and patronising us at every opportunity, with a few exceptions".

"Even your white classmates treated you badly. … Fellow students would do a very good job of making you feel inferior".

"I went to the white ward once … and a white medical student asked me what I was doing there".

"'White peers' generally aloof".

"our classmates – were like strangers, we didn't know them".

There was a general feeling of apathy towards the predicament of the black students and the black community in general.

"The lack of understanding and empathy for the black students' protest action in 1976 by our fellow white students who felt that we should be grateful for the world class education we were receiving"

"The main problem – white people didn't realise where black people stayed and what conditions they live under".

One respondent commented on a few white students who crossed the racial divide and socialised with black students, while another noted that religion formed an important factor in facilitating closer networks with white students.

"End of year party, some white guys came to party in Belthorn and other guys didn't appreciate that from them".

"I had more of an affinity with white evangelical students than others. This was the struggle throughout my student career …. There were those that I had good relationships with who knew what prejudice meant".

Of significance is the manner in which some respondents comment on the integral way in which the treatment of black students impacted on them.

"*My dignity as a person could have been respected more*".

"one was led to believe and made to feel inferior, not so much by UCT, but by the government. UCT didn't make anything easier".

A few respondents comment on the somewhat passive acceptance of the status quo by black students and raises issues with regard to the agency of black students in their own oppression. One respondent comments on the lack of protest by black students as a result of the demanding academic workload. One respondent speaks critically of the segregation of black students themselves.

"As we accepted it, so did they. One didn't really want to associate with them. We were part of our own clique".

"We knew we were excluded. We didn't think it was a problem".

"Nobody protested. You got used to it".

"To a certain extent we accepted the status quo. We were guilty because we were so involved in our studies".

"The mentality from students from non-white schools was that they tended to herd. I was always opposed to this. But in tutorials our names were always listed together, as non-white students. …. they gravitated to black groups/bodies. You were critical of rules, but you were also part of it".

While few respondents acknowledged that their entrance into UCT was their first contact with whites, many commented on the lack of collegial atmosphere with white students and the minimal tolerance for difference

"My exposure to white people at UCT was my first ever".

"I refused to compromise my blackness in exchange for friendliness. It was almost expected that to be accepted, you need to act 'white' and adopt their values".

One student commented on the prejudice levelled at students of the Jewish faith.

"They accepted me as a person of colour over Jews. I was invited to a kitchen tea and it was explicitly stated that they weren't inviting the Jewish girls".

Several commented on the apathy of UCT and highlighted that as an institution it upheld the apartheid system. Although there is an acknowledgement of the difficulty in being opposed to the government of the day, many believed that the university could have improved conditions of training for black students.

"There was complicity on the part of the Faculty that the world should be organised like that. Yes, they might not have agreed with the harsher laws, but they never made an effort to compensate or to provide support. Socially they also made no attempt".

"Apartheid, racism and separation was not a particularly Afrikaner principle. Sophisticated racism came from English people".

"*I would rather blame UCT as an organisation. I think in those days the apartheid regime was intolerant so not many took the chance to say anything*".

"UCT could have done more for the non-white students. They often spoke of changes but did nothing".

"A lot of lip-service was paid at this liberal university of academic freedom".

"The ultimate culpability lay with the government, but UCT could have done more"

"*Nobody actively challenged the legislation"*

3.2.6. Feelings of isolation

Given the minimal contact between white and black students and staff members, as well as the limitations on their training and student life, an overwhelming number of respondents comment on their alienation from UCT and the impact of segregation on their lives. Respondents comment on the preferential treatment of white students who were taught outside of university and who socialised with staff. They also speak of their isolation and feelings of being excluded from student life.

"absolute exclusion from interacting with living or dead white persons".

"A feeling of not being part of the institution".

"Never really part of the University… Never felt on equal ground. Even as a person".

"We were made to feel left out".

"We were deprived the feeling of belonging, of community at the hospital".

"Rag time or debates, you could not take part. We never felt part of the university".

"the lecturer informed the class that they would be studying the ecology of Langebaan that weekend. Pointing to each black student individually he said, 'But you are not allowed to join us'".

"We weren't part of the lives of each other";

"we were never students. We were always a minority and always felt that we were a minority. … White colleagues would always say what a nice time they had a lecturer's house or out socialising with a lecturer. We were never invited along";

"I used to look at Rag days and felt like an outsider. It was never my university … my colleagues privately feel that the university did little to acknowledge us or treat us as equals. I have very little memory of feeling 'at home' or proud of UCT";

"there was never really a place we could go to complain… no outlet or arenas created for discussing problems in your study".

"the order of the day would be that white lecturers would socialise with the white students".

"We were denied social function interaction and missed out in the opportunities of getting to know the other side".

Some respondents noted that the experience of social isolation during their medical training impacted on them to an extent that some continue to abstain from university social activities at present.

"There is deep resentment, so much so, that they don't want to attend reunions".

"At the reunion of our class … many of our colleagues didn't go because we felt we were let down by our team".

"had to persuade black colleagues to attend reunion. No-one really wanted to attend".

Several referred to their subjective experience as one of not being acknowledged or heard and being reminded that they were privileged to attend UCT.

"we were made to feel inferior. We knew it wasn't the case, but we were reminded of it all the time. No specific person did the reminding, It was common knowledge and it was allowed".

"We were the invisible group. When you asked them a question, they acted as if they had to go to so much trouble just to answer you".

"Being kicked out of a patient ward. … This was a very sore point".

Several respondents during this decade comment that despite the discrimination, the limited access to resources and facilities and the humiliating experience of being a student at UCT, there was an acknowledgement of good to excellent academic education.

"UCT teaches you to think, to reason and lateral thinking".

One respondent was of the opinion that training was geared towards doctors working abroad.

"They trained white doctors for the export market. More than half of the doctors trained here are overseas".

One respondent commented on the feeling of isolation not only at UCT but also from the broader black community, sectors that considered it deplorable that given the political climate in the country, black students were attending a white institution

"one felt a bit isolated and detached from your community while at UCT given the struggle and the turmoil and political activity present in black communities in the 70's and 80's"

"study permit was an evil. Myself and many of my colleagues were ostracised by our communities for applying for these permits. We fought against it and it was finally abolished in ± 1977"

Not only did students feel discriminated against by the white South Africans, they perceived foreigners as having more rights than they did as citizens of the country. One respondent highlights the inequity commenting on the treatment of (white) Zimbabwean students at UCT.

3.2.7. Violation of patient rights

Not only do respondents comment on the racist treatment of themselves but also the lack of respect for patients' rights whose privacy was violated. Mention is made of the abuse of patient rights.

"White patients were treated respectfully, were addressed by title. With non-white people it was talking down to them".

"I think the worst people to have suffered are the patients … Students should be taught how to handle the person, not the heart and lungs, etc. People are afraid of the white coat and also of a white person in a white coat".

"It was more of a general attitude towards patients that I saw as a problem. The way people were treated… it was the norm. Very often some of this bad treatment was carried out by nursing staff who were not white".

"Black patients were never really respected like they were on the other side. Confidentiality, privacy – none of that".

"a certain consultant who exposed a young coloured patient's breasts in final year to us as a big group. This would never have occurred if the patient was white".

One respondent commented on the absence of a holistic approach to medicine. Hence the individual element was often loss, with reference being made to the patient's anatomy rather than to the overall functioning of the patient. The depersonalisation of patients was referred to both generally as well as being related to racism. It is important to consider the retrospective nature of the questionnaires and take into account the culture in which medicine was taught during these decades.

"I don't think we saw medicine in its entirety as a social science. We were sometimes told, go feel that tummy…. The patient became the liver, a speech defect. It was never examined in the context of the community, wife, job".

Only one respondent in this decade highlighted the care of patients by staff despite the racist system.

"GSH was mixed. You had coloureds and whites. Most who worked there were of a very high standard. Care was impeccable. They set very high standards. Most cared about the patients, but they turned a blind eye to the system. I don't think they would have compromised a patient".

Mention was made of the violation of black patients' rights;

"With patients there was a power relation problem. They were poor, black and disempowered. People would be paraded. I'm not sure if there was truly consent. Pictures would be put up, with people's identities visible. No consent was truly given. There was violation of rights. I think some of these things are still going on today";

"People did not respect that they couldn't speak the first language of the patient";

"They never introduced the person. It was as if they were non-existent. Consultants would insult registrars. People were reduced to diseases".

3.3. 1986-1994

The sample for this decade comprised thirteen respondents, two of whom are African. This period was marked by student protests and marches, followed by periods of intense political negotiations with the final outcome being a Government of National Unity. While these transitions were occurring on a national level, numerous changes took place within the medical school, the most noteworthy being the admission of the first African students into the faculty.

Similar to previous decades, respondents commented on the following: transitional difficulties, transport and accommodation difficulties, social polarisation of students, minimal financial support, and little acknowledgement of the position of black students both academically and socially.

3.3.1. Institutional changes

Respondents in this decade generally comment on a feeling of change within the medical school system, although there were a few incidents of overt racism. Some report on a sense of being accepted and acknowledged towards the latter half of their medical school studies. However, it was noted that there continued to be areas of contention and resistance by some to change. Reported changes came in the form of all hospital wards being opened to black students; wards being comprised of all race groups; students being allowed to do their internship at GSH and tutorial groups being

mixed. The changes however were not without difficulties. Some comment on being able to enter white wards but not feeling welcome.

"They did allow us to go into White wards but the reception was not always warm".

Others noted that it remained problematic to work as an intern at GSH. Some white patients continued to object being examined by black students. Respondents continued to comment on feeling that they were a minority who should consider themselves privileged to attend UCT.

"you were made to feel that you were a minority and that you should feel privileged to be there"

3.3.2. Experience of African students

For the first group of African students as well as other black students, the transition was reported to be difficult. The level of education and language difficulties were noted as particular problem areas. Many comment that there was no acknowledgement from UCT of the different education systems which students came from.

"The whole atmosphere was Eurocentric and a shock to my system. I had difficulty in understanding small concepts. Then I understood exactly what Bantu education was".

One of the African students referred to the preference of students from outside South Africa.

"At UCT they would never take someone from Guguletu, but will take someone from Swaziland. The imbalance is a major concern of mine".

An African student commented on the isolation and discrimination experienced at UCT.

"You'd find people not wanting you to touch their instruments in the lab for experiments. Tutors just ignored our presence. They never looked you in the eyes".

Their difficulties extended into the medical residence where, although there were some who were accommodating, racism was experienced from other race groups.

"In residence our rooms were never cleaned. The cleaners didn't want to clean the rooms of the African students, and they were mostly coloured ladies".

Travelling was also commented as a difficulty for many black students.

As one of the first African students there was a feeling of needing to prove oneself academically.

"I was under pressure to prove that a black person could go to UCT and succeed".

The significant impact which the racist attitudes and system had on black students is aptly highlighted by one of the African respondents in this decade.

"On heavy workload days here, sometimes white doctors would snap back at me. I get angry with myself because I would immediately think that it is racist, when I realised afterwards that it is not. I think my soul has been damaged by UCT and I want to heal that".

3.3.3. Financial difficulties

Many black students commented on the financial difficulties they were faced with, some needing to supplement the family income while studying in order to pay their fees. The financial needs of black students were not considered. Of interest is the comment of one respondent who feels somewhat isolated in terms of the opportunities afforded to race groups on either end of the spectrum. Comments are made about the white students who had opportunities in terms of dual passports which enabled them to work abroad, adding that African students had numerous bursary opportunities

while other black groups continued to have the financial difficulties with few bursaries available to them.

"I also felt some resentment towards black students, My friend who was black had three international NGOs fighting over who would pay her fees, living expenses, etc. She ended up with two full bursaries whereas I could only get a partial bursary".

3.3.4. Perceived position of white staff members and white students

While some reported the supportive nature of staff members others commented on their racist attitudes.

"When they spoke to you, they spoke down. I'm not sure that they were even aware of how they spoke to you"

One respondent reported feeling uncertain as to whether staff members were racist or whether this was the way in which they interacted with individuals, while another noted that difference took on forms other than race.

"I vowed that I'd never want to work in a clinical capacity. I realised the kind of arrogance that medical doctors work with – whether it was professional or racial, I don't know".

"I felt disadvantaged, but I never felt black. I was treated differently but not because of race. There were things that people did that I didn't agree with and wouldn't have gone to because of drinking, etc or if I had a car".

With regards to interaction with white students there was acknowledgement from some respondents that entering university was their first experience of different race groups which was initially difficult to adapt to. Some also comment that there were minimal attempts to socially integrate from both sides

"I can't remember a white student coming to our social functions and vice versa. It was just the accepted way of doing things".

3.4. Special faculty assembly

The latter part of the questionnaire concerned respondents' comments on holding a special faculty assembly as well as their thoughts on reconciliation. The results of the analysis spanned the period 1945 to 1994. Respondents held a wide range of positions with regard to the purpose and usefulness of a Faculty Assembly.

TABLE 4: Do you think UCT Health Sciences Faculty should hold a Special Faculty Assembly and would you be prepared to attend?

Period	**Number of students**	**Yes**	**No**
1945-1959	4	1*	-
1960-1985	58	44	15
1986-1994	13	11	2
Total	**75**	**56 (74,6%)**	**15 (20%)**

* 1 did not answer this question

3.4.1. Ambivalence

Some appeared to be ambivalent, questioning the underlying meaning of reconciliation and the proposition for a special faculty assembly.

"Reconciliation – what does it mean? What has been the outcome? Perpetrators have gone free. Catharsis needs to take place. I don't know whether it is really necessary".

"I don't think I'm at a point to reconcile. Things at the moment are not good, or the way they ought to be. … The Faculty should be in a better place than it is now. When transformation is achieved, then it [Special Faculty Assembly] should be held".

Allied to these comments are feelings of bitterness about the injustices of the past, with one respondent noting that black students were merely a product of the apartheid system of the time.

"I can steal and then say I'm sorry. What does it mean? Nothing. These things are irrelevant, like the TRC. The person died. They say they're sorry and it means nothing".

"To me it's all a waste of time. Human beings are so versatile and unreliable. We act on the moment. The ANC fell into the trap of capitalists. Sometimes I think I've gotten more from apartheid. There is no long-term benefit: it's just roles for that generation".

3.4.2. Acknowledgement and understanding of past

An overwhelming number of respondents recognised the need to acknowledge the past in order that discrimination and injustice not be repeated. Emphasis is placed on the importance of understanding the history of students and documenting this. Respondents highlighted the need to be understood and heard.

"It is said that reconciliation is the way to go and transformation is greatly helped by acknowledging the errors of the past".

"it might be of interest to see how many white graduates would be interested in discussing these issues. They could be a useful vehicle for understanding how much they understood their role, voluntary or otherwise, in underpinning apartheid".

"sharing past experiences with colleagues is the way to go. God forbid any of the past university structures to be implemented ever again. … Present day students must be made aware of the inequalities of the past".

"if we can get reconciliation and get the young ones to appreciate and understand what happened to us, it would be good".

"There needs to be understanding before reconciliation. People telling their stories doesn't help if one continues to blame".

"Before these guys die, they and their children must come and listen".

"I don't want to witch hunt anybody. It would be wonderful if people could acknowledge that they were part of it".

"Clear humiliating experiences should be highlighted so that the type of situation should NEVER EVER be repeated".

One respondent highlights the importance of acknowledging the past by referring to a speech that he made at a class reunion.

"I was again asked to make a speech. I told them that I bear no grudges. We had no social life, no partying, etc. They sat shocked, saying they never realised it was that bad".

Some voiced an interest in determining individuals' understanding and perceptions of the role that they adopted within the apartheid era in order to ensure that the situation does not recur.

"A clear statement that the purpose of examining the past is not to embarrass anybody; it is to avoid the evils of the past".

3.4.3. Ongoing communication and education

With regard to the way ahead, suggestions were made that ethics and morality courses include the experiences of past students and that communication be fostered between students and staff. The need to pro-actively address the inequalities that dominated the history of medical school is highlighted by some respondents.

"prefer experiences to be entrenched in teachings of ethics and morality".

"A well thought out course in ethics can be valued if it is regarded as important and no perfunctory".

"There should be forums for staff and students to talk".

"one assembly will not be a very useful exercise. The past must be addressed on an ongoing basis".

"I'm a bit cynical that that [i.e. Special Faculty Assembly] would achieve much. Gathering experiences and publishing a book is more valuable".

"I'm not one for symbols unless symbols get translated to real action. They sing these songs but they have no clue. It's all at a theoretical level. I want to see clear programmes on a day to day basis. If it is to introduce some kind of process, then yes".

"it should be more than just a pledge. They should have a plan that they commit to. … People should be held accountable. The medical profession is too protective of their colleagues. Things should be brought to book and doing nothing when witnessing wrong is equally evil".

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CHAPTER 4: A POSTAL SURVEY OF ALUMNI FROM THE HEALTH SCIENCES FACULTY, UCT

INTRODUCTION

A questionnaire was drawn up from the themes of the responses of black alumni and posted to 1607 black and white alumni from the Health Sciences Faculty. Five aspects of student life were covered, namely demographic data, pre-tertiary preparation, UCT experiences, institutional restrictions and career trajectories, followed by items assessing the need for a Faculty assembly for purposes of reconciliation.

METHOD AND MATERIALS

One thousand six hundred and seven (1607) HSF alumni were mailed a copy of the *Questionnaire for Alumni of HSF*. Every alumnus in 17 (final-year) classes was sampled, with 'successive' sample classes being separated by an interval of three years – beginning with the class of 1945, then, the sampled final-year classes were those of 1948, 1951 and so forth, ending with the class of 1993. The questionnaire consists of thirty-seven items, with certain of these including contingency questions. In this regard, items were in the main closed-ended in order to facilitate what is predominantly a quantitative analysis, although, where further elaboration to answers was required, open-ended questions were incorporated.

Of the total number of mailed questionnaires, only 342 were completed – this translates into a response rate of 21%. While the implications of this figure will be discussed at a later stage, one should bear in mind that, in the research community, it is generally agreed that a 50% response rate is adequate (Babbie & Mouton, 2001).

For the purposes of analysis, a detailed coding scheme was devised, which was subsequently narrowed down as, and when, it became clear that categories were either redundant or insignificant.

RESULTS

- **Respondents by Race and Gender**

Table 3: Respondents by race and gender

TOTAL (%)	WHITE			BLACK		
	Total	Male	Female	Total	Male	Female
342 * (100%)	295 (86%)	212 (62%)	73 (21%)	40 (12%)	30 (9%)	10 (3%)

* no "race" provided by 7 (2%) respondents

Two percent (2%) of respondents refused to disclose their racial status. Throughout the six pre-democracy decades, then, it is clear that, in the case of this sample, white graduates constituted the overwhelming majority of UCT Medical School graduates, accounting for 87.6% of all graduates over this period (similar figure to our response rate). The lopsided racial demographics of this sample bear an important implication for all further analyses.

Parental occupation

From Tables 4 and 5, we note that men dominated the professional fields – in the main, women remained at home, taught, or assisted their husbands in entrepreneurial (non-professional commercial) endeavours. Moreover, when we introduce the race variable, it is obvious that the more prestigious occupations were largely occupied by the parents of white graduates. However, given that black graduates account for only

12% of this sample (Table 3), raw statistics are essentially meaningless, as one would therefore *expect* the parents of white graduates to appear relatively more affluent.

Looking at the percentages in Table 4, the fathers of black graduates were mainly working-class entrepreneurs (shopkeepers, salesmen etc) and teachers, whilst those of their white counterparts filled the more affluent professions to a relatively greater extent. The mothers (table 5) of all alumni filled the roles of housewives and teachers, with those of white alumni also featuring prominently in the 'entrepreneur' category as secretaries and clerks – literacy levels may account for this latter statistic.

Table 4: Father's Occupations

FATHERS' OCCUPATIONS (N = 322) (%)		
	RACE	
Description	**White**	**Black**
Deceased	12 (4.2)	1 (2.6)
Medical Professional	51 (18)	2 (5.2)
Legal	15 (5.3)	1 (2.6)
Commerce/ Business	64 (22.5)	3 (7.8)
Engineer	28 (9.8)	0
Agriculture	23 (8)	1 (2.6)
Educator	18 (6.3)	6 (15.8)
Entrepreneur	45 (15.8)	14 (36.8)
Retired	7 (2.4)	1 (2.6)
Labourer	4 (1.4)	6 (15.8)
Civil Service	7 (2.4)	1 (2.6)
Unemployed	3 (1.3)	1 (2.6)
Politician	1 (0.3)	0
Other	6 (2.1)	1 (2.6)
Total (%)	**284 (100)**	**38 (100)**

Table 5: Mother's Occupations

MOTHER'S OCCUPATION (N = 286) (%)		
	RACE	
Description	**White**	**Black**
Deceased	5	1
Health Professional	14	0
Legal	0	0
Commerce/Business	42	2
Housewife	106	20
Agriculture	11	0
Educator	25	10
Entrepreneur	20	1
Labourer	1	2
Civil Service	6	0
Politician	2	0
Unemployed	1	0
Retired	6	1
Other	10	0
Total (%)	**249 (100)**	**37 (100)**

- **Preparation for University**

In response to the question: "Do you feel that you were adequately prepared for the demands of academic work at UCT?", 71.4% of white graduates felt that they were adequately prepared, while only 37.5 % of blacks felt that their schooling prepared them adequately academically for studying at UCT.

Table 6: Preparation for university by race

PERIOD	WHITE		BLACK	
	Yes	**No**	**Yes**	**No**
1945 – 1959	71	22	2	4
1960 –1985	121	52	10	19
1986 – 1994	18	10	3	2
Totals (%)	210 (71.4%)	84 (28.6%)	15 (37.5%)	25 (62.5%)

The reasons given by black and white respondents for feeling that they were not adequately prepared academically for studying at UCT were similar in some respects. The areas where there was agreement were that their schools did not encourage them to think or work independently neither did they prepare them for the high volume of work at university. Black and white respondents complained of the inadequate teaching in Maths and Science at high school and the lack of advice on the choice of subjects that would have made studying medicine easier. Some respondents (from both black and white groups) came from Afrikaans backgrounds and this put them at a disadvantage in an English speaking environment at UCT.

In addition to the above, Black respondents spoke of the deficient schools, the low standards of education, poor teaching and the lack of facilities at black high schools (laboratory, library, etc).

Most of the black and white respondents came to UCT because of its proximity to their homes and the reputation of the medical school. Black respondents also gave reasons such as "*refused to go to UWC*" and the "*ministerial permit*" for studying at UCT. A few White respondents said that apartheid legislation had prevented them from studying at Natal University, which was closer to their homes.

- **Experiences as a student at UCT**

1. Accommodation

Initially only white students were allowed to live in residence at UCT. Up to 1987 black students were not allowed to live in residence. This meant that these students were obliged to either live at home with their parents or "board" with black families.

Table 7: Accommodation by race

ACCOMODATION	WHITE (%)	BLACK (%)
At home	86 (29%)	20 (48%)
With Relatives	6 (2%)	4 (9%)
Boarded	27 (9%)	16 (38%)
UCT Residence	153 (52%)	2 (4%)
Other	21 (7%)	-
Totals	293	42

Most black respondents, who lived at home, and white respondents generally experienced few difficulties in relation to the place where they lived. Some black respondents who lived at home had problems with transport and overcrowding at home as their families were large. To quote one respondent: "*besides my mother and father there were 13 of us children living in a 3 bed-roomed council semi-detached house…"*.

Black respondents who "boarded" listed their difficulties as being "*inadequate facilities for studying*", "*problems with transport*" and "*difficulties in accessing the library*". It was often difficult to find places to "board". One respondent said: "*to find board and lodge in Cape Town was extremely difficult as I was a total stranger in Cape Town. Choices were limited with poor food and accommodation*". Another difficulty was that black respondents had to board in areas designated "coloured" by the Group Areas Act. These were generally some distance from the medical faculty.

In later years, African students who were allowed to enter residence had problems of a different nature. To quote "*coloured cleaners did not clean African students' rooms regularly or properly*…".

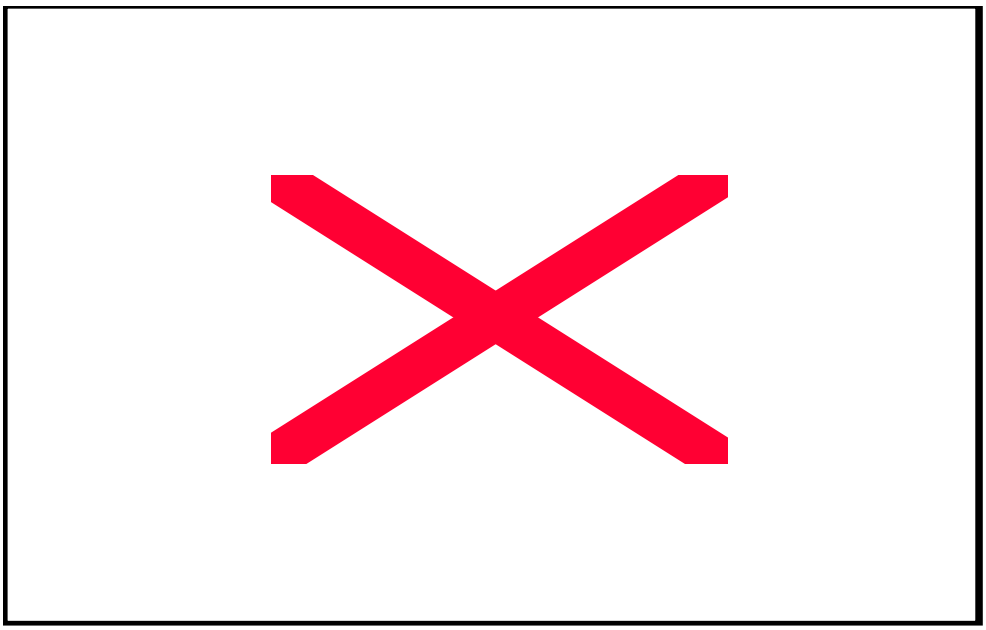
2. Financial Support

Table 8: Sources of Funding by race

FINANCES	WHITE	BLACK
Parents/Own	236	30
Relatives	3	1
Scholarship	21	5
Bursary	14	4
Other	16	0

In table 8 (as in other tables), the columns do not tally to 100% - this is because many students relied on several sources of income. In spite of that, white students, in relations to their black counterparts, relied relatively more heavily on the support of their parents' finances. A reason for this trend may be that black parents couldn't afford the university tuition and accommodation fees – and hence, their children had to look elsewhere for financial support.

3. Identification of race issues



Key to Figure 8:

0 = No discrimination; 1 = No access to white patients;

2 = No access to white corpses; 3 = Limited university admission for non-whites,

4 = No access to clubs/societies/sports; 5 = No access to residences;

6 = Gender discrimination; 7 = Physical abuse of non-whites; 9999 = Other

Far and away, the most significant case of discrimination is the limited access to white patients that students of colour had to endure. Many students recounted how black students had to leave the class whenever a white patient was being demonstrated, or had to wait outside the autopsy laboratory to ask the attendant of the day whether or not the cadaver up for dissection was white. One black student was suspended for "*being present when a white patient was examined*".

Yet, some white respondents thought that such humiliation of fellow students wasn't entirely disadvantageous:

- "*Yes – there was the time [when] only white students were allowed to attend ward rounds in white wards. This became more strict with time – even Chinese students being excluded. This of course limited patient material, but there was more 'material' in non-white wards.*" (white female)

- "*Non-white students [were] barred from examining white patients, but as there was a greater variety of pathology in non-white patients, this may not have been as bad as it sounds.*" (white female)

- "*The only discrimination was that black students were restricted to black wards. But that did not necessarily compromise their training*." (white male)

Approximately one in seven female respondents (compared to one in 258 males), too, reported incidents of gender discrimination:

- "*A gynaecology tutor ask[ed] me why I was in his tutorial and not at home, barefoot and pregnant*." (white female)

- "*In the case of the latter [gender discrimination], the 'usual' male arrogance was present in a few lecturers who either flirted with females or insinuated that we were taking the place of a male who would offer far more working years to society.*" (white female)

- "*… rude male registrars making coarse, sexual jokes at the expense of female students – most ended up in tears*." (white female)

Returning to the topic of racism, in Table 9, we note that white students, on relatively more occasions than their black counterparts, did not report *racial* incidents as the most significant acts of discrimination that they had witnessed – either they could not recall, or "*I didn't see a single incident in six years*", or they cited non-racial forms of discrimination. In Table 10, we also note that, across the decades, reports of racist incidents by white graduates were relatively constant. Although the figures for the first and last time periods are significantly smaller, these are somewhat misleading, given the small number of respondents representing those periods. However, one could reason that the low proportion of identified racist incidents for the 1945-1947 period can be explained by their occurrence in the *pre*-apartheid years, whilst that for the nineties was to be expected given that a new political dispensation (a non-racial democracy) was on the way.

Table 9. Reports of racial discrimination

RACIST INCIDENTS			
(N = 337*)			
RACE	**YES**	**NO**	**Total**
White	114	157	271
Black	29	9	38
Total			309

* 28 (26 white) graduates did not respond to this question.

Table 10: White respondents' reports of racial discrimination, by decade

RACIST INCIDENTS (%)		
(N = 261)		
DECADE	**YES**	**NO**
30-47	33.33	66.67
48-59	72.97	27.03
60-69	72.31	27.69
70-79	75.41	24.59
80-89	64.10	35.90
90-93	7.69	92.31
Total (%)	67.43	32.57

Moreover, with regards to their recollection of the racial integration in social and sporting events (Fig. 10), white graduates frequently responded that 'everyone' attended, only to concede in the following item that some groups (broadly, blacks) *were* excluded. This frequent contradiction is perhaps an attempt by some white alumni to downplay the racial tensions that existed during their years at UCT. As one white respondent stated:

"*I do not recall any racial discrimination as a student, although I don't think the black students were allowed into White wards and tea-rooms etc. The blacks kept to themselves. I did make friends with the Coloured girls in class…apartheid must have been functioning now that I think of it"* (white, male).

Seventy percent (70%) of the entire sample answered that whites, to the exclusion of other racial groups, participated in sporting and social events:

Table 11. Reported inclusion and exclusion of racial groups at sporting/social events

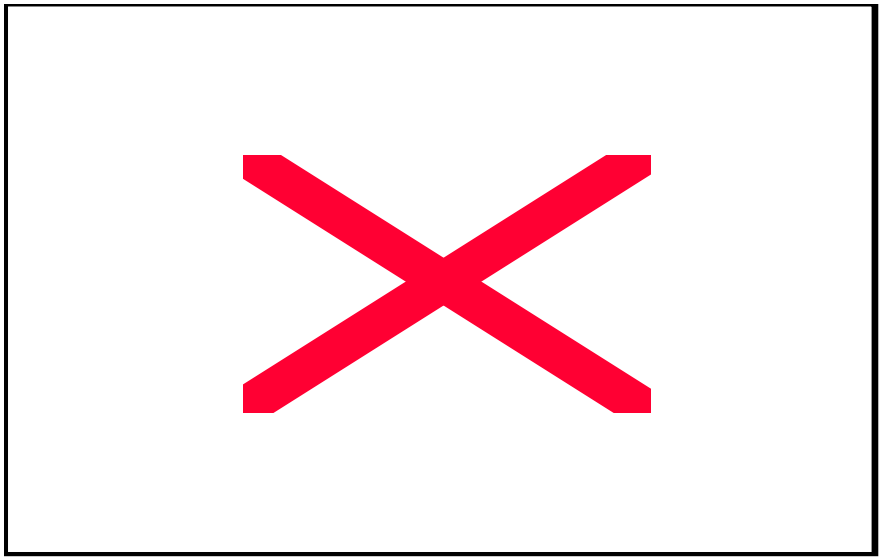
	EXCLUDED (%) (N = 247)				
INCLUDED(%)	**White**	**Black**	**No One**	**Other**	**Row Total**
White	0.00	70.04	0.00	0.00	70.04
Black	2.43	0.00	0.00	0.00	2.43
All	0.00	0.00	20.24	2.02	22.27
Other	0.00	0.00	0.00	5.26	5.26
Total (%)	2.43	70.04	20.24	7.29	100.00

- **Formal restrictions**

1. Likert Scales Items

Five closed-ended items attempted to measure the degree to which students thought that UCT was a discriminatory institution – these assessed the inter-racial quality of medical training, racist and sexist UCT policies, as well as staff racism and anti-racism.

Figure 1. UCT's degree of institutional racism



In Figure 1, it would appear that, as many white respondents claimed, UCT did its best under repressive circumstances to lessen the impact of apartheid legislation. However, we should also remember that well over 80% of our sample is white. Hence, upon introduction of the race variable (as in Table 12), it emerges that black respondents thought differently. Two-thirds of the black students felt that, during their stay at UCT, it exhibited a high degree of racism:

Table 12. Degree of institutional racism, by race

(N = 312) RACE	HIGH RACISM (%)	LOW RACISM (%)
White	20.15	79.85
Black	64.10	35.90
Total (%)	25.64	74.36

Many black respondents mentioned various 'formal restrictions', one of which was being subjected to exclusion policies. For example one graduate said, " *a black (African) student started his second year MBChB, but after a month was asked to leave*". Many students mentioned that although they were training at UCT they could not use the student residences, in spite of having to do all night duties at Groote Schuur hospital.

- "*Black students were not allowed to stay in residence. During our Obstetrics block period at Groote Schuur Hospital we had to sleep in 'makeshift' accommodation inside (the) hospital i.e. empty obstetrics ward!*"

- "*As students we were not allowed to sleep in the "white" quarters.*"

- "*…we could not do our housemanship at GSH – even though we trained at UCT!!! We earned half of what white doctors earned – though we worked just as hard.*"

Many black students mentioned that although there were high degrees of institutional racism at UCT, there were some staff members who put students and patients above upholding apartheid. For example one black student stated that "*individual academic(s) may have harboured apartheid attitudes, but by and large most were opposed to such policies, the likes of X, Y and Z, more than compensated for the apartheid mentality of few academics*". Another stated there were "*many brave men and women (who) were only to happy to teach us*". Another posited that "*there were some staff who made a special effort to help non-white students, this was much appreciated*". However, there were others who felt that " *the staff who actively opposed apartheid were extremely few. Most staff members were either unsympathetic, or seemingly did not care about the plight of non-white students*". Another claimed that " *by and large the majority of white staff and students protested verbally (tokenism), [but they] enormously enjoyed the privileges of apartheid… "* Evidently, much contention/contradiction is shown with regards to issues of institutional racism and the support thereof.

In partial agreement with the former, many white graduates felt teachers and staff at UCT did not conform to apartheid and often challenged the apartheid policies of this institution. One student said, "*most lecturers went out of their way to assist blacks/non-whites*". In sympathy with black students one white student stated "*it must*

have been degrading and awful for our "non-white" colleagues to be excluded from "white" wards". However, a great majority of white students felt that the discrimination issues which black students had to contend with were quite insignificant, and almost did not warrant this kind investigation; they received a good enough education in spite of the institutional restrictions imposed on them. As one white student said "*wards, ward rounds and teaching [were] opened to **all** students*." Ambivalence with regard to institutional racism is clearly demonstrated in these responses and highlighted in the following statement made by one white student:

"*Too much variability in the behaviours and policies of UCT by faculty, ranging from generous/inclusive to the worst imaginable…no concerted effort at supporting diversity [was made]*".

There were many white graduates, who argued that UCT staff and students did not necessarily support apartheid policies but that it was imposed on them. For example one white graduate argues, "*I don't think any of us or any staff members actively supported apartheid practices. You could say we "followed the rules"*." And yet another said, "*[It was possible to speak out against discriminatory policies] but white students [were] apathetic (comfortable)*".

Similar contradictions appear when determining whether or not UCT allowed freedom of speech. In Figure 2, the answer appears to lean towards the affirmative, but in Table 13, a different scenario emerges:

Figure 2. Was there freedom of speech at UCT?

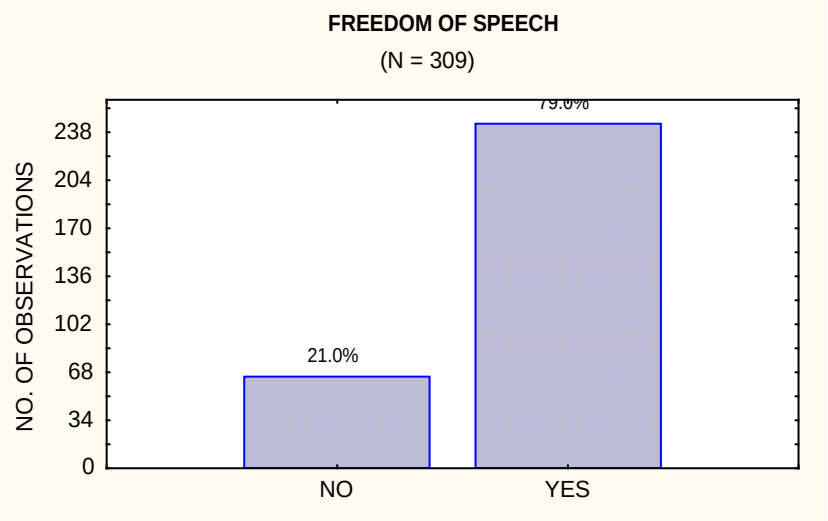


Table 13: Freedom of speech, by race

(N = 311)	FREEDOM OF SPEECH (%)	
RACE	**NO**	**YES**
White	15.81	84.19
Black	56.41	43.59
Total (%)	20.90	79.10

Again, due to the fact that our sample demographics are heavily influenced by white numbers, main effects easily override the specific ones. Here, although the sample as a whole 'concurs' that UCT encouraged freedom of expression (Figure 2), more than half of black students believed that *not* to be the case (Table 13). For white graduates, on the other hand, less than one in six felt that UCT's institutional arrangements restricted possibilities for free speech. Moreover, for each of our six time periods, more than 75% of white respondents felt that freedom of speech did in fact exist.

One white graduate said that he was " *personally involved in numerous NUSAS/SRC organised protest meetings, marches and sit-ins"*. Another student mentioned

(political) meetings and discussions at fellow students' digs. Others claimed that although "*it was possible…[it] invited the attention of the security police therefore [it was] unwise*". The fear of police interrogation seemed to be a real threat for many students who may have wanted to speak out. As one student stated it was not possible to speak out against discriminatory policies due to the threat of "*house arrests, detention without trial and harassment by security police…*".

One white graduate claims that "*most attempts were blocked by "it's the Law*"'. However, it was evident that one or two persons could and did make a difference in spite of the law, as well as the risk of losing their livelihoods.

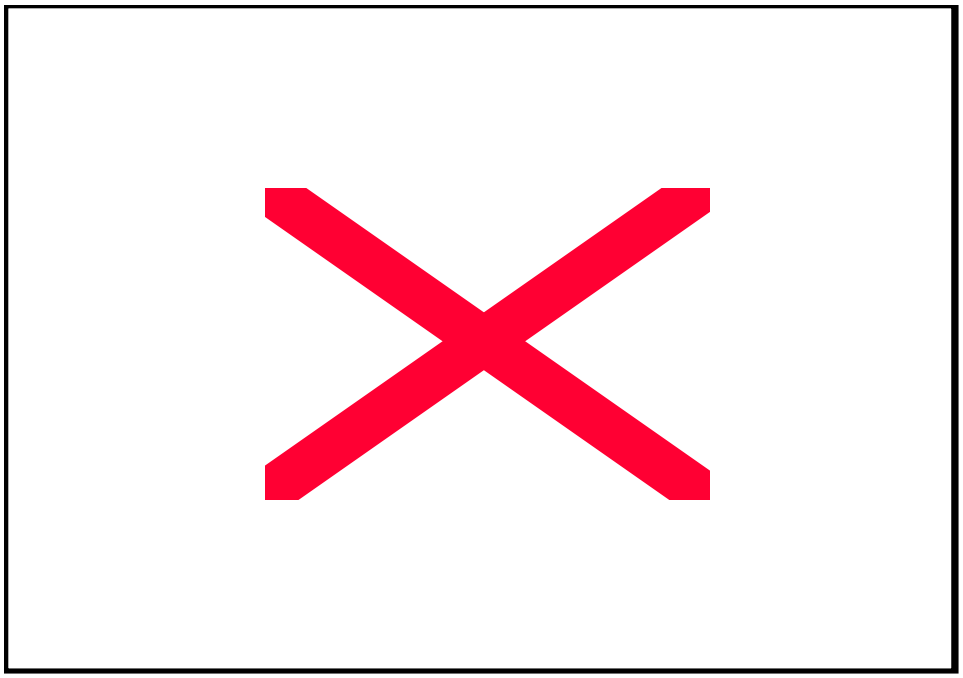
Another graduate mentioned "*although most people, if asked, would have denied supporting apartheid policies and practices, they would not have shouted it from the rooftops*". Fear of police brutality and government retaliation seemed to have been the dominant motivation for not speaking out against discrimination at UCT, this applies to most white graduates as well as to many black graduates.

Gender disparities regarding freedom of expression were detected, with 9% more women than men (28% versus 19%) feeling that such a freedom was restricted – however, this difference was not statistically significant (χ^2 (1) = 2.98; p > 0.05).

Hence, although possibilities for free speech may have existed, to actually utilise this freedom is an entirely different matter. Still, in spite of reported activities of the security police, veiled threats of expulsion and fears of victimisation, many staff members, particularly the oft-cited Professor Hoffenberg, spoke out against

discriminatory practices. Students, too, frequently made arrangements for anti-apartheid meetings, demonstrations and petitions. Sixty five percent (65%) of respondents recalled such activist stances:

Figure 3: Were there instances of anti-apartheid sentiment?



However, there are statistically significant gender variations that have been obscured by the large number of male graduates. 68% of males, compared to only 54% of females, recalled instances of anti-apartheid sentiment (χ^2 (1) = 4.72; p < .03). Perhaps surprisingly (for some sceptical white respondents, anyway), the race variable was not associated with alumni's recollections of dissenting voices (χ^2 (2) = 4.91; p > .05). This finding suggests that black alumni gave balanced accounts of their UCT experiences by acknowledging that UCT did have an anti-apartheid conscience. On the other hand, among white respondents, the time period variable (i.e. of the six decades) *was* associated with such recollections (χ^2 (5) = 36.52; p = .00). In

particular, white graduates of the sixties (81%) and seventies (73%) recalled relatively more instances of opposition to apartheid than those of any other decade.

Besides racial discrimination, one in four women (compared to one in ten men) rated UCT as a highly sexist institution:

Table 14: Gender discrimination, by sex (%)

	GENDER DISCRIMINATION (%) (N = 327)	
SEX	**HIGH**	**LOW**
Male	9.02	90.98
Female	25.00	75.00
Total (%)	12.54	87.46

Alumni's racial status was not significantly associated with their responses to the gender discrimination item (χ^2 (3) = 3.19; p > .3). However, amongst white respondents, the time period variable was significantly associated with the gender discrimination item (χ^2 (5) = 15.56; p < .01). Specifically, UCT appears to have become increasingly sexist over the past six decades, especially since the start of the seventies.

- **Career Trajectory**

Some black respondents had to go overseas to continue with postgraduate studies and ended up working and living in either African countries (outside of South Africa) or Europe and/or North America. The reason they gave was that many of them could not further their studies in South Africa. As one black graduate emphasised,

"*APARTHEID drove me away*". Another stated: *"[I] was refused training in paediatrics at UCT and Red Cross Hospital…. [I] trained in UK, returned to UCT in 1976 and sent to Somerset hospital. [I] was allowed to run a clinic at Red Cross Hospital, but was refused office in ICH building"*. Most of the black graduates who trained at UCT mainly mentioned Somerset Hospital as the place where they were allowed to do their internship, since they were prevented from doing this training at Red Cross and Groote Schuur hospital.

Some of those who left South Africa for further studies got married to foreign white partners and therefore, due to the Mixed Marriages Act, could not return to live in South Africa with their spouses. For example, *" I came to the UK for postgraduate study. When I got married in 1950 I could not return to South Africa because of the Mixed Marriages law*". These were particularly cases from the first two eras, 1945-1959 and 1960 – 1985, which the current research covers. A few black graduates ended up working in various hospitals in South Africa, and others working in rural community clinics, or as general practitioners in communities, which they often grew up in. An example of this is, *"[I work in] Rylands, Cape Flats. The community required my service as a medical practitioner…[the circumstances, which led me to be here was] Group Areas act*".

Compared to their black counterparts, it becomes apparent that most white graduates had much more freedom of choice in terms of continuing their studies in South Africa at an institution of their own choosing and/or going overseas to do this. Moreover, it appears as if most white graduates had the option of doing their internship at various

South African provincial hospitals including Somerset, Red Cross and Groote Schuur hospitals, and many currently continue to work at these institutions.

Some white respondents moved to a foreign, usually European or North American, country. Most of them did so by choice. As one said "*I left Africa out of my own free will*".

It seems as though quite a few white graduates' reasons for studying overseas were politically motivated, although the circumstances, which underpinned their decision, were different as opposed to their fellow black students. As one said "*After studying in UK [I] decided against returning to ZA – 1973- could not see a way forward given the politico-economic situation in ZA at the time – and feeling powerless in face of it".*

Another pointed out " *[After graduation I] specialised at Groote Schuur, emigrated to UK… [I now work in the] UK…[the circumstances which lead me to being here was the] local socio-political situation (in South Africa).*"

- **Training and careers**

Figure 3: Was UCT an adequate training institution?

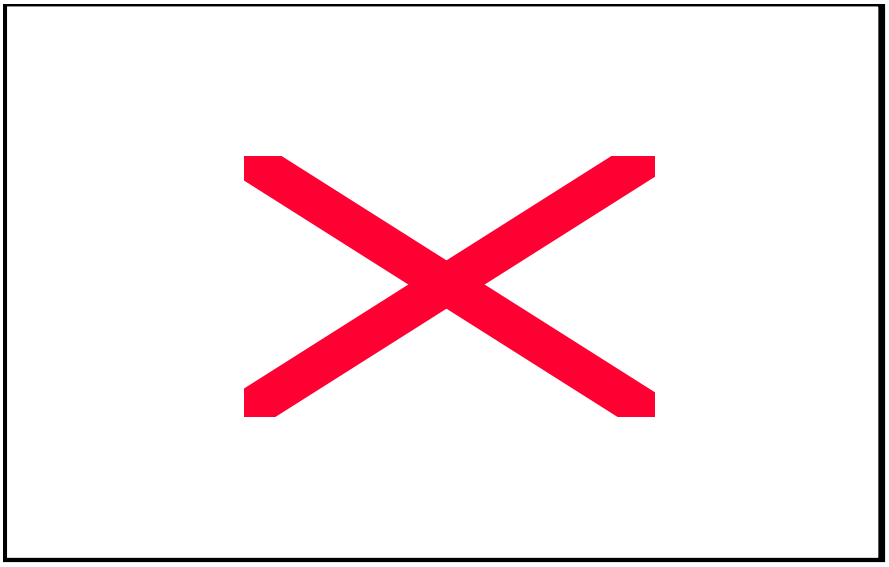
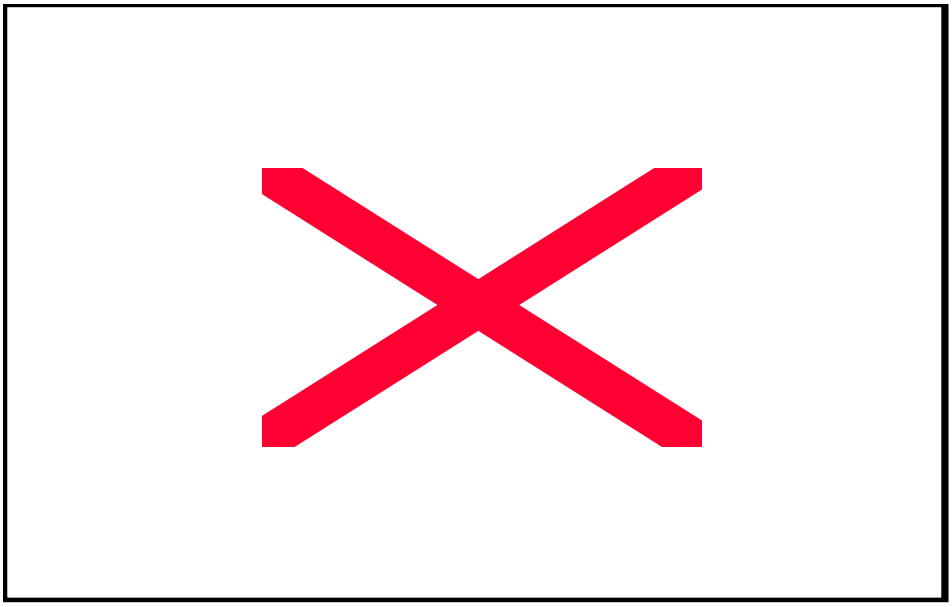


Table 15: Adequacy of UCT training, by race (%)

(N = 319)	QUALITY OF TRAINING (%)	
RACE	**NO**	**YES**
White	59 (18.27%)	220 (68.11%)
Black	11 (3.41%)	29 (8.98%)
Total (%)	20 (21.67%)	249 (77.09%)

As can be seen from Figures 4 and table 15, most UCT graduates were satisfied with the quality of their academic training – such satisfaction did not vary markedly across racial lines. As for the 22% who *were* discontented with the training that they received, the reasons for their dissatisfaction are summarised in Figure 5. Twenty seven percent (27.1%) felt that they lacked training in the financial aspects of practice management, 25.7% believed that they had not been sufficiently prepared for the peculiarities of general practice, whilst 20% felt the quality of their practical training to be lacking:



Key to Figure 5:

2 = Inadequate practicals; 3 = Poor GP training; 6 = No available support systems;

7 = No coverage of relevant business skills; 8 = No research experience; 9999 = Other

Overall, most graduates were satisfied with their career trajectories. However, after a racial breakdown, the majority of black students were not:

Table 16. Satisfaction with career trajectory, by race (%)

SATISFACTION WITH CAREER TRAJECTORY (%) (N = 311)		
RACE	**YES**	**NO**
White	73.53	26.47
Black	46.15	53.85
Total (%)	70.10	29.90

Nearly three in every four white graduates were happy with the course of their careers, but for black alumni, as we see in Table 16, the percentages are far lower. There were cases of black graduates being denied academic posts and opportunities for specialisation, with some of them deciding to pursue their postgraduate training overseas. Across the decades, though, most students were satisfied with their career trajectories (Table 17), although, in the sixties, the figure is somewhat lower – perhaps a qualitative analysis would shed some light on this anomaly:

A theme that kept on resurfacing in many responses was that many graduates of this period (1960s) felt they wished they could have specialised in something else as opposed to what they were doing, or that they could have been advised more on other possible career options in medicine. Another strong theme was that many said their lives would have been different had it not been for apartheid. Some graduates said they would have been able to do the appropriate postgraduate training in South Africa (mostly black); whereas others felt that they could have made contributions to

institutions and communities in South Africa had they not been compelled to leave under the apartheid conditions (both black and white).

Table 19: Satisfaction with career trajectory by decade (%)

SATISFACTION WITH CAREER TRAJECTORY (%) (N = 316)		
DECADE	**YES**	**NO**
30-47	90.00	10.00
48-59	80.00	20.00
60-69	56.79	43.21
70-79	65.38	34.62
80-89	72.34	27.66
90-93	80.00	20.00
Total (%)	69.62	30.38

Feelings about the Reconciliation Process

White respondents constantly pointed out that the past was precisely that: passe. Some even considered this project to be a waste of money since UCT was embarking on a journey of "self-flagellation" and "navel-gazing". Following is a selection of comments made by white respondents:

- "*There has been enough apologising! I am tired of racism being attributed only to the whites and apartheid. Racism is at present practised by* ***all*** *societies – acknowledge it!*" (white female)

- "*UCT should* ***never*** *be ashamed of itself. Life in SA is bad enough with everybody else crawling around on their hands and knees.*" (white female)

- *"… the past is gone. We are all guilty by default of having been there but that has been declared over and again. Let's move on. Nelson has done so, why can't we? It won't change what has happened; it just keeps the angst alive."* (white female)

- "*It is fatuous to apologise for the wrongdoings of preceding generations*." (white male)

- "*I think one should let the past R.I.P."* (white male)

- "*Let us consign this politically correct bullshit to the dustbin where it belongs and hold our heads high!"* (white male)

In fact, one (white male) respondent went as far as to label the efforts towards Reconciliation as being (reverse) racism, that should provoke 'outrage' and 'disgust':

- "It is heartbreaking to see the University now supporting racism in every facet of its present workings, let along this pointless piece of public self-flagellation. I hope that many alumni to whom I have spoken join me in expressing disgust and outrage at this absurd project."

But we must also not overlook the sentiments of some white alumni who regard the reconciliation process in a positive light:

- "*Congratulations on initiating a very necessary project*." (white male)

- *"Thank you for this opportunity – it brings back many very bad memories."* (white female)

- *"I do believe reconciliation is important, and we all need to work together for a better future."* (white male)

Interestingly, Chi-square analyses revealed that the responses of white alumni regarding the need for an official apology were strongly associated with their Likert-scale ratings of UCT racism (χ^2 (2) = 13.04; $p < .01$). Of those white respondents who felt that racism was not prominent at UCT, 67% did not see the need for a Faculty meeting – as for those who rated UCT racism as significant, 58% believed that a Faculty meeting was in order. In other words, the mere fact that the majority of white graduates do not support the idea of holding a Faculty assembly does not mean that they are attempting to muffle some or other "racist" history. On the contrary, their reluctance to support such an assembly is consistent with their opinions regarding the historical presence of racism at UCT.

For black colleagues, we get a similar sense of the significance of a Faculty assembly, namely one of urgency yet trepidation. But for others, there is a sense that any attempt at reparation is an exercise in futility. Moreover, several black graduates share the sentiments of their white counterparts in commenting that the past is done. Here are some responses:

- "*Thanks for the opportunity to respond in this way. Students of my generation had a hard time but were responsible, disciplined and committed."* (black male)

- "*It is regrettable that action to rectify the wrongs of the apartheid years at UCT is only being taken now. Many of the medical students who were subjected to the discriminatory practices are now deceased."* (black male)

- "*Many unpleasant memories may be repressed/forgotten. [I am] not sure whether I want to open that Pandora's box of emotion and pain." (*black female*)*

- "*It [an assembly] will give graduates an opportunity to publicly recognise… those who stimulated and gave a helping hand to the underprivileged UCT students."* (black male)

The sense one gets is that black graduates do not view a potential assembly as an opportunity to parade whatever bitterness they may harbour – it appears that the significance of a Faculty meeting may rather reside in its ability to close a salient chapter in the lives of many people. As one black participant phrases it:

- "*I do not expect retribution from those who now hold the reins…. Humiliating those who were not responsible for the acts of the past will serve no purpose, give no satisfaction, produce no closure. It would only plant bitter seeds of lingering hate and ultimate[ly] discord. Restitution should embody understanding and compassion for those who seek redemption and those who were the victims of racial discord and avarice."* (black male*)*

Discussion

It is clear that, on average, black students at UCT Medical School experienced great difficulty and hardship under the apartheid regime. They felt that they were relatively less prepared for a tertiary education at UCT, and they were denied access to university residences, social events, white patients and even white cadavers, amongst other things. For students of colour, UCT was a racist institution, and for some, its policies impacted negatively on their careers. Still, regardless of race, many students acknowledged that some staff members were outspoken critics of the apartheid regime.

Some respondents felt that the wording of certain items in the questionnaire *presumed* that UCT was guilty of some or other transgression, and hence, some respondents refused to complete the questionnaire. One respondent even remarked that, since the Reconciliation Project (i.e. the questionnaire) *assumed* that UCT had a racist past, it prevented itself "*from having any scientific or historical benefit at all*." Another respondent indicated his intention not to complete the questionnaire because the subject was passé and a waste of money, a view he claimed to share with other medical colleagues, of both "white and non-white skin colour." It is quite possible, then, that the particularly low response rate may have had something to do with the bias that pervades the questionnaire – and certainly, we may have lost potentially illuminating data in the process.

Nonetheless, the survey provides useful insights into a cross-section of respondents, and when viewed in the context of the findings of the other chapters, provides a

consistent picture of how the institution could be both racist and have individuals who opposed racism in its profile.

References:

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Chapter 5: Teaching at UCT during apartheid

HISTORICAL CONTEXT

During the 1920's and 1930's the University of Cape Town's Medical School was affiliated to the New Somerset Hospital and the Peninsula Maternity Home. Both hospitals were managed by the Cape Hospital Board. In 1938, Groote Schuur Hospital was opened and became the main teaching hospital for the University of Cape Town's Medical School. Groote Schuur Hospital was the biggest and most modern of the Cape Provincial hospitals providing clinical instruction to senior UCT medical students. Red Cross Memorial hospital was opened in 1956 as a specialist children's hospital. From the mid-1950's, undergraduate teaching and post-graduate training and research was actively developed and consolidated. This was accompanied by an increase in full-time staff, the introduction of full-time registrars, the formation of new specialist departments and clinics, and the establishment of organised research in clinical departments.

In 1950, the Cape Hospital Board was abolished and its functions taken over by the Cape Provincial Administration. In the same year, the University and the Provincial Administration signed an agreement that established their joint control over medical education and training, and patient treatment and care.[1] This came into effect in 1951. The implications of this joint relationship were twofold. Firstly, three levels of employment were in operation with staff positioned differently within this system. Staff appointments were made by the Cape Provincial Administration, the University

of Cape Town and jointly between the two. Therefore within these different employment categories, staff had different kinds of investments in each institution, which affected and informed both their decisions and actions. This is reflected in the report.

Secondly, during the period under review all institutional facilities at Cape Provincial hospitals were racially segregated. For example at Groote Schuur Hospital there were separate wards for black and white patients, separate entrances, toilet facilities, outpatient waiting rooms, canteens and intensive care units. Institutional segregation was eventually overturned in 1988 with the opening of a new hospital wing at Groote Schuur hospital when all the facilities were finally integrated. However up to this period, institutional segregation had a direct effect on black staff and students who were denied access to white wards and patients.

It is important, therefore, to locate this report within the context of the ongoing tensions and divisions that were created by this joint relationship between the institutional apartheid of the provincial hospital system and the supposedly liberal medical school and University. At the same, this report should be read against the broader South African political context of ongoing political repression by the Nationalist Party government, and the subsequent political and social unrest and protest that followed in its wake from the 1960's.

METHODOLOGY

[1] Ralph Kirsch and Catherine Knox [Eds], *University of Cape Town Medical School at 75*,

SAMPLE

Thirty Taped Oral History Interviews were conducted by Dr. Sean Field from the Centre for Popular Memory. Respondents were drawn from past and current staff members, all holding senior appointments within the Faculty of Health Sciences. Respondents were drawn from a range of medical disciplines and departments such as anaesthetics, bacteriology, biochemistry, emergency medicine, forensic medicine, human genetics, general medicine, obstetrics and gynaecology, pathology, paediatrics, psychiatry, public health, pathology, rehabilitation sciences and surgery. Six people refused to participate in the study.

The questions in the interview guide were compiled by the Faculty of Health Sciences.

BREAKDOWN OF RESPONDENTS:

Table 1: Race and gender of Respondents

Total	**White**		**Black**	
	Male	**Female**	**Male**	**Female**
30	20	7	3	-

Refusals: 6

Group I: Pre 1970's Staff
Respondents: 10
Race: White
Gender: 2 Women; 8 Men
Refusals: 2

Department of Medicine, University of Cape Town, Cape Town, 1987, p.300.

Group II: Post 1970's Staff
Respondents: 10
Race: White
Gender: 2 Women; 8 Men
Refusals: 2

Group III: Current Staff
Respondents: 10
Race: 7 White; 3 Black
Gender: 3 Women; 7 Men
Refusals: 2

There were overlaps between Groups II and Groups III in that 4 current staff members have been employed in the Faculty of Health Sciences since the 1970's.

RESULTS

DISCRIMINATION AGAINST STUDENTS

The majority of respondents identified two key areas where racial discrimination against black students studying medicine at the University of Cape Town was quite explicit: University admission policies and aspects of the University's medical training and teaching, both at undergraduate and post-graduate levels. Until the late 1970's and early 1980's white males made up the majority of the Medical School student intake. Female students and black students remained in the minority. Figures for the period reveal that black students made up 10% and female students 15% of the student intake. [2]

Admission Policies

For the pre-1970's period, from the late 1940's to the 1960's, respondents noted that the number of black medical students was always very small. Only Coloured and Asian students were admitted, as the University of Cape Town did not accept African students. One respondent described the medical school in this period as 'lily white', while another noted that there were 'only a handful' of Coloured and Asian students and identified no more than four black students in her class when she trained during the 1950s.

[2] R. Kirsch and C Knox, *UCT Medical School at 75*, Department of Medicine, UCT, Cape Town, 1987: J.H. Louw, *In the Shadow of Table Mountain: A History of the University of Cape Town Medical School*, Struik, Cape town, 1969, p.426.

After the Extension of the University Education Act of 1958, black students were required to obtain a permit to study medicine at the University of Cape Town. Government controlled admission policies continued to influence admission policies and black student numbers in the medical faculty remained relatively low for the post 1970's period as well. The permit system in fact made it very difficult for black students to gain admission into UCT as they were forced to study at designated black institutions such as the University of Western Cape, Durban/Westville and later at MEDUNSA outside Pretoria.

Two black respondents were not only directly disadvantaged academically by the permit system as students, but were also affected in practical and financial ways, as they initially had to study so far away from their homes. In addition, application procedures for permits were riddled with bureaucratic red tape. These respondents encountered enormous difficulties as the Minister of Interior repeatedly refused them permission to study medicine at the University of Cape Town. For one respondent it was all '*a lot of nonsense, which lowered your dignity.*' His persistence eventually paid off and he was finally granted a study permit. One respondent felt that the permit system had more pervasive and unforeseen effects in that he encountered patronising attitudes and a lack of sensitivity from senior faculty staff members. He recalls being told how privileged he was to have been given a permit to study at the university. For him this was yet another '*slap in the face.*' Another respondent reported that racial agendas still existed in the early 1980's when he was forced to apply for a permit for post-graduate study. He remembers feeling '*absolutely disgusted*' with the whole system, reflecting that he '*should probably have left the country*.'

Racial discrimination not only influenced the selection of medical students but was also implicated in the selection of students in other related medical disciplines such as physiotherapy, occupational therapy, radiography and medical technology. Respondents noted that white students were selected in preference to black students as a result of higher standards of education and school qualifications.

One senior faculty staff member spoke of the frustrations and difficulties he encountered with regard to the admission of African students in the early 1980's. Despite repeated efforts over the years on the part of the Medical School to offer places to African undergraduate students, the government consistently refused to provide permits for these students. In 1983 the University Amendment Bill was passed, replacing the government-controlled permit system with a racially determined quota system. In an attempt to encourage African enrolment at MEDUNSA, Universities such as UCT were prohibited from admitting African medical students.[3] It was therefore beyond the means of the faculty to do anything about this state of affairs, except to continually lodge official complaints. While African students were admitted to other courses at the University of Cape Town, it was several years before the Medical School was permitted to admit its first African students. According to this respondent, the first African student was accepted to study medicine at the University as late as 1986.

While acknowledging the all-pervasive discrimination of these admission policies, the majority of respondents pointed out that these policies were imposed on the University by the Nationalist Party Government. The general consensus among

respondents was that the University did its best under very difficult circumstances. Subsequent years have seen a steady increase in the number of black and female students.

Teaching Practices

The majority of respondents from the pre and post 1970's groups reported that they were aware of various discriminatory teaching practices at the Medical School. Undergraduate black students were denied access to all white patients and white bodies. Black students could not dissect white cadavers in second year anatomy classes. These classes were racially segregated and held in separate rooms from white students. Third year black students were also precluded from attending post mortem examinations on white bodies at the pathology department at the medical school.

One respondent said, '*Now I don't know to this day if there was a law that said black people could not watch a white body-a post mortem on a white body. So what they did was when we went to post mortems in our third year, the professors* (named) *would tell the black man at the door-the worker there-to debar all black students because today they were dissecting a white body. And so we were turned away at the door and all the white students would pile in.*'

Racial discrimination carried through into clinical training for black students in the fourth, fifth and final years of undergraduate study. Because of the institutional segregation of the wards at Cape Provincial training hospitals such as Groote Schuur,

[3] S. Saunders, *Vice-Chancellor on a Tightrope: A Personal Account of Climactic Years in South*

black students, as well as black housemen and registrars could not rotate to white wards and were barred from the all-white intensive care wards. One black respondent recalled that '*we were not allowed to examine white patients. When black wards rounds were finished the professor or consultant would just walk on to the white ward and we would just disappear*.'

Black students were barred from lectures when clinical presentations on white patients were given. According to one respondent the few black students '*formed separate groups in lectures, usually sitting at the back of the lecture theatre. It was just automatically expected that black students would get up and walk out when white cases were presented in lectures.*' White respondents described this as part of '*traditional apartheid*', an '*unwritten gentleman's agreement'*, that was '*generally accepted and understood by Coloured students.'*

Respondents identified staff members who directly enforced segregation in lectures. Professor (named), '*observed the niceties of apartheid and sent out black students.*' One respondent remembered that, '*The Head of Dermatology when he taught us in fourth and fifth year would personally stand at the door of the E4 lecture theatre and tell the black students, "Sorry, you cannot come in now. We are showing a white patient." And all the white students would file in, he would show them the skin lesions of this patient and then when it was done, he let the white patient out, and get a black patient in, and then let us in.'*

Africa', David Philip, Cape Town, 2000, pp. 143-144.

According to one respondent these discriminatory practices had a distancing effect on black students. *'We formed 'clans' and we became an amorphous group known as the "Coloured students". It pushed us into corners. I did not befriend a single white student.'*

Two respondents from the pre-1970's group felt these policies might possibly be justified in certain situations and that white patients had the right to refuse to be examined by young black students.

'*Where I think there's got to be sensitivity is when you are in a gynae situation. When you have got an elderly white woman and a black student….that you have people with established prejudices…. who feel really uncomfortable about that. And I think some of us have to respect that….. You know you can understand how sensitive people could be and how it needed negotiation.'*

'There might have been the odd occasion when you had to be careful, if you like, not to teach and expose clinically-undress if you like… a white patient in the presence of Coloured, but that becomes part of human dignity and care and respect of the individual anyway.'

UCT OPPOSITION TO DISCRIMINATION AGAINST STUDENTS

According to respondents from the pre-1970's group, very few staff or white students were conscientised about these issues to any great extent:

'Over the years I have been troubled by the fact that those professors whom I knew and had taught me and I admired were clearly not doing anything about it, were taking it as a matter of course. So it was clear to me and it's more and more clear as I reflected on it over the years how hurtful any number of those practices were. And how little we dealt with it at the time.'

'There were not very many black students anyway. They kept very quiet. We were preoccupied with work and exams and hard work. There was not a sense of awareness about human rights. People were not as aware then as now.'

'It is obvious today – but we did not take umbrage then. There was very little awareness of discriminatory practices, we were single minded about our patients, but there was very little awareness.'

A small number of respondents from the post 1970's group saw discriminatory practices against students rather as an effect of the problematic relationship between an apartheid government hospital system and a liberal, anti-government University and Medical School.

"Obviously we had to work in a government facility so that the government ethos and laws of that era applied to what we did to render a service.'

'There was no discrimination in the Medical School and the University-everybody mixed equally and there was none at all - one did not give it a thought. However when

they crossed the boundary into the hospital, which was then under the jurisdiction of the medical superintendent, who was a government employee, then we had problems.'

' I accepted that situation. I thought hard about it. At that time there was a medical school in Durban and Johannesburg and I thought well these students have come here knowing what the background is. That there is this discrimination against them. They had chosen to come to the University of Cape Town in spite of this. And that maybe the administration had negotiated with the public at large, and that the white community had said, "We do not want to be seen by black students." That was an assumption that I made from the background ethos of the country having come from Zimbabwe, where there was a different ethos. That is the way I rationalised the situation.'

However most respondents remarked that racism was endemic at both the teaching hospitals and the medical school. As one respondent observed. *'There was no doubt about it, there was discrimination. They were just treated differently. This was regarded as the law.'* Another respondent recalled that black undergraduate students were exposed to a range of discriminatory practices that *'pervaded both the university and medical school. We felt acutely embarrassed about it. It was an artificial and uncomfortable society.'*

As lecturers and consultants, some respondents noted that they did not enforce these policies. Some departments were more flexible than others in their approaches to teaching, and staff were given the freedom to work around the system. This was

achieved, for example, by selecting only black patients for lectures and clinical presentations.

'There was no question of not being aware of the iniquities and what was happening. We were aware of marked discrimination, we felt it very strongly. A great deal of effort went to make sure that individuals did not feel hurt and harmed and were treated with the same respect in every way as everybody else.'

Respondents described a general shift in attitudes and by the late 1970's and early 1980's it became a matter of personal choice for lecturers to teach black and white students together. *'Staff had reached a point in the early eighties where you know, everybody was just fed up with the whole thing.'*

IMPACT OF DISRIMINATION ON STUDENTS

However, respondents across all the groups were in general agreement that racial discrimination had little or no impact on the standards of teaching and medical education. Both black and white students had the same teachers and lecturers. Some general comments made were: *'Teachers superb'; 'No discrimination in teaching' 'Maintained highest levels of teaching'; 'Standards were of the highest order'; 'One of the best medical training available anywhere'; 'Superb medical training.'*

Although black respondents felt that they were disadvantaged by the lack of access to white patients this was discounted by white respondents who felt that black students did not miss out in the long run because of the *'enormous pathology amongst black*

patients.' Respondents felt that black students missed out only if a case was very unusual-one that was unlikely to be repeated in the black wards.

However, black respondents gave contradictory views. They reported that although there was some crossover in pathology, the disease spectrum between black and white patients was different. The bulk of the clinical material in the black wards tended to be acute diseases that were often caused by poverty, such as TB, infectious and gastro-intestinal disease, trauma cases, perforations and today aids. Black patients tended to be younger in contrast to white patients who tended to be older. White patients suffered to a greater extent from chronic diseases such as hypertension, heart disease, diabetes, aneurisms and endocrine diseases. One respondent felt that there were gaps in his training as a result of racist policies that went unnoticed by white lecturers.

'Not once did he say, "Hey, wait a minute fellas!…. You have never seen diseases that I've seen commonly in white patients, like coronary heart disease, how to read an ECG". You know, I mean, so I never saw a damn ECG as a student. I mean coronary heart disease!'

However black respondents noted that dedicated lecturers and teachers (named) were instrumental in assisting them with extra tuition. In the words of one respondent, *'They walked the extra mile.'*

In terms of current teaching programmes, one respondent reported that staff were grappling with issues of transformation and dealing with such sensitive issues as

cultural diversity. '*It is difficult being a student, you know. One is coming from a lack of competence, a lack of knowledge and coming into an organic body that works in a strange way and every body is busy and has got pressures. But I must say, I would think that most students here get a pretty good deal. I mean the amount of time and effort that is spent on them.…… I do not think they are discriminated against'.*

DISCRIMINATION AGAINST PATIENTS

Despite the fact that facilities at the provincial hospitals were strictly segregated up to the mid 1980's, the majority of respondents from all three groups described patient care and medical treatment as of the highest standards. Many respondents emphasised that the patient-centred approach was the focus of their work. Whether black or white, patients were regarded as the most important people in the whole system.

'The care was the same. If you are sick you have the same treatment. There was no discrimination, no medical discrimination. The facilities were discriminated-we had black and white toilets for example, Coloured and black wards. But as regards the care of the individual, the teaching of the individual-there was no discrimination at all.'

'Well there was a coloured entrance and a white entrance. There was a coloured toilet and a white toilet, there were coloured wards and white wards. This is the way discrimination was applied. But within that constraint the standard of care and the dedication of care was the same. There was no discrimination. People who lived at

that time…I am thinking of the patients….Coloureds and black patients accepted this as a part of the life they were living and the circumstance in which they were sick.'

'We have got a very high standard here. Hopefully we have always had. And you were a doctor and the nurses were dedicated. It was a tremendous sort of feeling. The treatment was universal. After all, we are a teaching hospital, an academic hospital. How can you give different treatment to the one and not the other? It's not on, just not on.'

'The treatment was good. It was good no matter what the skin colour was. I mean they did not suffer from a treatment point of view. There was no discrimination, there was no discrimination in treatment……But as regards medical treatment, absolutely colour blind.'

'Oh look! Ja, 90% if not more were non-white patients, you know, and so they got first class medicine. In fact sometimes better than you could get outside because the expertise was in this institution.'

'The patients were treated with absolute equality. At all times. There was never any distinction, in my opinion, between the way that I looked after or that I saw anybody else looking after the black or the Coloured -there were very few black patients. Obviously most of them were Coloured patients- but there was absolutely no discrimination in the care which they received and the way in which they were treated and spoken to. Absolutely not.'

'80 % of the patients were black in any case, or – black/Coloured. And I always used to ask my trainees, "Who is your boss?" And they would say, "You are the boss." I would say, "No, no, not me". …And I would say, "your patient, he is your top boss. No patient, no hospital. No hospital and you are out of work." The patient was the most important person. We did not worry what colour they were….. The patient was your work.'

But a few respondents thought that the ethics of patient care was far more problematic than appeared on the surface of things and that the nature of treatment was not so straightforward. One respondent expressed her concern over the abuse and exploitation of patients' rights and the kinds of unquestioned access to patients that was given to students.

'At that time of course, most patients were black and whites could afford private care and blacks could not. So the availability of "black flesh" and black pathology was a gift. I think that is why I don't think doctors were so good. I mean, you know, if I had students coming from Germany or somewhere to do their lectures, they would be amazed that they could lay their hands on patients. You see in their country the professor examined the patients and showed the students, you see. I mean the invasion of "black flesh" was something that was accepted by all of us.'

Another respondent noted that race played an important part, in that the system favoured white patients. *'I mean basically in those days it was easy to get into a white ward if you were sick because there were plenty of beds… and the black wards would be very, very busy and you had to be desperately sick to get in. Whereas on the white*

side the reverse. And the doctors on the black sides were usually more junior doctors. Certainly as far as the registrars were concerned.'

A second respondent recalled, *'In those days the white ward was like a private ward. When you walked into the white ward, there was the exact number of beds, but it was half full, or half empty and it was quiet…. it was serene, you did not have acutely ill patients, you did not have confused patients, but the same number of staff. And the most senior registrar who had already got his degree was looking after those patients and the most junior staff were looking after the sickest patients….. But in the early years, I mean the way they practised, it's almost like they were unaware that what they were doing wasn't exactly the right thing to do.'*

Another respondent noted that there was a general insensitivity to language and cultural differences. *'No doubt about it, black [African] patients got a raw deal, particularly if they cannot speak English or Afrikaans. Much of medicine depends on getting a history. If you get a decent history the diagnosis is already there….. People don't seem to notice it. For instance you will see doctors spending time with a white patient explaining everything to them. With a black patient, less time, probably because of the language problem.'*

Another respondent commented that racism and discrimination against black patients was often very subtle and less overt. For example he noticed that there were differences in attitudes and politeness shown to patients. '*More deference was paid to white patients than to black patients.'*

'This was a hospital that prided itself on the excellence of the care it gave patients. And set standards….. giving wonderful attention to everyone. But the place was segregated strictly and when special facilities developed, like intensive care- there would be an intensive care ward for whites and not blacks. I asked Professor (named) *about it and he said, "Well, look it is experimental, we have to start somewhere." You could argue that we won't experiment on blacks, but on the other hand, intensive care was an advantage to people. So the institution saw itself as giving excellent and non-discriminatory care. But when you looked hard, it was not that simple.'*

The same respondent remarked that discrimination against black patients went far deeper than institutional racism. *'No one seemed to relate the impact of apartheid on health. They [ANC] seemed to exonerate doctors and health. That was part of the aura of being a doctor. The idea that apartheid was causing disease and making for poverty and therefore disease came very late. It came late in the minds of politicians; and it certainly came late in the minds of people such as myself and ourselves.'*

Another respondent also noted these broader patterns. As a doctor she witnessed the effects of forced removals, the Mixed Marriages Act, the effects of solitary confinement on political prisoners- '*severely distressed patients'* whose lives were *'entangled in apartheid.'*

One respondent from the current group felt that patients at the present time are discriminated against in terms of economic realities that have seen severe budget cuts in the public sector. The lack of funds now limits the ability of doctors to prescribe

certain drugs and to undertake different investigations. In the Western Cape, the number of beds has been drastically cut and fewer nursing staff are employed, which adds to the pressures. What is surprising to her is that patients' are very accepting of this and don't often complain.

DISCRIMINATION AGAINST STAFF

Respondents for the pre-1970's group noted that there were very few black staff appointments. Respondents from the post-1970s group noted that at post-graduate level, black housemen and registrars were discriminated against in terms of staff appointments, salaries and access to white wards and patients. Black post–graduate students were limited in their choice of specialities and were overlooked in favour of white registrars, who according to one respondent later emigrated. They were also expected to do their training at the New Somerset hospital, which was reserved exclusively for Coloured post-graduate training.

'And you know, they did not show a commitment, the Heads of Departments. The Head of Medicine did not show a commitment to train people who would actually stay. Every year in and out, every speciality was taken by white registrars. There just weren't jobs for us. So in the end I landed up where nobody else wanted to work'…. So that is the one thing that sticks out in my mind fairly clearly and you can't forget it because your career path changed.'

'The Coloured registrars were supposed to go and work at Somerset Hospital. But that was nonsense because they were not then covering all branches of surgery. They

have to do neuro-surgery, cardiac surgery and all the rest of it, but there wasn't cardiac surgery. For a long time before we got official permission, we just took no notice. We appointed them to the staff of Somerset hospital but rotated the staff and mixed them all up between Red Cross hospital and Somerset and they did a rotation and that was that.'

Despite being employed by the University, black interns and registrars earned lower salaries than their white counterparts but were expected to cover the same work-load. In 1975 there was a strike at Somerset hospital over pay differentials as the '*situation was intolerable.'* Two white respondents reported that they offered to take pay cuts as a form of protest and as a way of highlighting the situation but black doctors were opposed to this. Eventually black staff received pay equity around 1978.

Discrimination extended to black consultants who found it very difficult to find employment at Groote Schuur. All the top medical posts were occupied by white doctors and all administration and medical superintendent posts were reserved for whites. However one respondent noted that a black consultant at Groote Schuur was able to eventually work with white patients after a '*cautious opening*' of the wards had started. Unfortunately, given the negative circumstances, few black consultants were able to attain the same status as their white colleagues and many chose to emigrate.

Respondents from the current group remarked that they had experienced discrimination as staff members in subtle ways that was often difficult to pin-point. *'Often its just a feeling, emotional really. You have to prove that you are good*

enough. Perceptions are that you have to prove yourself -"he is not as good as he thinks he is". Another respondent was aware of patronising attitudes from white colleagues. "*We must accept that black fellow because he is extremely talented." 'But they do not say that about white students and doctors. The feeling is that they are only taking him because it is unusual to get a clever black. The early years were very difficult, but it is getting better.'*

One respondent spoke about the distancing effects of racial discrimination on both black and white staff. *'Part of the problem was that people just simply kept apart because that was the practice. One really did not know what peoples' feelings were. There was distancing from both sides.'*

Respondents noted that discrimination against staff also took the form of 'petty apartheid' that could become quite ridiculous. Theatre staff at Red Cross were forced by administrative staff to use separate coat hooks for their coats- yet they did the same work, the changing rooms were mixed, but they were not allowed to share coat pegs!

One respondent described how discrimination affected his work. '*We were surrounded by apartheid, both professionally and personally. It dictated and influenced a large part of the work and operations'*. Another stated that, *'Apartheid determined where they could eat, sleep and work. Some very good people who deserved to get on staff did not because of race'*.

A major impact of apartheid and discrimination was emigration. One respondent calculated that in the early 1980's, over 70% of students and staff emigrated. *'We*

were not training African students. We were training for export and within the faculty you had the professional class and the very young and nothing in between.'

Another respondent noted that white staff benefited from apartheid, especially in terms of furthering their academic careers. *'Groote Schuur and the Medical School maintained their eminent position…. The government put a lot of money into tertiary institutions like Groote Schuur which was clearly to the good of the Medical School as research and resources went into white patients, producing a world class health service ….For the role of the university academic is to publish in prestigious overseas journals. And within the framework of the ivory tower of the academic, there was nothing wrong with that.'*

MONITORING

Respondents noted that apartheid policies were monitored in a number of different ways. This was done through the authorities such as the medical superintendents and administrative staff. One respondent, who became an activist, was phoned by the medical superintendent and threatened with dismissal. Patients and the public lodged complaints usually with the provincial administration. In the 1980's, government threatened to close the hospital down in response to pressure from senior members of staff to integrate.

The closest monitoring was experienced by the psychiatric department. Police remained in wards with political detainees. *'Political detainees were always admitted to Groote Schuur, with the police sitting outside. Those were difficult days. They*

would want to sit in on therapy sessions but this was an intrusion of the law and they were interfering in the work'

However according to other respondents monitoring was often unnecessary.
'Rather, there were high levels of acceptance of the status quo- now everyone is crawling out of woodwork saying I always resented it. I can't say that I did.'

'There were grey areas. While many people were opposed, only a small number of people were actually active. Increasingly it is becoming politically correct of course, to be associated with protest. We were not politicised. We accepted the status quo.'

'There was never the sense that big brother was looking over your shoulder. Rather opposition was tolerated. And one did have the space to criticise.'

UCT OPPOSITION TO APARTHEID POLICIES

Respondents identified three key moments in UCT's opposition to apartheid policies. The first was the banning of Sir Raymond Hoffenberg for his political activism and his subsequent exile in Britain.

The second was the death of Steve Biko in police detention. One respondent reported how she received very little support from her colleagues. *'The Biko case. I mean that profound disillusion with my colleagues-that taught me an immense amount. You know that was such a long struggle to get anybody to see it as a threat to the integrity of the medical profession..... I was never very politically aware and I do not think*

any medical students were. For a long time I felt that men were superior until the final disillusionment with the Biko business.'

The third was the death in detention of Dr Neil Aggett. *'The Medical Council had decided not to take the Biko investigation any further. The Medical Council and the medical profession were keeping out of the issue of health care for detainees and condoning what happened to Biko. Aggett, another detainee who died was also a doctor. It is our business because people are getting sick and dying in detention- that is medical business. The irony is that he was a doctor and colleague.'*

These three events alerted medical personnel to the ills of the apartheid state. However, one respondent argued that not everyone engaged in activism. *'Many felt "lets get on with our work and do a good job." The Medical School always tried to work within government rules. Whenever they could relax those rules, they did have the space to criticise.'* Another respondent noted that leadership in opposing government policies was in fact provided by senior staff such as the medical superintendent, Dr. Reeve Sanders, Professor Benatar and the vice-chancellor, Stuart Saunders.

But other respondents noted that they were in a difficult position when it came to their employment. *'Of course we were part civil servants as medical lecturers because we were on the hospital staff. As well as being lecturers at the university. But our salaries were basically paid by the state. The medical office was the state.'*

One respondent raised the issue of silences. *'Again, it's more the individuals. That there was a minority of individuals who were very progressive. If one looks at the pushing into the death of Steve Biko and all those things. It really was a minority of UCT academics who opposed the government at the time. The majority were just prepared to go alongside silently and accept what was happening. And I think that is the more damaging thing. And so those who were that majority can still claim today that they did not support apartheid. They just did not do anything about it. But their silence to my view means that they supported it. It is a very conservative faculty. People are not prepared to stand up for what is right'*

Several respondents acknowledged that with hindsight they should have done more '*We did not do enough. When you see these things happening under your eyes then you must object. And a few did and we had mass meetings'; 'On the surface, UCT opposed apartheid practices-but we did not try hard enough'; 'I did not get the idea that they were opposing actively, because if you opposed it actively in those days you were likely to be under house arrest or encouraged not to be in the job you're in. We were cocooned to a certain extent, aware of what was going on, but content to carry on with our comfortable way of life.'*

SOCIAL EVENTS

The majority of respondents noted that there was very little social interaction between staff and students. Reasons for this were given as lack of time and 'impossible hours.' Staff/ student structures at the Medical School were very hierarchical and did not encourage socialisation, particularly at undergraduate level. Students and junior

doctors *'knew their place.'* One respondent thought that doctors were *'regarded as God, or second to God'* and this prevented more informal ties being established between students and staff. Informal social functions such as braais, tended to take place in smaller departments, where students and staff would meet at someone's home.

Respondents noted that black students did not participate in white functions such as end of year formal dinners and medical balls. *'A limited number of Coloured students kept to themselves- most wanted to stay in their own groups'.*

Those respondents who played sport did interact with students but these tended to be white students. Sporting codes included squash, hockey, cricket, and golf. In the 1980's black students formed their own separate sporting codes.

Current staff noted that staff/student relationships have improved in recent years and are now less formal and relaxed. They saw this as a positive outcome.

INTERACTION WITH STUDENTS

Gender

Female respondents from the pre-1970's group noted that when they were students their anatomy classes were held separately from the male students. They also noted that female student numbers were small. At the present time women make up 50% of the student intake at UCT. This is part of a world-wide trend that started in the late

1970's. Male respondents noted that female students are very competitive and more than *'hold their own academically.'*

A male respondent, ruefully admitting his own chauvinism, commented, *'I don't think women are discriminated against. Although it might sound childish, we used to call medical student women the 'third sex'. I suppose because some of them looked a bit dowdy. But on the other hand there were some outstanding attractive girls. But some of us who were maybe chauvinistic at the time and ignorant used to talk about the women medical students as being different.'*

Two female respondents did not feel that they had suffered from any sort of discrimination as women. *'Your progress up the career ladder is dependent on yourself.'* The other respondent felt that her sex had in fact worked to her advantage in her medical career. *'I am very aware of the fact that I use my gender. The fact that I am a woman is a powerful tool.'*

However the other female respondents commented that they had to work twice as hard to prove themselves. They also had to juggle the burden of *'double burden of career and family.'*

'As a mother with four 4 young sons it was very nice to have a patriarchal medical faculty with a handful of women and men being dominant under their fatherly guidance. If you stepped out of line and challenged them you were sharply reprimanded. If you needed time off for sick kids, the male boss reacts saying "that is the problem with employing women who have children. Their children always take

precedent over work." In fairness women mostly lend themselves to being managed by men. Its comfortable its part of our culture. In my time and for some years I had a slave mentality.'

'As I got older and watched the struggles of female doctors trying to combine dual role of a career and mothering- things have not changed all that much. Women still suffer appallingly and get relatively little know-how. But to me it's very disappointing that things have not become any easier for women.'

'Women should be more articulate and assertive about their situation and accept that the main burden of parental care is on them, but insist on adequate pre and post natal flexi-time employment. There needs to be a recognition of part-time specialisation.'

One male respondent commented that, *' Women do have a really hard time. Men have very little appreciation of what it is like for them. Its got better, but it was really bad. Women themselves have done more to draw attention to it. Women have had a very hard time in an institution that has prided itself on being non- discriminatory. Teachers are very condescending towards students generally but even more so to women. Very little allowances are made, including family, social and the biological. Medicine is a very hard profession, a demanding one, physically very demanding. Women have to be heroic to get through it.*

Another male respondent made different comments *'Women go into general practice, then have babies and stop practising. It is a waste-one of the hazards of having female students. A certain number would stop practising after a few years.'*

'If you want to specialise as a woman and have a family, it is very difficult. We need to build capacity so that there is a sharing of responsibilities, so that we are able to go away and it is not going to interrupt our training and promotional prospects.'

'Now that the number of women is increasing to over 50%, there is still an atmosphere of having to prove yourself.'

Disability

Respondents all noted that there were very few disabled students and staff on the medical campus. One respondent suggested that the University should begin an active recruitment plan to employ more disabled people. Other respondents noted that the disability unit has raised the profile of the disabled on campus. Several respondents mentioned Cathy Jago as an outstanding advocate for the rights of the disabled.

Sexual Orientation

As with the disabled, respondents had very little to say about sexual orientation. Respondents commented that there seemed to be more openness about the subject and that there seemed to be far more tolerance around issues of sexual preference in recent years.

Tutorial Groups

Respondents noted that various criteria were adopted when students were assigned to tutorial groups. Either they were randomly or alphabetically assigned to different groups by the Dean's Office. This was often done to mix students more evenly and to prevent them from automatically staying within their own social groups (ie ethnic, religious, racial or gender).

Racial Incidents

Respondents noted the strike at the Somerset hospital in 1975 over unequal salaries for black and white interns and registrars. This was only resolved some years later.

One respondent commented that students would view bad marks as discrimination More black students were made to take oral exams. Black students understood this to be racially motivated.

Black medical students staged a boycott of year end exams in solidarity with school boycotts. This was not supported by the faculty and students reluctantly took their exams.

The black student body refused to take the Declaration of Geneva Oath, which stated,' I will not allow matters of race or other things to come between myself and my patient.'

Boycotts And Protests

Respondents identified numerous boycotts and protests:

The 1958 protest march in Cape Town against the University Extension Act.

The T.B. Davie Memorial Lecture when the Academic Torch was extinguished.

Robert Kennedy Speech in Jamieson Hall in 1966

The 1967 banning of Sir Raymond Hoffenberg- protest marches

Civil disobedience on Upper Campus in the 1980's and massed marches

Health Workers Trade Union Strike.

Student Boycott of Final Year Dinner and Class Photograph.

Redress

Twenty four (24) respondents did not think any form of redress was necessary. Three (3) respondents were in favour of redress and 3 were undecided.

There were a range of comments:

'No. One cannot now have retrospective pogroms. And what purpose would it serve? What can one even prove by doing it? How can you create not an idealistic new world, but a practical new dispensation by doing it?'

'No. It is pointless. UCT medical school did a lot to try and change the system. No apology is necessary. It is best to put it behind one. Retribution and revenge destroys the person.'

'No. The world needs to be told of the great achievement of the Medical faculty in functioning under the apartheid regime, in not discriminating and opposing to the best of its ability, while maintaining the highest possible standards. Not enough credit is given to the medical school. There were courageous dedicated people.'

'*Redress for what? Apartheid troubles? No. A witch-hunt was not UCT's attitude. Anyway, rather get on with the job. It's an important job that the medical school has to do. There was no discrimination really, but what could UCT do? They were all anti- teaching went on, training went on, medical work went on in the hospital. It goes against the medical ethos. There was no discrimination between different patients.'*

'There was discrimination in this hospital, much enforced by government. Many people were opposed to them and they were good role models to students- but also others who supported the system. Everyone should know that the university is not as clean as they project themselves. We grew up believing Stellenbosch university was

the one that was doing all the discrimination. Maybe its time to admit. Apologise would be a small thing to do.'

'Yes. Definitely. At the faculty launch people all around were saying, "I will never forget/forgive." Its all right for them to talk but they don't know what it is really like. It is about healing- being able not to forget and to be able to move on to see what needs to be done…. Corrective action needs to deal with diversity. It is a place to start and encourage.'

'The Steve Biko memorial showed our connection with the past and that there are some things in our past that we are actually ashamed of. And I think it says a lot for the institution, it really does and it also gives it part of a feel nationally, that we are part of the mainstream. We have had a few rotten apples in our midst, and we need to show we are sorry for this kind of thing, institutionally.'

'I am undecided. There was a lot wrong and I feel bad about. I have seen all the wrongs. I think there is an enormous need to have a record. I think what you are doing is very important. I thought the TRC was very important. And I am unshakeable in my belief that the record should be taken and thought about and recorded and explained.'

'Apologise I think we should come to the conclusion, after proper reflection and analysis and record taking that what happened was profoundly wrong and very, hurtful and very damaging to everyone including ourselves- need to all understand how people suffered including patients.'

'A categoric no! We did not do anything that requires redress. The whole business of hand wringing is a 'lot of bloody nonsense'.. One or two who chose to exclude Coloured students from lectures! That was their problem, .not UCT.'

'Corrective Action? Yes. Employment issues still weighted to people with lots of advantages. Still not a big pool of black and Coloured staff. Very few have had the same choices. Need to apply corrective action in employment. There is a danger of standards of doctors slipping because people selected do not have the same experience and qualifications. There is not much of a process in place to develop potential. Students either sink or swim. There is not enough mentoring and support- I am really talking about capacity development.'

FINAL COMMENTS

'I loved being a UCT doctor, the medical residence formal dinners- traditions that are now being swept away. A lot has been lost. They were wonderful golden years. I hope future students will enjoy the same privilege to have been at UCT.'

'One's first duty was to the care of people care of all people. I have strong views on the way medicine is going. The future of medicine in this country needs to look at present and future and not at the past.'

'I am optimistic that the medical school is going forward and will prosper with increasing numbers of black students, post grads. A mix of staff and students that

understand each other so that there is less polarisation. We have a good set-up for integration.'

'UCT was very good to me. It was important to give something back through teaching.'

'I am sad, sad about cuts in hospital budgets that are damaging tertiary medical education. The standards of medicine were equal to the best. Now it is not equal. Now it is third world. Groote Schuur is losing good staff because of poor working conditions. This university hospital was the best in the world.'

'It is going to take decades to understand each other. I don't think events are the way to go. It's rather cultural change. We were able to change teaching and understanding and how that happened. I would not be here if I did not feel that I had something to contribute here, to oppose some of the apartheid things and to be around to not give in to some of the present problems that I perceived.'

Annex: Additional Notes on the Research Project on Reconciliation and Transformation in the Faculty of Health Sciences, University of Cape Town. 24/02/2003

This part of the research project attempted to confront past discriminatory actions and practices within the Medical School community in order to acknowledge and learn from that past and facilitate moves towards reconciliation and transformation within the Faculty of Health Sciences. A few respondents provided important insights into the nature of these past injustices, and spoke quite openly about their own experiences. However, as is evident in this report, there was a failure on the part of most of the respondents to engage in any kind of reflexive process or self-disclosure about the underlying meanings of their individual white identities and subjectivities and their positioning within a system of white privilege.

On reflection, part of the problem seems to be that individual respondents so strongly identified themselves with the Medical School and the University that it was impossible for them to distance themselves from these institutions and perhaps take a more critical stance. While respondents were able to take a principled stand against the state and provincial governments, both the Medical School and the University were described by respondents as bastions of liberal protest that were doing all that was possible to make a difference within a flawed system. In addition, respondents resorted to discourses about their professional roles as healers, of giving lifelong service and saving lives to the benefit of many communities. While all of these are valid points, these kinds of responses served to deflect any kind of critical confrontation of a more individual and personnel nature about white racism and discrimination.

The assumption that UCT was inevitably anti-apartheid is widely held. For example, one respondent to an alumnus questionnaire (Chapter 4) claimed that "As a student, registrar and lecturer at UCT, I, along with practically everybody else adopted a consistent stand against the social engineering policies of the Nationalist Government." This respondent, a white male, went on to dismiss the Reconciliation Research as (reverse) racism and "pointless self-flagellation" that would only bring "humiliation of a once great institution." The investment in UCT's greatness is evident. Moreover, narratives from black (and some white) alumni in chapters 3 and 4 paint a very different picture of what was actually done (or not done) in opposing "the social engineering policies of the Nationalist Government."

Given the limited outcomes of these interviews, a second point to note is one concerning methodology and research design. Due to the consultative nature of this research project and despite these obvious good intentions, many of the respondents had already prejudged the merits of the project and qualified their participation in the project before the tape recorder was even switched on. This had the effect of putting respondents on the defensive, directing their anger and hostility at the interviewers, making the interview situation strained and difficult. A further constraint was that the questionnaire was quite narrow and directed for such a sensitive subject. While sensitive to all these issues, the overriding feeling of the interviewers was that respondents, with reputations to uphold, were not going to open up from such a defensive position and this was reflected in their often very guarded responses. Clearly research that is directed at such uncomfortable subjects as white racism and discrimination and that has attempted to uncover varying degrees of guilt and shame associated with this, is difficult and often frustrating. One of the ways to overcome

these problems in any future research of this nature might be to use in-depth life history interviews, where more time can be taken in establishing relationships and exploring a wider range of topics. However, if anything has emerged from this research project it is that forms of discrimination remain deeply embedded within our society and that the privileged position of whites in the old order still tends to be taken for granted. From this perspective it is even more imperative to continue research of this nature in order to foster a much greater awareness of these issues.

Chapter 6: Current experiences at UCT – perspectives of black, female and disabled staff members

1. INTRODUCTION

The Faculty of Health Sciences, in line with current policy at UCT of employment equity, is taking steps to redress the composition of its staff and students with respect to race, gender and disability. This research on everyday experiences of black, disabled and women staff in the Faculty forms part of a programme of transforming institutional culture.

UCT's efforts to redress the composition of its staff include the appointments of a Transformation Officer and equity representatives on selection committees, research to reconcile past injustices, impacts on the HSF, and institutional innovations to create awareness about diversity of cultures at UCT. These changes have posed complex challenges for the HSF. Other challenges include revising old traditions and practices to find new criteria for making appointments, finding new ways to nurture and mentor staff in professional capacities, and exploring new work and social arrangements. Furthermore, these changes have challenged the institution to re-examine established ways of teaching, to develop new role models and to inculcate new values. At UCT, these concerns have been linked with international, national, economic and social development goals and transformation has been made obligatory by recent policy developments.

2. PROBLEM IDENTIFICATION

The HSF has embraced the position that equity is inseparable from excellence. The Faculty has accordingly set out to make its training as accessible as possible to a wide range of talented individuals, reflecting the diversity of its students and staff (Employment Equity Audit and Plan 2001). The Faculty has taken its staff profile into account and is seeking ways to include and maintain staff from the designated groups[i].

This research project forms part of the activities of the Transformation Office. Its aims are to investigate institutional culture, and the social, historical and personal factors that hinder employment equity and transformation. It is informed by the low numbers of staff in academic posts from the designated groups (in particular black and disabled staff) in senior positions; low numbers from these groups among applicants for promotion; the small number of women in academic posts especially at senior level; the slow advancement of black staff; and the rapid turnover of the few black staff that are employed.

Figures quoted in the employment equity and audit plan for 2001 illustrate the extent of the disparities in staffing and a huge under-representation of black and disabled people in the HSF. In terms of race, Africans are severely underrepresented with the largest concentration in junior research positions (59%). There are no African men in senior posts. Black men occupy 5 % of posts, and African women 9%. Of the 46 professors[ii] there are 9 of colour. These figures may have changed slightly since the 2001 audit. Most Coloured men and women on the staff are found in administrative posts as departmental assistants or in administrative support jobs. White women comprise the bulk of the staff, but are outnumbered in senior positions by white men by a ratio of 3:1.

Staff members with known disabilities totalled 52.

The quantitative data highlighted the need for further research, particularly into the subjective experiences of staff members from designated groups. This data would complement the quantitative data.

By comparing staff responses, the researcher will be able to identify some of the ways in which the institutional culture, personal, social or historical factors may perpetuate or redress inequity, and to make suggestions as to how institutional culture may be changed to support Transformation objectives. The research would amongst other strategies inform and directly contribute to the process of formulating employment equity plans and their implementation.

The results will also be useful for the formulation of policies around career development and nurturing academics and support staff from designated groups.

2.1 The Researcher

Salma Ismail, a lecturer in the Centre for Higher Education and Development (CHED) carried out the research. This study follows on from previous research done on staff's experiences of institutional culture at UCT in other Faculties. This work forms part of CHED's supportive role to Faculties in institutional development and transformation.

2.2 Research Aims

1. To record accounts of everyday experiences in various aspects of work such as teaching, research, technical, administration and support, as well as in the social aspects and institutional culture of the HSF. To explore how staff from the designated groups make sense of their experiences in the HSF and to place these experiences in a historical context
2. To capture in particular the experiences of the above staff in the HSF who view discrimination as an obstacle, and to explore with them their experiences in the HSF.
3. To identify barriers and obstacles to the designated group's career development, as well as existing and potential factors which might facilitate their development.
4. To recommend policies which will encourage employment equity, and the retention and career development of staff from designated groups.
5. To formulate the recommendations based on the findings into policies that will form part of the HSF mission statement/constitution.

2.3 Target Group

Staff were chosen from the designated groups in academic, administrative, technical or other support posts in the HSF in June 2001. This included staff on temporary contracts and on joint Western Cape Provincial Administration and University posts. In addition to the main target group, Heads of Departments were included for interviews in order to complement the views of the primary subjects.

3. ETHICS AND PROCEDURES

The researcher explained the aims, purpose and possible outcomes of the research in all the data gathering procedures and assured participants of confidentiality.

Throughout this report, care has been taken to remain faithful to the expectations of confidentiality by not using specific direct quotations that could identify participants. The original quotations from which the inferences can be validated are in the possession of the researcher. Generic comments that cannot be linked to a particular participant have been included verbatim.

The interviews were recorded and transcribed with the permission of the participants.

All data from the interviews were kept in a secure place by the researcher during the research period, and at completion, were securely stored with the Transformation Officer. Access to these records was given only to the researcher, Transformation Officer, Portfolio Manager and interviewees who wanted to view the transcription of their own interview. In addition, participants were offered the opportunity to read their interview transcriptions and to give feedback on the draft results before the report was finalised.

4. VALIDITY

Research ethics as outlined above were strictly adhered to and participant checks were used to avoid errors of interpretation. Validity in this type of research does not refer to the confidence with which one may generalise, but to the authenticity of the data in representing fully the perspectives of participants. The usefulness of the data is in its illumination of perspectives, rather than in its representivity. However, participants in focus groups and individual interviews were selected with particular reference groups in mind.

5. METHODOLOGY

To elicit information on everyday experiences a qualitative study was required.

The research design, methodology, data presentation and report followed the constant comparative method as recommended by Glaser and Strauss (1967) and Maykut and Morehouse (1994). This method was followed because of the sensitive nature of the data and the possible impact the data may have on equity policy. Other sound reasons for using this research method are that, "This method was followed as it derives data and propositions which stay close to the research participants' feelings, thoughts and actions as they broadly relate to the focus of inquiry. This method is both illuminating and challenging" (Maykut and Morehouse: 126-127).

Methods of investigation were by focus group and semi-structured individual interviews. Email interviews were conducted when participants wanted to participate in the study but could not leave their offices or the time schedule was unsuitable for them. The study elicited and compared personal perceptions from particular groups of staff.

The interviews varied from one hour to one and half-hours in length. This timeframe allowed the interviewer to establish rapport and to establish a climate of trust.

5.1 Analysis of data

Interviews were recorded and transcribed and the data was collated into different themes/patterns. Themes were identified from the data using the constant comparative method. This form of analysis is well-documented (see Glaser and Strauss (1967) and Market and Morehouse (1994)). Data from email correspondence, telephone calls and themes in the literature review were included.

Connections with different themes will be made and summarised into suggested policy recommendations for integration into the constitution/mission statement of the HSF.

5.2 Data Collection

5.2.1 Sample

Purposive sampling was used, stratified by gender and race. The initial invitation to participate was posted by the Transformation Officer in the HSF on the electronic notice-board. When too few people responded to this invitation, a random selection of staff members from the designated categories were invited to participate by telephone/email. The sampling frame was drawn from the employment equity database for the Faculty. Heads of departments (HODs) and senior academics were invited to individual, semi-structured interviews and were selected for being key members of the Faculty. Criteria for being "key" was that they had many years of experience of the Faculty, represented a missing category in the sampling frame, and have engaged in issues of Transformation in the Faculty.

The views of senior staff on the experiences and difficulties faced by persons from the designated groups was intended to complement that of the participants, and provide insights into policy options and strategies available. In some instances, participants required further follow up after the interviews. In these cases, telephone or email correspondence was used.

A total of 22 staff members from the designated categories participated in the focus group interviews; nine senior staff including HODs participated in individual interviews. Three email interviews and two informal conversations with senior staff were held.

Focus group interviews (FGIs)

The focus group interviews sought in-depth knowledge of the target group's experiences. Five focus group interviews were planned and held using an interview guide schedule with the designated categories of staff. In most of the focus group interviews, academic, technical, and administrative and support staff were present.

All White Women Interview

In this interview, 3 white women; two academic staff at Lecturer level from the same department and one technical staff member from another department were present.

All three were in permanent posts and had been at the university for more than 3 years. The two lecturers held joint posts.

All Black Women Interview

Present were two black women academic staff members, both at Lecturer level, one who had recently progressed from a development post into a lecturer's post but who was still on contract, and the other in a 3 year contract development post.

All Black Staff Interview

Present in this interview were 6 participants; two black women academics recently appointed at junior level, two (African) black male staff members appointed at junior research level in contract posts, and one senior and one junior administrative staff in permanent posts.

All Black Male Interview

Present in this interview were 3 black males. One was a post- graduate researcher employed on contract, the other two were joint appointees, one a senior administrative staff member in a permanent post who had been employed in a joint post for more than 3 years, and another support staff member recently appointed in a permanent post.

All Women Interview

Present were 8 women: two academics at Lecturer level in permanent posts, three administrative staff members (one on contract and two in permanent posts), one junior technical staff member in a permanent post, and one white woman in a senior administrative permanent post.

Individual interviews

Disabled Staff Members

A focus group interview had been planned for disabled staff. However only one staff member responded to the email invitation and it was difficult to identify other staff with disabilities in order to invite them to individual interviews. One white woman was interviewed in a permanent support post at junior level.

Heads of Departments (HODs) and Senior Academics

Nine individual interviews were planned and held with senior staff including HODs and acting HODs, heads of divisions, senior academics and senior researchers.

On some occasions in this report HODs and managers are referred to interchangeable. It should be noted that this is a new term for HODs and that besides HODs senior academics and researchers often have management responsibilities. These interviews were guided by an interview schedule. All the participants had been at the University for a very long time, mostly more than 12 years, and all participated or had participated on selection committees and ad- hominen promotion committees. Some had also participated in meetings concerning the restructuring of the HSF and some had been involved in the design of the new undergraduate MBCHB curriculum.

In this group of senior academics there were:
Four women, one black woman (HOD) and three white women (one of whom was a HOD).

Two white male HODs, and two black males that were prominent senior members in their respective departments. No African males in senior positions were interviewed. It was intended to interview Professor Dumo Baqwa but he died tragically before the interview could be held. Because there was no senior African manager in the HSF at the time of the study, no African male in management positions could be interviewed.

One white, senior, male staff member who is very active on selection committees and ad hominen committees in the Humanities faculty was interviewed. The main purpose of this interview was to compare and review selection and ad hominem procedures in the HSF faculty.

These interviews did not focus on a particular individual staff member's performance or credibility. Instead, they tried to solicit general views on institutional/personal barriers that hinder change and identify facilitative factors that encourage change.

The issues explored in these interviews related to the recruitment, retention and advancement of the staff in the designated categories

Email Interviews

Three interviews were done by email. The participants were emailed a set of questions from the interview guide. They generally responded to these questions in detail and did not add any other information.

Participants included one senior black male, one senior female academic who had been in the Faculty for more than 10 years and one black senior administrative staff member who had been in the faculty for 2 years.

Informal conversations

Two informal conversations took place with two white male HODs who have been in the Faculty for more than 12 years. The participants were informed of this research and could not participate formally, as they were preparing to go on sabbatical leave but wanted to voice some concerns and opinions.

Total: 22 staff members from designated categories, 5 focus group interviews,
9 individual interviews, 3 email interviews, 2 informal conversations

Table 1. Summary of Composition of the Interviews

	Academic	Technical	Support	Admin.	Academic Senior	HOD/ Manager	Junior Researchers	Disabled
White Women	2	1						
All Black Women	2							
All Black Staff	2 (female)			2 (female)			2 (male)	
All Black Male	1		1	1				
All Women	3	1		4				
Individual					2 (female)	2(female)		1(female)
Individual					2 (male)	3 (male)		
Email	1 (female)			1 (female)		1 (male)		
Informal Conversations					2 (male)			

Membership of the interviews

It appears that junior staff members felt comfortable with the focus group interviews and welcomed this forum in which to air their views, whereas the senior staff preferred the individual interviews. No senior academic from the designated categories responded to the invitation to participate in a focus group interview, and only one senior administrative staff member participated in these interviews.

To some extent the profile of the participants in these interviews reflect the general staff profile in the HSF. Black women and men present in the FGI were in junior academic or research posts or administrative positions. HODs and senior staff preferred to participate in the individual interviews.

Another issue of interest was that all participants stressed the need for the utmost confidentiality, and they sought the researcher's reassurance on this during and after the interviews.

The non-participation of senior staff in the FGIs and the insistence on confidentiality by all staff was different to the researcher's previous experience when undertaking similar research at UCT in other Faculties.

5.3 Methodological issues

- Data from the Employment Equity Office (EE) may not reflect the most recent staff profile in the HSF, and it can be difficult to obtain data on the number of disabled staff and their location in the Faculty from the EE Office.

- Although the set number of focus group interviews were held, the number participating in each group was lower than anticipated and was often not the optimal number for FGIs.

- The political categories used for distinguishing staff provided by employment equity policies produce its own tensions and contradictions. One example of this contradiction is that staff members in designated categories become stereotyped and are seen as victims or people to be acted upon. Their individual identities are subsumed by the assigned categories and agency is taken away from them. Perhaps in future equal opportunities research, in addition to the designated categories, social class needs to be considered as a descriptor to explain or to illuminate hidden power relations and the slow progress towards change in institutions.

- Initial sampling was by volunteering and when too few people came forward, random sampling was used. Because of the two different sampling methods used some of the data collected from individuals would represent genuine individual feelings and opinions or staff have recounted "critical incidences" which might not be generalisable to a designated group. The data are therefore presented without the intention of widespread generalisability to the Faculty, but rather to provide depth of the data contained in successive employment equity reports.

6. DEFINITIONAL ISSUES

6.1 Institutional Culture

Institutional culture refers to traditions and practices, often deep- rooted, operating at both social and professional levels that have become the established norm in an institution. Ways in which institutional culture can be captured is reflected in the physical and administrative arrangements that enhance or detract from individual and collective progress. These include the amenities provided and the nature of the physical surroundings.

Institutional culture includes the ways in which various groups within the institution interact or avoid interaction with each other (including the extent to which others perspectives are taken into account), and individual's personal perception of the institution as a comfortable working environment. Also included is how people experience the physical surroundings, administrative arrangements, employment practices interpersonal aspects and academic culture of the Faculty.

Expanding on this definition, the task team on gender equity added language, ceremonies such as graduation, sexual and racial harassment violence, recipients of honorary awards, religious and political tolerance, outreach and extension services.

6.2 Race

This is a classification system of African, Indian, and coloured (collectively black) and white used in the EE Act and which aims to allow redress of past discrimination under apartheid. It is used here because of the aims and purposes of the study and is not used in any derogatory way or for discriminatory purposes.

6.3 Gender

In this study, gender is understood as a social construction. Sexual orientation of staff is not taken into consideration. However, account will be taken of staff 's experiences of unfavourable or favourable discrimination due to sexual orientation.

6.4 Class

The Employment Equity Plans do not take into account the category of class. It is assumed that the redress of class inequality is subsumed by race, as these two categories are so closely linked in South African society. This assumption may have to be reviewed in the future. However, we will explore the issue of class in the group interviews even though we haven't selected groups on this basis.

6.5 Career

The term career is typically used to indicate general developments in occupation over time and it is also used to refer to patterns of events in a life; which incidents should be construed as progress or retreats or digressions.

7. LITERATURE REVIEW

This review discusses career advancement for the designated groups with regard to equal opportunities legislation, it suggest a critical reading of definitions such as career advancement and merit as well as careful scrutiny of the institutional culture. It identifies institutional, historical, personal and social factors as barriers to advancement within academia. The literature also draws on a previous study into staff experiences of institutional culture at UCT. Some of the recommendations from the literature on addressing more balanced equity ratios and career advancement for the designated groups suggest redefining the institutional culture, setting new goals for organisations and a redistribution of power.

The literature review has taken into consideration the changing context of the HSF as described in the introduction of this report. There is a huge amount of material on this subject both internationally and nationally. In the international literature, various debates of transformation in higher education have been pursued as well as statistical case studies showing trends in employment patterns. The primary focus of the national literature reviewed was case studies of institutional transformation or else a statistical representation of change in staff profile in previously white institutions.

7.1 Experiences of employment equity legislation

The literature pertinent to this study was reviewed taking note that the profiles of the staff in the HSF remain overwhelmingly white and that the posts at senior level are mostly male. However the changes in student composition reflect a greater diversity.

Apartheid polices created huge inequities in the training of medical professionals, by excluding black students from the majority of medical schools. For example, between 1968 and 1977 the proportion of medical graduates in South Africa who were African averaged 3% (Tobias 1983: 136).

Thus training institutions that were formerly White institutions (UCT included), have actively sought to recruit black students. The first African students were admitted in 1986 in the HSF at UCT, and by 2000, first year students totalled 184 of whom 36% were African and 65% black (Dean's Circular, HSF-UCT, August, 2000).

The literature reviewed confirmed accounts that showed that trends of employment patterns in the HSF (see problem identification) reflected worldwide trends. This research showed that in many universities (North and South) white males dominated the hierarchy and while white women have moved to the top this has been a slow process (Morley: 1996 and 2001, Walsh: 1996, Kettle: 1996, and Heward:1996 and Coker: 2001).

One explanation offered for this continued trend (ibid.) is that the status quo has been maintained because the power relations have remained intact, and it is these power relations that underlie the stubborn resistance of senior positions to change. Power is maintained through old networks, social class, institutional culture and forms of assessment. For example, senior academics control the career aspirations of their peers and junior colleagues by evaluating intellectual outputs, theses, papers, books, research applications as well as work performance. It is suggested that in any understanding of the career progressions of academic professionals, one would need to understand these processes of evaluation.

Other theorists argued that one would only see change in management positions when the strongest anti-discrimination measures are taken, viz. reserving posts for staff from the designated groups (Rao and Stuart: 1997).

Further explanations for the continued skewed trend in employment patterns are that equal opportunities legislation was reluctantly managed and did not address the institution of hegemonic masculinity. Management had failed to address power relations and rarely provoked action to change. These views were also echoed in a previous study at UCT in which participants said that employment policies were in place but there was limited accountability to implement the policies and were perceived as "window dressing" (Ismail 2000).

Many authors caution against the view that a diverse student body would translate in future years into a more diverse staff composition (Morley and Walsh: 1996). This view holds that any increase of the numbers of women and blacks or disabled at the bottom would automatically yield a greater number of them at the top.

They argue that this view is fallacious, as access and participation in the system was based on current policy set within, and therefore likely to reinforce, the existing hierarchy. These policies masqueraded as equality, and claimed that there was nothing social about the purpose of Higher education. Participation in the system had failed to secure advancement as it reflected and reinforced an implicit vertical progression, which remained self-referential and exclusive. Once black staff had gained access into higher education, their participation and upward progress was entirely dependent on individual achievement. The ideology that each person should make it on his or her own terms was strong and masculine and secure, and therefore a systematic approach to nurturing and mentoring was avoided. (Heward 1996)

These views were also expressed in the previous study quoted (Ismail 2000) in which black academics felt that the student diversity had not translated into a change in staff profile and that black staff in senior positions were not effective as they had very little decision making powers.

A more radical view to the above is presented by Jane Thompson (2000;10). In her view the challenge presented by widening participation in Higher education "is not about helping the socially excluded into higher education, it should not even be thought of as a system designed for an elite or to accommodate a wider selection of the population in the interests of meritocracy. Rather, it should be about developing a sustained critique of current rhetoric. Such a critique should develop a distinctive social theory of knowledge derived from a politically committed analysis of theory and power, which result in a pedagogy that was concerned to democratise knowledge". This view poses a challenge to Higher education that goes beyond rhetoric and pragmatism, reclaiming social purpose and standing for a newly democratic settlement in Higher education.

The writing suggested that the advancement of equal opportunities with regard to the employment and advancement of women and black staff members has proven ineffectual, because it is based on a deficit model of women's and black people's careers.

7.2 Barriers to Career Advancement

The literature suggested a critical reading of definitions. Many interviewees in this study expressed a similar sentiment. Many of these definitions derive from a male oriented approach to advancement and are associated with an institutional culture that prioritises a liberal philosophy and advantages certain social classes. The unchanged interpretation and meanings associated with these definitions also assists in reinforcing and maintaining the current situation.

Morley and Heward (1996) suggested that the current definition of **career advancement** privileged men and disadvantaged women, as upward progress required special attributes which included self-confidence in intellectual ability, self-advertisement in making a reputation, and networking. This is equally true for black staff.

The work ethic, which is macho and fiercely competitive, with the top priorities being to publish and to acquire lucrative external funded research money, created the perception that when one was at work you were not concerned with family. This

perception, it was felt, needed to change, as women despite being at work are still the primary carers of the family. Working relationships needed to include this aspect in addressing gender inequality by for instance changing meeting times more suitable for women, and to include support when women with families were away on study leave.

Women's problems with promotion are associated with domestic responsibilities, which are ameliorated with career breaks, and crèches.

Therefore a linear perspective for understanding careers is too limiting to describe women's career patterns, which are characterised by diversity and flexibility with periods out of the labour market, part time, temporary or occasional teaching.

Women and men have different biographies and make different life choices.
So too do black staff, they have different life histories, and therefore identities, which are different to their white counterparts. Recognition should be given for ideological differences as well as material constraints in career choices. Black staff gained entry into the higher echelons on an individual basis and some who would have liked to actively change the culture of the organisation found that their efforts were frustrated as the structures which excluded them in the past continue to exclude them.

However, not all black staff entered Higher education to change the structures of exclusion. They had different aims; often their aims were merely to become part of the professional group (Morley and Walsh 1996).

Evidence from a study of successful women and men academics suggested that seeing yourself and being seen as academically able was an important feature on which successful careers are built (de La Rey1997, Heward and Morley 1996). So too were self-confidence, and a positive evaluation of their own academic ability from the outset of their career. Other features of success were; encouragement received from peers early on in careers and qualifying with a good doctoral degree. These tested significant for future success. These studies suggested that the relation between self-confidence and perceived ability was problematic for women and black staff

The literature recounting the experiences of older women in higher education reported that older women perceived that there is a powerful "culture of youth" which sits alongside a "contempt for old age". This discourse of ageism makes it seem natural to appoint men or sometimes younger women in management positions" (Maguire 1996: 24). They also express the view that in this age of redundancy there is a discourse, which asserts value of age for selection, and this needed to be revealed (Maguire 1996: 24-26).

Disabled women in Higher education often became invisible, and were seen as dependent and passive. They were seen as recipients of charity as the academy was there to preserve the life of the mind.

Other socially constrained factors, which affected career advancement included:

- Women were more aware than men of making a choice between following a career were and raising a family; women were more tentative in career plans;
- Women experienced conflict between choices, as well as conflict between femininity and a career as this choice was seen as a selfish choice. They became stereotyped as "women who behave like men" or have the "Queen bee syndrome".
- Self-confidence, being assertive and self-advertisement were seen as anti feminine.

According to the literature, "it was well known that the main currency in the academic profession was **REPUTATION** (Heward 1996: 19). This was a conscious process of self-advertisement. The judgements of senior eminent members of the academy were highly significant, as they were the "gatekeepers". Making a reputation therefore posed problems for dominant understandings of femininities and female sexualities.

For black academics making a reputation means that you have to be particularly outstanding and even then you are not allowed past the glass ceiling. Progressing into senior management was dependent on ideologies and the institutional culture of the academy.

7.3 Facilitative factors

The literature identified some facilitative factors, which contribute to advancement: these were **networks of contacts** and **mentoring** within the academic community. These became increasingly important in middle and later stages of academic careers. Patrons and informal networks were crucial in determining who was invited to apply for posts and who was successful. It was through the informal networks of subject communities that the values by which members of the academic profession were recruited and promotion was sustained. The values of the gatekeepers of these networks were mostly conservative.

Geographic mobility was essential for networking, but women with families are often not as mobile as men or single women. According to the literature, men benefit more than women do as they are usually invited for such appointments, while women have to seek them out.

The literature suggested that the concept **merit** be re-examined in the context of equity and transformation. Since this concept underlies staff selection and promotion procedures, and was seen by many as a universal and an objective measurement.
In exploring different meanings of "merit" the following views were expressed:

- That this concept should be defined more closely and should not parade as equality; and that it should be acknowledged that merit included personal favouritism (rank favouritism) or admitting a personal friend.
- Furthermore, one needed to be aware of contested meanings of this concept.

The literature suggested that merit be defined in terms of what an institution was trying to accomplish, i.e. permitting students to benefit from educational diversity and addressing long-term societal needs.

According to Bower and Bok current policy (1998: 275-290) should not exclusively focus on qualifications, as these were not the only means of measurement. Other qualities such as hard work, effort, ability, family circumstances, early upbringing, quality of education received and knowing strategies to get ahead should also be considered as these contributed in later life to professional development.

7.4 Recommendations from the literature

Bower and Bok (1998) recommended that the rules should change over time as circumstances changed and as institutions learnt from mistakes. Institutions should engage with networks of social and community relations, which underpinned people's ability to engage in education, training and work and to sustain a healthy civic community.

The literature recommended that a way forward was to link goals identified from the designated categories to organisational goals and to use these goals as lever with which to work. Mentoring and nurturing programme should start from where people, were and strategies should be negotiated as there was no blueprint of mentoring that would be suitable to all staff, and that all staff should view themselves as change agents and not leave change up to management to implement. This view on staff could help to bring silent voices to the fore.

The key conditions for **nurturing** include reciprocity, trust, and exchange of information and support a willingness to take on responsibility for service.

HODs/managers should not focus on a single purpose and on one course of action to achieve this purpose, as was demonstrated by the current policies on advancement in which staff were identified as rational and the only aspect valued was the intellect. They should take into account that staff also operated on intuition, emotions, and ego, that individuals are complex. That staff was conscious that people were motivated often not so much by intellect or merit, but also by status and power. Staff were aware of the practice of power and this was often expressed in questions as to who controlled information, sources of funding and who was invited to the inner circle of power.

The literature recommended, "Power should be distributed and seen as energies for change". That difference should be viewed as a potential resource. Uniqueness should be seen as a valuable asset rather than a constraint. Each strategy for change should be grounded in an understanding of the deep structures of the organisation, the

monoculture of instrumentality, the importance of the work-family split, and an understanding of power as control (Rao and Stuart 1997: 12-16).

8. RESULTS

The researcher identified the following themes from the data. Most of the themes are interspersed with relevant quotes from the data to give voice to the views and opinions of the participants.
The themes are: Institutional Culture; Recruitment and Retention of Black Staff; Career Progression; Personal Instances of Discriminatory Practices; Reasons for Black Staff Leaving and Perceptions of Change.

8.1 Abbreviations used in the presentation of the data

White women academic/ administrative/ technical/support (wh-w-acad/ admin/ tech/supp)
Black woman academic- administrative/ technical/support (Bl-w-acad admin/ tech/ supp)
Black male academic – - administrative/ technical/support (bl-m-acad/ admin/ tech/ supp)
White male academic- - administrative/ technical/support (wh-m-acad/ admin/ tech/ supp)

There are very few black staff in senior management positions or HODs and this made them easily identifiable, therefore these categories were abbreviated as (sen).
Where race or gender is not specified in the data e.g. staff, this implies all staff both black and white and all genders and of all abilities are included.

8.1 Institutional Culture

8.2.1 Academic Culture

Black staff members expressed general feelings of alienation and isolation. Feelings of isolation were strongly felt by staff on joint posts. Staff in junior posts felt that there was no caring concern for them. There were very few staff meetings or social gathering in which to meet other staff. The restructuring had decreased opportunities for socialisation as the “departments have grown too big to manage”.

> *Last week I lectured, the first years, on upper campus and the venue had changed. There is always a problem with the venues. I was probably going to go to the wrong place. So I went to the venue. There weren't first years*

there, so I had to phone the department and ask them where the right venue is. Then I thought: Do I use my cell-phone or do I go and use one of UCT's phones? So I thought, you know, if I was at my previous workplace it would be nothing for me to walk into any ward and say: "Can I use your phone? because I'm a staff member". But here I have to think about it because I don't feel part of the institution. And then I thought: I'm actually going to try and use UCT's phone and say: I am a UCT staff member (bl-w-acad).

White women expressed similar sentiments regarding loneliness, isolation, low participation rates in meetings, people not trusting each other and the competitive nature of institutional culture. They also commented on the absence of beautiful social spaces. They felt that institutional preoccupation with saving money and not attending to social and emotional needs downgraded the positive work experience.

The disabled staff member felt that people were wary of the disabled, but not in a nasty way. She found moving around the HSF campus a nightmare and so tended to stay in her own work environment. This meant that she remained invisible to the rest of the community.

The work ethic was gender driven and fiercely competitive. One had to be mobile (to take advantage of research and study leave) and work an 18-hour day. Life was work driven and the top priorities were to publish and to acquire lucrative externally funded research grants.

And I keep on saying: "I can't do this job unless I can work at home at night." And I think that's what's helped me in the last two years that I work at home. I mark or I do reading or I write or whatever, I work at night. And now that I have a baby, I can't do it. It really frustrates me that you can't do this job unless you can work extra hours" (Bl-w a).

New black lecturers felt scrutinised by white staff and students. These lecturers also felt that they were given menial tasks and acted as assistants. If they were the only black staff in a department, then they also had to prove themselves to the white

administrative staff. Some black lecturers believed that administrative staff would initially view them with suspicion and refused to "service" their needs.

> *The secretary was expected to do some work for me. And, you know, she just acted very, very strangely and very bossy, and made weird, "off" comments. She was actually quite offensive. She was actually very rude to me in the beginning and I thought it was a racial issue. Obviously she knew, that I thought her behaviour was really inappropriate. When she realised after a while that I'm actually not a threat to her, I'm actually a person with a nice personality, she simply changed (bl-w-acad).*

Overall the academic culture eroded black and women's staff confidence and self-perception.

> *If you going through a process of negation every day of your life here at UCT, it can erode your confidence. You get to a point where you say," must I open my room", I'll close it and I'm not going to be told that is stupid or something. You get a lot of paternalism and you feel, why must I open my mouth. If you going through that on a daily basis, eventually your confidence erodes (bl-w a).*

However there were pockets of staff within the HSF who experienced a more positive academic culture. These staff members experienced much sharing of information, even conference spaces and air tickets, and time was made for social activities and staff celebrated each other's achievements. In these instances the HODs supported activities. These HODs valued collaboration, encouraged social activities and emphasised that these rewards were the result of many hours of hard work by their staff.

In another exceptional instance, the staff in a particular department were encouraged to work in teams, not to gossip and they were trained in interpersonal skills and group work as well as resolving individual conflict. This philosophy of building relationships was transferred to their teaching plans.

HODs and some senior staff expressed different opinions about the need to change the institutional culture. Some of them felt that overall the academic culture was not problematic, they felt that there had been many changes and that emphasis on individual achievement was the ideal formula for the success of the institution.

8.2.2 Networking

New networks were being developed along gendered or racial lines. For some staff, they did not exist at all. This situation reinforces a historical precedent in which networks were racialised, gendered and class based – a typical and much quoted example is the "Old Boys' Network".

Initially black staff tended to find it difficult to build up their own networks and they often went outside the university to find collaboration for their projects or research interests. They felt that change here was slow and they had to pioneer the way for other black staff. A very significant finding was that they were opposed to forming a black staff association, as they wanted to feel part of the UCT community.

8.2.3 Interpersonal communication

Women and black staff felt that it was difficult to participate in meetings, or to air opposing views. Other factors which influenced participation, were language, age, cultural differences and self-confidence.

> *So I'd rather not go to that meeting, not say anything. I can give ideas and get ideas because there's definitely a culture of people knowing each other, and then you come into that hall, I actually hate it. I think I told you. I just hate the way people come in and they all know each other, so they make their little jokes and stuff and you sit on the side and you don't know who to make conversation with or what to make conversation about because they're from completely different backgrounds to what you're from. (Bl-w-acad).*

> *You need an enabling environment to speak up. Most meetings are dominated by a few Professors. Most people have the feeling that what they want to say is not worth saying. It's a skill that has to be learnt. (w-w-acad*).

Some meeting times were unsuitable for most women with families, as they were either at 7am or after 5pm. Many women who were mothers felt that it was very difficult to be a good mother and advance at the same rate as their peers.

Black administrative staff felt that senior academic staff and doctors were rude to them, communicated with them in an offhand manner and did not trust them with responsible tasks. Their more senior white counterparts undermined them and did not give them major responsibilities, withheld important information and left them uninformed of important meetings or the whereabouts of the HODs.

> *The academics don't have a good manner of approaching you. Just because you are an administrator, you don't have to accept rudeness. I mean to me it's like how can someone treat me like that, and expect me to accept and they apologise like saying okay I know I made the fault. You have to accept their behaviour, not complain about it (bl-w-admin).*

> *She's been with the department 11 years and the HOD didn't even know who she was. (bl-w-admin).*

> *I'm not surprised because I worked here since '93. I probably spoke to 20 people. (bl-w-admin).*

> *So they're saving money and getting money and getting grants and things like, you know that's fantastic for the department, but you know I don't think it filters down into caring concern for the staff. Are staff happy? I mean if you're happy with your going overseas 6 times a year and your 2.5 million research grant and things like that, then you don't really* ***do*** *the slides, the interactive search. (wh—w-tech).*

Some senior staff and HODs felt that socialising in people's homes was a good idea and that these social occasions would inform staff of the diversity of their colleagues but felt dissuaded from doing so as they felt it could lead to embarrassing situations.

The restructuring had some positive impact on interpersonal relations, brought together staff from other disciplines; staff got to know about each other's context and work.

> *I relate the restructuring to the curriculum process, and that has brought us together. I think personal relations sometimes can be problematic. I don't think men are necessarily good at interpersonal relation;, women are better. I mean that's acknowledged. The changes that have occurred within the faculty has thrown a number of us together. We wouldn't perhaps have ordinarily found ourselves moving in larger families, so that has been positive (wh-w-acad).*

> *I think that is extremely important in this process of restructuring that there is a shared understanding about the way people communicate and what is acceptable and what is not acceptable, what the lines of communication and authority are. I mean, I think that is fundamental (wh-w-acad).*

However, this process was also fraught with fears: expecting too much from the new curriculum, fears of job losses and fears of not being able to cope with present workloads which sometimes threatened to erode positive working relationships.

> *One of the things that people has said in the re-structuring is that they feel they are loaded more, there is more work to do and they feel that whatever internal cultures such as working in teams are established, it would be more difficult to maintain now and would undermine inter-personal relationship;, you know, things like that. (wh-w-acad).*

> The teatime breaks at 10am and 3pm were criticised as social rituals belonging to a white colonial era or another generation. This finding was also cited in previous research into staff everyday experiences at UCT (Ismail 2000).

> Some staff members felt that these breaks should not be used to celebrate all occasions including birthdays, special achievements and farewells.

They felt that alternative ways of celebrating different occasions should be considered as not all staff drank tea nor did everyone take their breaks at those set times and staff were so conditioned in their interactions at these occasions that they did not mix and remained in their separate cliques.

8.2.4 Working arrangements

Technical staff felt that they were not valued, as often they were not acknowledged in research papers or publications. They often assisted in many research projects by allowing academics time for their research, took on teaching duties, made the slides, obtained information from the Internet, captured data and set up the laboratories for experiments.

Technical staff felt that they were very far down in the hierarchy and therefore felt powerless to complain or enter into grievance procedures.

> *Because you're a technical person and not academic, you cannot complain, you dare not complain. There is a total lack of communication higher up. (w-w- techn).*

Technical staff queried the policy, which stated that they could not apply for posts that were two pay classes higher than their present posts.

There were some HODs who were very supportive and had strategic plans which were helpful and guided staff.

Staff at all levels felt that restructuring had overloaded and overwhelmed them while others were not clear how this process had developed. Because of the outsourcing and restructuring, some staff felt that no supportive structures had been put in place to help them with added administrative duties, and cleaning and tea duties.

> *We are Toilet paper fetcher, examination venue set upper, audio visual fixer, the messenger, runner, photostater. (w-w-acad).*

There were no clear guidelines to differentiate between secretarial jobs and senior administrative jobs.

8.3 Career Progression

8.3.1 Professional development

White women felt that middle and top management structures were already filled and top- heavy and very few vacancies were forthcoming.

The stress on formal qualifications disadvantaged technical and support staff. They did not want to return to long years of formal study. They felt that their knowledge and skills acquired over many years had to be recognised in upgrading their posts. They said that there were no incentives, e.g. financial or guarantee of upward mobility, in their careers to persuade them to embark on a formal study route.

> *Investigating how I can get into that position or having myself upgraded into that faculty, I've been told that you need a degree to get there and I know from other secretaries that they do not have a degree and there is always some blockage. I know from experience that the work I'm doing is in line of an Admin Assistant. (bl-w-admin).*

Junior academic staff claimed they didn't have access to or were not receiving the same information about research funding. They were dissuaded from applying for research grants while white staff members were privileged in this regard. These staff members also voiced experiences of senior white staff openly saying that they wouldn't mentor or share information with black staff as they (white staff) were being disadvantaged by equity policies.

New researchers felt that it was unfair for them to compete for research funds with consultants and more experienced senior researchers.

> *I would like to start by saying that with regard to controlling information and access to resources we are handicapped by example, if you are told up front that you cannot apply for funding that was made available for research for the entire department, and everyone else applies and you are told not to*

apply then that excludes you, and you start to wonder well, why was I told not to apply, or why when information about possible research funding becomes available it's only given to certain people in the department and suddenly everybody else is wondering what happened; does everyone actually know about it until somebody actually gets the research award. (bl-w-acad).

"Attitude of the senior white staff is very mediocre. People who have been here for years are afraid and they will come out and tell you, I'm not going to impart my experience, my knowledge to you so that you can go further in your field" (bl-w-admin).

Black staff felt that different criteria in terms of qualifications were required of them. They had to have higher qualifications at entry level and had to prove themselves all the time, and were given more work than their white colleagues. Historically white staff entered with lower qualifications and were also promoted faster once they were selected into the academy.

The amount of workload that's placed on you in the department is incredibly high. The white person in the department who has a PhD gets promoted to senior lecturer because she was promoted in terms of developing her research, so then with active promotion from the HOD she has the opportunity and space and time to start her research, where with me I have so many departmental activities that I have to be involved with so that there is no time for me to do research. So then in that sense not only am I not told about research opportunities that comes up, (funding and that kind of stuff) I'm also not given recognition for the work that I do in the department because that's the kind of work that you don't get promoted for, that's the kind of work that holds the department together so the goal post has changed .But I think in most places in the world you need to have a PhD as a minimum requirement, but in the S African context you see if the requirement for you to have a PhD but not for somebody else, but somebody else is never another black person. (bl-w-acad).

Administrative staff and Technicians felt that there was no programme in place to upgrade their skills in particular computer skills. These skills were learnt piecemeal from postgraduate students.

Academics involved in local issues and publishing in local journals were overlooked and did not enjoy similar rewards to those publishing internationally.

White women expressed the sentiment that they never felt sufficiently confident or felt that they were not good enough. These negative feelings made them put off applying for promotion.

Some white women felt that their schooling socialised them into passive stereotypical feminine roles, and therefore they did not think of taking on management functions.

8.3.2 Orientation and mentoring

Younger and new black women members of staff felt that they were not properly orientated to the academic context, there was no identified quantifiable workload, they felt insecure and lost confidence when they did not meet goals. In comparison to new white staff, young black staff felt they had more tasks. This stunted their programme of research and formal study.

> *When I started on the first day this was my introduction: "This is your office and this is your work description, and, okay, goodbye." And then I had to find my own way to do everything. I had to find out what the infrastructure is within our division, within the department, within the faculty. I had to actually find that out all on my own. I think, in a sense, that for me it was problematic that I wasn't orientated, you know, properly. Or whether that's a divisional, departmental, faculty or university responsibility, I actually don't know. But I think that's something for them to think about (Bl-w-a).*

> *I just remember I studied at UCT so I knew the building, but when I came in I didn't know what was expected from me as a lecturer. I knew what some of the expectations were, but it wasn't clear and people kept saying: "You learn by osmosis". And that's really true. You just have to pick up and you learn as*

you're going along. So that was anxiety provoking because you don't know what it is that you are supposed to know. And you feel stupid. (Bl-w-a).

White women HODs felt that their careers had suffered since they were not part of the Old Boy's' Network and on entry did not understand which academic contributions were valued. They learnt this through bitter experience. They felt they were nurturing and mentoring staff to their own career disadvantage. Generally, women felt that this role was expected of them because of their gender.

It took me a long time in this faculty to realise that I had not been part of the Old Boys Club, is a very subtle thing. It is not that there was very much evidence of exclusion of intention, but the nurturing that colleagues did to one another and the way in which they promoted one another and the guidelines which they shared were unknown to me. It was not because I was intentionally excluded, but not having the same framework myself, I never knew for a very long time that I was not part of it (wh-w-acad).

I had complete autonomy, no support, because people, said, "well we don't know what is your involvement or what your issues are", and no mentoring, no understanding that what I was doing was contrary to my own professional development. So when I started meeting up with people from overseas during a first. My first experience was during a sabbatical in 1994, which was the first sabbatical I have every had where people who had heard me talk, said, but where have you published this? And I said that it was not documented, but why not, you know. Then I started to realise my mistake. So I have put in place the kind of guidance and mentoring that I myself never had (wh-w-acad).

8.4 Reasons for Black Staff Leaving

8.4.1 Institutional barriers

Young black staff were not given the opportunities, nor was a career path made visible to them.

"I think also with young people when you really don't lay out clear opportunities for them, then they become frustrated and then they also look

at the environment and also they look at the other older black members of the staff and they see that really things here move slowly. Why should I stay whereas outside there could be other offers, and I think that is what happens. In my department we lost 2 young people who were really very promising, 2 black members. (bl-w-acad).

I believe it's one of the big difficulties, which our youngsters face, so there is their debt, if that could be forgiven. Okay that might go somewhere towards remedying them to take the less well-paid academic route (wh-w-acad).

The institutional culture eroded their confidence, was alienating, stereotyped them, and did not see career advancement and working relations were strained.

Our HOD was saying all the time she was supporting young black academics, but really when you capture it in terms of where they are, how they are feeling, you find that they are alone really feeling very unhappy and very frustrated and at the end they left us. (bl-w-acad).

They come to the meeting and never say a word and they are disempowered by the system. They get to a position where they never say anything and afterwards when you talk to people you realise how many people supported your position but in that forum they're not able to say that; they come to me afterwards and say I really admired that you were able to say that I really support you on that, but in that public forum they actually aren't involved. (bl-w-acad).

The system of ad hominem promotions favoured white staff especially those who were published authors with a reputation.

Most deans in departments are still white; it's very difficult to get the upper hand and force the guidelines and policies when it comes to recruiting people and set up a selection committee. They have a way of selecting that they make sure they're getting a white person and making sure to keep the

black person out of that post, raising the criteria for the black person, making it impossible for that black person to reach that criteria (bl-w-acad).

Senior black academics did not advance into key decision making posts and were isolated from the top management structures.

8.4.2 Financial

Students were in debt on completion of their studies and sought the quickest means of repayment

They had to support their own and extended families.

There were more lucrative opportunities in the private sector.

8.5 Personal Experiences of Discriminatory/ Unfair Practices

The following are personal critical incidences of discrimination as perceived by the interviewees. I have not used quotes as illustrations here so as to retain the confidentiality of the participants.

8.5.1 Selection and promotion

1. Black staff questioned the fairness of selection committees; they cited many examples of inconsistencies. Some of committees were not seen as objective but as political. Most of them felt that being represented on these committees was a token gesture.

2. Black candidates who applied for senior posts and were unsuccessful said that they were invited to apply for the respective posts. Their experiences of this process were very negative and they felt that this exercise was used by the university to justify its selection of candidates, whom they felt had already been selected prior to the selection process.

3. Black staff were not necessarily fearful of applying for ad hominen promotions but would have liked to be given an explanation and possibly counselling when they did not receive the award. This applies to job applications and other awards.

4. Time spent on selection committees and equity and transformation committee as equity representatives were not highly regarded and could not compete with publication counts.

5. Senior black academics felt that the Dean had not used opportunities to change the profile of top management as he had not selected and supported them onto positions of top management. They felt that the Dean had surrounded himself with the "old guard" and has thereby kept the status quo intact.

8.5.2 Research and teaching

1. Publications were prioritised above other criteria.

2. Junior staff members were not aware that certain reading places were allocated for doctoral students and therefore were not able to claim a reading space in the library.

3. A senior white woman staff member complained that when she secured funding to undertake research at a prestigious overseas university for a year her, application for study and research leave was turned down. Only after a bitter struggle was she allowed taking up this award. A double injury was caused when this achievement was not acknowledged in the Department's records.

4. Women who presented their research were undermined openly in public forums. This dissuaded other women from participating in open forums.

5. White and black students questioned new black staff members about their qualifications and their teaching abilities. The black staff members related this to their age as some of them were young and others felt that they were questioned because it was a new experience for white students to be lectured in departments where the teaching staff has remained largely white. Most of the staff members did not like being singled out for questioning about their professional abilities and qualities.

6. An example of a black student who questioned her examination marks. White lecturers marked her examination scripts. She took it up firstly as unfair discrimination as a white student with a similar academic record passed his exams. But later, on being told that the white student passed because he worked much harder than she did and he was more intelligent, she pursued a charge of racism.

7. Black administrative staff felt that academic staff did not respect them, and did not see them as responsible and accountable. They feel this is evidenced in these ways; academic staff did not return audio-visual and teaching equipment on time, nor did they take safety measures such as locking up equipment or returning keys to the correct places.

8.5.3 Recruitment

1. Many black staff voiced suspicions surrounding job advertisements. The most common suspicions were that; firstly, the time given to respond to adverts was very limited, which limited the time of exposure of the advert and therefore attracted few applications; and secondly, administrative jobs were often advertised as half-day jobs, which over a short period of time became full time posts. They felt that this was a strategy used by the university to employ white female staff. The explanation offered for such a strategy was that black female staff would not be attracted to such a post because the income would not be sufficient to support a family.

2. Age discrimination was cited in job applications. Staff gave examples of competing with older applicants for posts and promotions and felt that the older applicants were not successful because of their age.

8.5.4 Grievance procedures

Some staff members who had taken up grievance procedures recalled the following experiences:

1. When they were given no reasonable explanation for not receiving a post and they were the only black candidates who met all the criteria. Less qualified white

males were given the posts. They found it difficult to institute grievance procedures, as the opposing candidates were now their HODs who had to oversee the grievance procedure.

2. When a senior white academic staff member went into a process of conflict resolution because a junior black staff member accused her of racism, she felt that all the responsibility for a fair resolution was placed onto her. She had to set up all arrangements such as arranging the meetings and making sure that they had the meeting. She felt that she had lost the energy to do this and the whole resolution process petered out. She advised that the HR officer should manage the process, arrange the meetings and have debriefings after each meeting.

3. Black administrative staff felt that they were subjected to offensive behaviour from academics and are sceptical of instituting grievance procedures. Examples recounted were being subjected to insults, shouted at, almost being spat on and being accused of taking white people's jobs. In some cases the HOD witnessed this behaviour but did not act responsibly and reprimand the staff member, in other cases administrative staff complained to HODs who advised that they be tolerant of different people's personalities.

8.5.5 Grievances

1. In one department, white staff had more comfortable social spaces and appliances for making lunches. The staff on this floor was all white whereas their black colleagues had no such facilities. This difference of provision in material comforts was interpreted as racist.

2. Black staff said that they experienced a heavier workload than white staff, and had to be more qualified to reach the same academic levels as their white counterparts.

3. Black staff interpreted white administrative staff behaviour as rude and felt that white staff went out of their way to make life difficult for them.

4. Black staff recounted many experiences where they were asked to account for their time out of the office, while white staff were not subjected to this kind of interrogation. On one such occasion, a black staff member had kept records of the movements of his white colleagues and when confronted again by the HOD for being out of the office he presented his documentation and questioned the HOD's discriminatory action.

5. Black staff recounted many insulting experiences of having their English checked. A common experience was that all letters and typing was checked for spelling and grammatical errors (sometimes in public) before being posted. They found this behaviour discriminating, unprofessional and offensive. They also questioned the explanation (that English was their second language) given for doing a spell and grammar check as immigrant white staff for whom English is also a second language were not subjected to such scrutiny.

6. Black administrative male staff were irritated when asked to do menial tasks by secretaries and HODs like buying lunches, cigarettes, run domestic errands or were asked to make coffee/tea outside the usual tea breaks.

7. When a black administrative staff member queried her low salary, she was told that she could not earn more than her white counterparts even though she had more experience and was better qualified.

8. Black staff were questioned by Campus Control if they parked in staff parking bays.

9. Disabled staff experienced problems with securing suitable undercover parking and had to go through a long bureaucratic procedure to secure such parking.

10. Some HODs could not remember the names of their black staff and therefore ignored them; this has caused untold incidences of embarrassment.

Many black staff felt that racism was still intact but had become subtler. An expression they used was “it has gone underground.”

8.6 Recruitment and Retention of Staff in Designated Categories

The themes emerging from this category were financial issues, historical barriers and institutional barriers.

8.6.1 Financial issues

There were some differences of opinion expressed around the retention and attraction of black staff. Some senior managers felt that this was not a problem particular to black staff, as the financial rewards in private practice or overseas were much higher for everyone. They said that this brain drain was experienced in most of Africa.

Many staff members said that black students had families to support on completion of their studies. This meant that they sought out the option with greater financial rewards.

> *Black youngsters qualify, as do our white and brown youngsters, owing the bank managers a great deal of money. Something to tune of sixty or a hundred thousand rand. In the case of black youngsters, they will be supported, if only morally, by an extended family; the additional pressure is upon them I think, to deliver back to that family. I’m thinking now of a young lady whom I’m hoping will join us as a trainee next year, who would have joined us this year, but came to me and said, please let me continue to function in England because I’m earning so many pounds: I will underpin my family financially and join you next year. So I mean that is all the reality (wh-w-acad).*

> *It may be that when black doctors qualify they have more debt and they have a greater need to pay off these debts and therefore, a greater need to earn more. That might be a factor. I think that I’ve also heard that they have had loans for six/seven years, and if you just continued in the public sector, the earnings really would make it difficult to pay off those debts within a*

reasonable time, so they then get a job where they do locums whatever else, where they earn more faster. (bl-m-acad).

Some staff felt that blacks were at a moment in their history where they could easily access material rewards previously denied to them therefore they preferred to go into private practice.

I think that they've seen that it's very possible to buy a house a BMW, put kids in good schools, that the wife can buy expensive shoes. They going through that phase, cell phones for the whole family, they're going into that; I think soon I hope not as far way as the next generation, that soon people will be seeing that there is enormous satisfaction in academia with the lower salary, without the fancy shoes, and without the BMW. (w-m-acad).

8.6.2 Institutional barriers

Some managers said that academia meant working at night and weekends, and these long hours may be unattractive. However, others said that long hours were not seen as a deterrent as doctors in private practice also worked many late nights, were on call, and it was not unusual for them to work week-ends and during Christmas and New Year. The financial rewards for long hours at work were probably higher in private practice than for academics in public institutions.

Others said that even when qualified black people entered the system, they usually did so at the lowest level and this dissuaded them from continuing at UCT

In our department, we have three development posts, two white young women were appointed and one black woman was appointed and the black woman was at the lowest salary (bl-w-acad).

Development posts[iii] were unattractive to qualified black doctoral candidates.

HODs also complained about the short term nature of development posts, and the difficulty of getting funding for these posts as well as the time and energy spent on nurturing staff in these short term posts.

> *You know, within the context of the university's transformation strategies, my own experience has been in the appointment against a development post. I was successful in eventually achieving the appointment of a full-time position for somebody who went through for three years in a development position, but it was a huge struggle and it took me the whole of that three years to work with the individual and the university to actually secure that post. Now I am on the second round of mentoring another person in a development post, who I am also fighting for, so that when we're finished we get the post. There is no plan in place for that. (wh-w-acad).*

Many senior staff and HODs gave examples of casting their "nets wide open" when recruiting new staff but could not identify potential or good candidates and had to select from an already advantaged category.

> *If you're are actually looking at transformation and equity, if you're really serious about getting in black staff, where are you going to get black PhD's for a lecturers post? (bl-w-acad).*

> *Part of the strategic plan of the faculty should be to fast-track people by getting replacements for them so that people who are poised to do PhD can do PhD and step out of their jobs temporarily. (wh-w-acad).*

Others felt that the rewards of academia were not visible and blacks did not have a long cultural history of learning and teaching in academia.

> *There's something rewarding in teaching the students, energising them and seeing the spark of understanding happen in them, it's a reward, and there's some reward in writing and publishing in researching, to make them hungry for those things, is not easy, one would try to nurture that sort of values, there are those rewards. (wh-m-acad).*

Some staff disputed this reason and felt that many black staff members worked very hard and like in any category there were people who did not pull their weight. Black staff felt that they have to "watch their backs" for fear of being stereotyped.

> *I agree that there are very few black academics in the Medical Faculty. But those that are there and those that I know, I think have fully participated and enjoyed it, otherwise I don't think they would still be here. (bl-m-acad).*

> *I think when a black person is unable to do the job then the reason is that it's because she or he is an affirmative action employee, while when a white person is useless, then it's just that the person is incompetent, so they always put a label on you. (bl-w-admin).*

> *They want you to make mistakes, they are waiting for you and they actually count on you to make mistakes and feel disappointed when you don't. (bl-w-acad).*

One of the mechanisms suggested for identifying and supporting promising black students was to give increased financial support in the form of bursaries. Another was to provide some form of "on the job training" in which post- graduate students could earn a small income by working in the Faculty.

> *I think we've got to identify at undergraduate level the youngsters who we believe show academic ability, show merit, show personality because at the end of the day you got to be a role model, show professionalism, ethical behaviour, integrity and ability to teach, ability to lead that can be apparent with a quite junior stage. I think we have got to identify those young people and before they qualify show them that we have our eyes on them. We've got to validate them and encourage them. (wh-w-acad).*

It appeared that some professions like Surgery were not attractive to women because of the long hours.

Many felt that the medical profession was not an enabling environment for disabled staff.

8.6.3 Historical barriers

Most people agreed that there was no significant pool of black candidates (because of historical circumstances) to draw on and that this required time. This was seen as a long-term project, as time was needed for training, mentoring and identifying such potential academics. It took at least another six years after an initial degree to build up a reputation to advance in academia.

Senior managers were hopeful that the Model C schools would produce a cohort of potential black candidates who would progress in the HSF.

> *We haven't been in the habit in this medical school or other English speaking or Afrikaans medical school of graduating and training black medics, so we have to catch up and to qualify blacks in sufficient numbers. There's another barrier and that is to surface, as an academic requires a minimum of six years. An endeavour you've got to do. You've got to do housemanship, you've got to do your community service year, then you have to probably do a senior health officer year, but that is three years already and then you have to apply to specialise, and specialisation takes somewhere between three and four years typically. (wh-w-acad).*

> *Blacks are not in academic practice because they're out in private practice. I mean, when we were registrars in training, many, many years ago — 10, 15 years ago — I think they had quotas, they had restrictions and there weren't enough places in academia, you know. You had to a white male, Jewish. You had to be a white male, Afrikaner. (Bl-m-acad).*

> *I think the major problem is the small number of black candidates in medicine and this is obvious from, for example, when we were advertising two Chairs one in Chris Barnard Chair cardiac surgery and the other is ENT and there's only one black cardiac surgeon in the whole of South Africa. The reason is that there haven't been sufficient numbers of blacks training.*

So we are advertising the Chair of Cardiac surgeon, and there is one black cardiac surgeon and he is in Pretoria and his not interested because he has an enormous private practice. Therefore there are no African applications. Now what about women? Cardiac surgery all over the world has very few women practitioners it doesn't seem to be a choice. There's one cardiac surgeon working in Cape Town, but she wants to stay in private practice. There is a very small group to lecture ENT. We're lecturing no black ENT people in South Africa and ENT doesn't seem to be a choice for women in UK, US or anywhere else so there's a very small pool. (w-m-acad).

I have no doubt that we are going to produce first class professors down the line, researchers and so on; I have no doubt about that. It's the time factor, where people must go through the promotion process and the training process to come there, that's part of institutional culture (w-m-acad).

8.7 Perceptions of Change

There was lots of discussion on how change was defined, as different staff members had different perceptions of change. Staff who had been associated with the HSF for more than 15 years were in agreement that there had been some change in terms of how the HSF presented itself, but felt there had been no fundamental change. Reasons given for this belief was that there had been no change in terms of attitudes and practices as control was still vested in a small group of people from the "old boy's network" who dictated policy and there was very little input from black staff.

Some of data from the interviews confirmed this view. A HOD said that "the university is an elitist institution and inequalitarian and one couldn't change this; that people confused broadening access with moves to a more equalitarian institution". This, he felt, was a wrong perception, as the university was based on individual achievement and merit, on forming cliques and class determined that collegiality. He added that some changes could be made like making appointment and promotion procedures more transparent and changing the institutional culture to be more representative of the different cultures.

Some senior black staff members felt that being involved as transformation representatives on committees put them at risk. Since there were so few of them, they had been present at almost every selection or ad hominem meeting. This resulted in an overload of work. Their own research was sacrificed and the work on these committees was not really valued. They quoted an example of a senior black male academic that spent lots of his time on transformation and equity issues and was overlooked for promotion.

Black staff said that they tended not to get involved in activities contributing to change as not many of them were specialists yet, and or were involved in their own disciplines. They didn't have administrative skills and hadn't been developed for these roles. They felt that the present leadership should train black academics for these roles with careful guidelines and measurable outcomes. Some staff were cautious and felt that one could not assume that when black candidates were appointed in leadership roles that they would then be agents of change.

Staff felt that people needed to understand what the end- product of transformation really had to be. They felt that there had been insufficient discussion on this vision and a strategic plan was urgently needed.

The Transformation Officer and Portfolio Manager were praised for their efforts to highlight equity issues, and to institute measures of reform. The research on equity issues and in particular the Reconciliation process, the awareness raising workshops, the series of seminars on institutional culture and diversity workshops, were welcomed. The Transformation Officer was praised but there was some critique from junior staff members who were not aware of the appointment and were unclear of the role or the extent of decision-making powers accorded to this post.

9. DISCUSSION OF RESULTS

9.1 Institutional Culture

Most of the black staff members were critical of the institutional culture especially social practices and celebrations, and they welcomed institutional changes.

Black female administrative staff members highlighted interpersonal relations as a key issue. They felt that academics' interaction with them was aloof and often rude, and felt devalued and unacknowledged. They complained that the institutional culture was unfriendly to women as meeting times were not suitable for women with families, their participation in meetings was often little as they were afraid of being questioned and then made fun of or belittled in other ways.

They emphasised the cold individualised institutional culture that undermined working arrangements. Institutional changes such as the mergers overloaded them and strained already weak lines of communication. These changes made them insecure, as their revised job descriptions were unclear. They gave detailed accounts of coping mechanisms (some very sad accounts) and related incidents of being excluded from processes and work within their own contexts.

Most female staff members felt that the institutional culture did not recognise women's nurturing role, that they do more work inside departments and are allowed little time for university-wide recognition (do things such as showing visitors around, making elective students feel at home, mentoring new staff and have meetings at home, making sure that tea is available). Women were also perceived to be friendly and non- threatening and therefore all these domestic roles came to them. This perception of women was also expressed in previous research (Ismail, 2000).

Senior women felt less confident of their abilities and experienced greater social isolation and were very conscious of criticism. They often interpreted criticism as personal and hurtful. Many felt that men would not support them and that to secure co-operation from male colleagues was difficult. Women said that they were not necessarily interested in a culture of risk- taking and preferred affirmative acknowledgement. Some women said they preferred teaching and clinical work to leadership or political roles.

A few women felt that they could not accept management roles without proper support and that men found these roles easier and seemed less put out by criticism and were more confident that their decisions were the best ones. Some women said they

published their work not because they wanted promotion, but because they felt that it was important and they wanted to make it public.

Older women academics said that they felt that younger women were more assertive and had more self-confidence. “Younger people started their careers speaking about career paths and have set goals and seem to know what they want to achieve” (wh-w-acad). Younger mothers also seemed to have more supportive husbands who participated in parenting. Women felt that they needed a support group at home and at work.

Women called for a revision of the organisational culture and ethics to one of recognising women’s strengths and differences.

Opinions on social practices varied. Younger staff members felt that they were excluded from social activities as they did not drink tea or coffee and their favourite drinks were Coca- Cola / fruit juices. Since these were not available during the set tea breaks and most social activities, they had to buy their own. This meant that they then did not participate in these social activities. Staff who came from other cultures where tea was not a regular beverage felt that staff should explore different varieties of cold and hot beverages. This should also be done for other social celebrations.

A few staff members recounted experiences of annual staff and end of year celebrations, which were incorrectly timetabled, as these did not take into account religious practices of other religious groups. Examples given were Ramadaan and Eid.

However some staff also told of incidences where HODs went out of their way to include these celebrations before Ramadaan and Eid and allowed Muslim staff time-off for the Friday afternoon prayers. The Dean was complimented for agreeing to house a Muslim prayer room in the Faculty. Sometimes these celebrations excluded technical and support staff who were in joint posts.

Many members of staff expressed the need for attractive, comfortable social spaces.

9.2 Career Progression

Where career progression is concerned, staff clearly expressed a belief that the HSF needed to implement a clear procedure and system for skills training, mentoring and nurturing staff, and to clarify career paths for support, technical, administrative and academic staff.

There was a strong belief amongst black staff that they faced barriers to advancement either through active discrimination or by an institutional culture that reinforces individual achievement and learning by "osmosis" or subtle forms of closure against them implicit in a discourse of meritorious achievement. That they were overlooked for ad hominem promotions, that the HSF was not serious about attracting, retaining or employing black staff that there was a complacency and self-satisfaction amongst HODs who were resisting changes.

Barriers that hampered career progression were: inadequate access to information on research opportunities, (which included availability of research funds, where to apply, notices of conferences, procedural knowledge of how to apply); language, historical disadvantages, different life experiences, racism, unfair discrimination, overloaded with departmental work, not being orientated to the institutional culture and working arrangements.

Junior black staff spoke quite openly about the bad working arrangements, not being orientated and mentored properly, and therefore not being able to recognise what was expected of them in terms of quantifiable hours of work. They were concerned about the social aspects of work, as their interests were different from more senior staff who often related to them as "teenage kids". They felt that career paths at UCT were very insecure and that the institutional culture favoured young white women.

Concerns raised were the barriers presented to black staff in terms of academic qualifications. They perceived that blacks required higher qualifications to enter the HSF and to progress. They felt that different criteria were applied to black staff in selection committees. They recounted incidences of white staff threatening their career advancement. Other experiences were that senior white staff members were reluctant to pass on their deeper skill knowledge, as they feared that they would b e

training black and women staff who might overtake them in their career advancement. Similar accounts were recorded in Dolny's (2000) experiences of institutional reform in the Land bank.

Three black women related personal experiences of racial and gender discrimination. These incidences cannot be described here, as they would reveal the identities of the participants.

Black men spoke at length about their autobiographical journey into higher education and they felt that this journey had been hard and they were steeled for conditions at UCT. But they felt and, a similar sentiment was expressed in a study undertaken by Jane Castle in 1995 of the career progression of black managers, that the Institution and in particular affirmative action policies " which is about doing something to someone" sometimes made them passive. Their different experiences showed lots of active learning, active in making their own choices and helping themselves and active in making their own lives. These qualities were not taken into account in selection procedures and in promotion for career advancement.

This category of staff also complained that there was still no formal programme for skills training for technical/support or administrative staff in spite of government legislation advising employers to embark on programmes of skill development. Junior black researchers thought it unfair that they had to compete with recognised consultants for research funds.

Some black male staff felt that they have been disadvantaged because white women formed part of the designated categories. White women in South Africa they felt had enjoyed many of the privileges of their male counterparts materially, educationally and economically. They felt that the only category for their claim to disadvantage has been their socialisation into feminine roles and occupations. This disadvantage, they felt, was waning as women status had changed. They felt that white women were privileged in appointments and that it was therefore easy to maintain the institutional culture and values as white women came from the same social classes and cultural background as white men. White women, they said did not appear particularly different to their white male counterparts. Therefore employing white women may

change the gender composition in a Faculty in which white women already constituted 73%, but would not address racial imbalances. Academic institutions, they said, had very deep institutional values, which were maintained by employing and promoting people from the same liberal class base.

It should be noted that the Employment Equity plan has indirectly recognised this issue in relation to lower level academic posts where white women are already in abundance (90%) therefore white woman are not counted as designated groups for target purposes in these posts.

Black members of joint staff recounted discriminatory practices and felt that there was an assumption that the senior staff had the prerogative in deciding when and how they should be rewarded. Staff in joint posts felt insecure in their posts because of the threat of privatisation policies. Many senior staff wanted a formal incentive scheme that recognised and rewarded their mentoring role.

The results indicated that while there was no active discrimination against white women, the acceptance and currency of particular values and beliefs within the liberal tradition make it difficult for women to succeed, despite the existence of formal policies to redress inequalities.

Concerns raised by white and black female staff involved a too heavy workload, especially in relation to the restructuring and outsourcing of cleaning services. They felt that meeting times were gender biased and did not accommodate single parents or women with families. Advancement was curtailed for some academic staff where there were few staff members in their departments and this meant that there was not sufficient replacement staff for others to go on study leave to complete doctoral studies. There was also no recognition for duties that go beyond the average expectations of lecturers.

Data from the interviews suggested that women blamed their poor career advancement on lack of self-confidence, which caused their non-participation in meetings. The relation between self-confidence and perceived ability are important factors cited in the literature for career advancement. The importance of self-

advertisement and assertiveness was seen as anti-feminine. Senior women interviewees said that "Women are called aggressive or taunted when they are assertive or ambitious. One male HOD referred to competent women in disparaging tones as though it was a terrible thing for a women to be". Quite a few women said that they would like to be seen as "nice", non-threatening and "feminine".

A senior white woman academic compared herself to her male colleagues and said that it had taken her 19 years to achieve the rank of associate professorship while her male colleagues usually gained this status in under 10 years. She confirmed that this trend applied to her female colleagues who had taken up posts overseas.

Career progression for female technical staff appeared far in the distance, as there was no alternative mechanism to recognise academic achievements beside formal study.

Most of the administrative staff felt that their careers were retrogressing.
There was some discussion about pay structures, which discriminated against upward mobility. Staff felt that these structures were linked to educational experience alone and that these structures mirrored the hierarchical management structure.

9.3 Working Arrangements

Working arrangements were unclear, especially for secretarial and administrative staff. Restructuring and outsourcing have further clouded working arrangements for all categories of staff.

Black staff were in agreement that where discrimination exists, it is often difficult to prove, especially in the present context in which there is general consensus that differences should be recognised and respected.

In terms of disability, the one staff member interviewed expressed positive sentiments about working conditions but felt like a statistic that UCT used to absolve itself in its affirmative action plans. Apart form one incident of unfair discrimination, which she resolved, she was content with her work and colleagues, and did not at this time think about career advancement.

9.4 Recruitment and Retention of staff in the designated categories

Attracting and training black staff for an academic career was seen by all as a major challenge and a long-term project.

Most of the managers and senior academics felt that the poor equity ratios reflected historical legacies and that the present student profile at UCT and in model C schools would impact on a future staff profile. But they saw this as a long-term project.

However, the literature cautions against this view and the experiences of other black medical schools (Medunsa was quoted) have not shown an increased black academic staff. Factors, which dissuaded black staff from pursuing academic careers, were:
the differential in income compared to the private sector (both inside and outside SA); student debt on qualifying; dependent extended families; self-enrichment; the institutional culture; the lengthy period of study before any significant career progression in academia; and the poor system of nurturing and mentoring for those within the academy.

Another future development quoted was that in a few years time, there would be an increased number of black applicants for academic posts "when the corporate sector became more competitive (because there would be far more black people with credentials) and that those opportunities which present themselves now in government won't be there in a few years time" (wh-m-acad). Others added that this could be a possibility if the government could stem the brain drain from both its black and white graduates.

Most of the black managers attributed their own success to personal attributes. In some instances they mentioned a particular HOD who took an interest in their careers.

Some managers felt that a systematic developmental programme should be implemented for all posts-graduate students (specialists). Others felt that HODs needed to identify particular potential students and groom them for academic careers.

A senior white academic felt that "we have got to identify at undergraduate level the black youngsters who we believe show academic ability, show merit, show

personality and before they qualify show them we have got our eyes on them, we have got to validate them and encourage them". (wh-w-acad)

At issue was the undergraduate and postgraduate curriculum which, according to some managers, "does not emphasise scientific training and this makes it difficult to build a good cadre of scientists and researchers".

Some HODs said that black staff did not realise how much hard work it took to become a successful academic, that it was not a nine to five job and that there were many sacrifices of time. One HOD said that white male staff members were not necessarily privileged, as they didn't get to the top only by being privileged or belonging to the "Old Boys Club" but also worked very hard. He inferred that a learning culture of teaching, studying and reading amongst black staff was still being cultivated and that black staff often felt entitled to career advancement without putting in the necessary hard work. Many blacks staff members who felt that they worked much harder than white staff contradicted this view.

Some HODs felt that the issue of retention should be on the agenda of the executive team. They said that the "cabinet" lacked a transformation perspective and therefore there were very few issues of transformation on the executive's agenda. Many staff were of the opinion that careers in medicine for disabled staff were severely limited due to the nature of work, as it required "all your faculties".

9.5 Impact of the Restructuring on Equity and Transformation

There was divided opinion about the benefits of restructuring of the faculty and the appointment of a black dean. Some HODs felt that the restructuring of the faculty had brought together different departments without adequate resources and this could disadvantage some units within department. Managers/HODs have been given more administrative duties without adequate support; they had to be both managers and academics at the same time. At the same time they had to teach, write, publish and fundraise and some of them had clinical duties, resulting in the sacrifice of academic duties like publishing.

They felt that the university was expecting too much management from people who were not trained managers, and needed to separate management functions from clinical and research functions. They felt that all these extra functions undermined their ability to focus on equity and transformation issues.

Some felt that the work on designing a new undergraduate curriculum, brought different people together and made staff members aware of each other's expertise, and informed staff of different teaching methods and forms of assessment.

Two senior members expressed the view that the undergraduate curriculum did not train scientists as it emphasised practitioner training. They felt that this curriculum should also influence career options towards more scientific options. Some felt that if students exited from the MBCHB early on, then a scientific orientation could provide a possible option for career advancement.

A HOD said that because of the financial cuts in staff and in research funding, the opportunity for the registrars to spend time in the laboratory was not there anymore, and that this further undermined encouragement to train black staff as researchers and scientists.

Some HODs and senior academics felt that the Dean had done a very good job in the restructuring and was generally emphasising equity issues and playing an important role in bringing together a diverse staff.

Others, however, criticised the Dean for not including senior black academics in his team and felt that the Status Quo had remained intact. They gave examples of themselves being high achievers in research with excellent academic records, the ability to attract huge sums of funds for research and to manage large research projects, yet being overlooked for meaningful participation in research committees or the inner circle of senior management. They outlined clear ideological differences between themselves and other managers and said that lots of window-dressing was happening without real change.

Some felt that the Dean was an outsider. He had no previous personal experience of working within UCT. This they said may be problematic, as he did not fully understand the transformation process that needed to happen at UCT.

Staff in all the categories felt overloaded by the restructuring and was fearful that no support structures would be put in place to assist them with their added duties.

9.6 Mentoring and Nurturing

Staff questioned equal opportunity policies that focussed only on individual merit, as this assumed that the institution had fair structures and policies. They felt that individual merit was fraught with assumptions and advantaged those who were historically advantaged. They felt that candidates' potential and other personal qualities should also be considered in selection committees. The criteria for evaluating a candidate should be specified as exit level criteria rather than entry-level criteria measured often candidates.

There appeared to be different views on nurturing and mentoring. The traditional system of spotting potential students and mentoring them for professional development was very strong. But many were in favour of working towards a system wherein each individual was mentored and nurtured to his or her capacity. This idea was gradually gaining support as it related to capacity building of a team of people rather than on one individual. These new work arrangements are in tandem with a neo-liberal economy.

Staff said that those who mentored and developed more junior staff should be acknowledged for this work in their performance appraisals.

9.7 Selection procedures and Ad Hominem and merit awards

In this section the views of a senior white staff member who was interviewed because he is very active on selection committees are taken into account. The main purpose of the interview as discussed earlier under the composition of interviews was to compare and review these procedures across the two Faculties

Many staff members were suspicious of selection procedures, promotion and merit award procedures, as well as of the constitution of these committees. It was said that these processes were controlled by small cliques of senior managers that representativity was a token gesture and that equity considerations were not prioritised in selection of new candidates.

Some staff members felt that workshops were needed to explain these processes and to assist staff to apply for these awards. They felt they needed workshops to explain norms and expectations and also practical matters such as putting together Curriculum Vitae (CV).

Some managers felt that staff who came in at entry level were highly qualified and therefore should not require assistance with applications such as applying for funding, applying for merit awards, ad hominem promotions and preparing a staff profile for annual review.

However, a different view was held by some HODs, who felt that they had a pastoral role to play and should guide staff through procedures for selection and promotion. They empathised with the fears that staff had about these processes.
HODs felt they had to advise staff whether they were under-stating or overstating their case and make known the benchmarks against which staff were being measured. HODs also advised staff when to apply for promotion and gave advice as to whether they should focus on teaching or research.

They felt that generally staff used their peers as a reference group to judge themselves.
This process, it was felt, had little to do with intellectual capacity, as they were difficult areas for people to deal with.

"There are anxieties about applying and they are not confined to any one group of people it's a human thing. Anxieties relate to exposing yourself, exposing your career, and putting yourself up for evaluation by some anonymous committee that sits there in judgement upon you. And is critical of you. Nobody is comfortable with that thought. It's a very demanding procedure and candidates have to put in a lot of

documentation. For some people this may constitute a deterrent. It is an important procedure and it's very important that the committee who assesses does this on full documentation" (wh-m-acad from Humanities).

In comparing, these procedures across the Humanities and HSF the common views expressed are discussed below. Sometimes candidates did not present themselves well because their portfolios were not put together properly. There was a wide range of applications. Some HOD's were very active in supporting candidates, encouraged them to go through the process, and were supportive in the oral presentation of their candidates. Where there were problems with applications there was often special scrutiny and the committees often erred on the side of the candidate when they thought that the candidate had not received fair treatment and discounted negative messages that they received from problematic HODs.

Generally, the members of the committees listened very carefully and critically to negative comments by HODs, as they would not like an individual's assessment to be affected by personal preferences of favouritism or feuding.

The constitution of the committees was very important and academics on these committees were often of the highest calibre.

> *All were very forceful, nobody was a push- over and there was no mission leader (wh-m-acad).*

Some senior staff conceded that at times an opinion expressed by a powerful HOD or Dean could sway decisions.

It was felt that every applicant was given a thorough consideration. The HODs felt that the perception that committees are of the old guard still held currency, "because it's a perception that is enduring beyond the reality and because one is sitting in judgement on a person's life and career" (wh-m-acad). Decisions were very confidential.

Accusations that there was window dressing in applicant procedures by ensuring that committees were representative of all staff categories as well as the profile of candidates were refuted. Managers pointed out that no quick decisions were made and it was not easy to be selected or to receive an award as committee members asked discomforting questions.

9.8 Perceptions of Change

Generally most people were positive about the changes in the student profile, the new curriculum which was more inclusive especially of the Allied Health Sciences and welcomed changes in staff profile to reflect equity.

10. CONCLUSION

Overall, staff from the designated categories expressed concern about the institutional culture of UCT. Their everyday experiences were not positive.

Institutional transformation was an imperative for them in terms of career advancement, addressing historical imbalances and removing discriminatory practices. They identified barriers such as the institutional culture, discriminatory practices and personal flaws. They have made the following recommendations to ensure a healthy working environment which they and the researcher hopes will be implemented and will assist in improving and enhance the working environment in the HSF.

Many of the recommendations are similar to those arising from previous research into staff experiences of institutional culture across all Faculties at UCT (Ismail: 2000). These recommendations require urgent and serious scrutiny both from the equity office and from the Hods and senior staff in the HSF. It is imperative that the Faculty implements a systematic programme based on the above recommendations if it is serious about changing its staff profile.

The biggest obstacle identified from the literature and the data to advancement of black staff is social class, but this factor has received little attention because the overriding category to explain the slow pace of transformation has been race. These two categories, race and class are intertwined in South Africa's history. It is therefore

recommended that more attention and further equal opportunities research take into account the category of social class.

The establishment of fixed categories in the equal opportunity policies, according to Morley (1996), reifies and essentialises social groups. The focus on numbers and fixed categories of designated groups needs to develop, but with this we have to bring back social class as an analytical construct and develop an analysis which explores the intersections of class, race and gender relations.

Social class, she claims, had a widespread but quiet usage across all educational levels.
Facilitative factors identified in some parts of the HSF were: strategic plans which guided staff with clear measurable outcomes; a programme of orientation for junior staff; nurturing and mentoring for all staff; redefining the definitions which required assessment the example given was merit; a clear programme of skills development and training and an outline of a career path; movement towards a collective team approach to work; encouragement of social activities and changes to forms of social activities.

In summary, no single, simple barrier to the advanement of black & disabled staff members could be identified. Instead, the obstacles are complex and multifaceted and include personal, social historical, and institutional barriers, and in particular the power and authority of senior managers to influence access to executive positions and thereby to positions of power and authority.

This is the second time that the author is researching the impact of institutional culture at UCT on the lives of its staff. I would like to express the **hope** that this social "research can confront and act upon oppressive structures and provide possibilities for change" (Morley: 1996; 136).

11. RECOMMENDATIONS

11.1 Equity policies

a. Issues of Transformation such as recruitment and retention of black staff must be a standing item on Faculty Board's agenda.

b. UCT should lead discussions and debates on definitions of merit, mentoring, nurturing so that these terms can be re-examined and redefined in the new context of redress and equity. It is also important that the definitions are disseminated and specific steps are taken to implement them.

c. More prominence should be given to the job, role, tasks and powers of the Transformation Office and Officer.

d. Equity polices must be reviewed to assess their implementation and to refine appropriate implementation.

e. The Faculty's strategic plan should put in place equity policies at all levels, which includes divisions and departments. These plans should address transformation issues.
Individual departments and divisions also need to develop their own strategic plans and objectives.

f. HODs and senior academics should be held accountable for the implementation of equity policies.

11.2 Institutional and Organisational culture

a. Workshops should be held for all staff to create awareness of cultural differences as well as people's behaviours and feelings and how these affect other staff members.

b. Social gatherings should be used as opportunities for staff to meet new members and to break down isolation. Social gatherings in staff 's homes can also create social spaces for breaking down cultural and class barriers and allow staff time to appreciate staff diversity.

c. Interpersonal communication and interaction between staff members of different rank and cultures should be professional and respectful.

d. Review meeting times to take into account women's family responsibilities. This recommendation is applicable to men as well who take equal responsibility for parenting.

e. HODs or the Dean should secure the most convenient parking for disabled staff. It is noted that it is the hospital administration, which has authority over parking at Groote Schuur Hospital therefore the Dean, should take responsibility in instances when parking is outside the authority of the HOD.

f. UCT should build physical structures, which are user friendly for disabled staff.

g. The Human Resource manager/officer should play an increased role for ensuring that conflict between staff is amicably resolved and not leave it to the individual staff members to manage the entire process.

h. The HR manager or the Dean should oversee grievance procedures when a staff member is contesting an appointment in which the HOD was also a candidate.

11.3 Recruitment and Retention

a. Extend nurturing and mentoring programmes to undergraduates with the aim of developing young academics. These programmes should include "on the job training" and financial support.

b. The post-graduate curriculum should be reviewed with the aim of making academic and scientific careers attractive to black post-graduate students.

c. In appointments there should be clear criteria for selection, which are known to all the candidates.

d. Selection and recruitment policies should be reviewed to assess whether affirmative action legislation has been considered before making appointments.

e. In selection and recruitment procedures the following criteria should be considered in addition to the EE legislation criteria.

- To take account of a candidates' history and experiences.
- To prioritise equity considerations, especially if candidates have the potential for development and whether they can be nurtured into posts.
- To consider qualities such as hard work, ability and family circumstances.

f. Posts should be advertised for a longer period and the recruitment office should caste a wider net to recruit staff from the designated categories.

g. Senior black professional staff should be recruited to create role models for black staff.

h. The Transformation Office should explore more short opportunities for developing black professionals such as fellowships or learnerships[iv].

11.4 Career Progression and Support

a. Formal orientation, nurturing and mentoring programmes for new staff should be developed to allow for individual growth and professional development.

These programmes should include the following aspects:

- Include white academics as they have expressed a similar need for development and their inclusion would stem white resentment and insecurity, as they may perceive these programmes to favour black staff. Their inclusion would also ease black suspicions that blacks are treated as special cases or inadequate.

- Be flexible, as a standardised programme may not be suitable for all staff.
- Mentors should not patronise black and women staff and make them passive recipients. These programmes should have a balance between nurturing and

ensuring that black and women staff are given the appropriate level of responsibility and are active in their own learning.

- In the case of the HSF many of the mentors would probably be white as there are too few black staff in senior positions to provide enough role models, these mentors it was felt must be willing and able to confidently discuss and challenge issues of race and racism.
- Mentors should be sensitive to the mentoring relationship, avoid stereotyping and keep in mind that mentoring is only one mechanism for aiding professional development and may not be sufficient on its own to overcome barriers to progression.
- Senior academics and HODs should participate in these programmes and share experiences on their own career progression and be prepared to talk on how they were mentored, their fears and expectations and how they overcame hurdles in their careers.
- "Mentees" should have meetings in which they reflect on the process and link their learning with the learning of the organisation.

b. A more proactive approach should be taken to research mentoring. Staff made the following recommendations;

- Inform staff of conferences, seminars and other public places in which to present their research and assist staff in accessing this information.
- Inform and advise staff of funding for conference attendance and research.
- Introduce publishing opportunities and advise staff on how and where to publish their research.
- Introduce staff to networks and offer meaningful opportunities for participation

within these networks.

- HOD's and senior researchers should AS POLICY, routinely undertake sharing of funding opportunities with junior staff and collaborate on projects to develop research expertise.

c. Leadership and management training should be instituted for staff from the designated categories and how to mentor staff.

d. HODs should be trained in management skills, as many of them are academics with very little management experience.

e. Workshops should be held for staff to explain application procedures for ad-hominen promotions, merit awards, performance appraisals and new posts.

f. The ad- hominem process needs to be demystified, be made more transparent and staff need to be informed where to find the information to encourage more applications from black staff.

g. Staff who do not receive promotion, merit awards or notch increases should be counselled. In this regard, staff need to be given clear reasons for "failure" and be given adequate support in their following applications.

h. Time spent on the activities listed below should be considered in the evaluation of performance reviews, ad-hominen and merit applications.

- nurturing and mentoring roles
- work on transformation committees and issues
- departmental work which improve the functioning of departments
- duties that go beyond the average expectations of lecturers such as welcoming visiting lecturers and ensuring that they have a positive experience

11.5. Resource Issues

a. The Employment Equity Office must provide greater clarity to HODs and staff on the following:

- the relationship between development posts and permanent posts,
- how to access funding for development posts,
- consider increasing the number of development posts
- decrease the administrative work attached to secure funding for development posts
- how to provide incentives for HODs to promote such posts.

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b. Replacement funding for black and woman staff whom intend to further their studies.

c. Larger financial incentives and paid study- leave for support and administrative staff who wished to upgrade their skills.

d. Enhance the working environment by providing attractive, comfortable and welcoming social spaces.

e. Increase the number of posts in departments in which staff are performing multiple roles with huge teaching, research and clinical responsibilities.

11.6 Further research

a. This study raises a number of questions that would benefit from more research attention. One such study could investigate the generalisability of the findings in this report, for which one would require a quantitative study with a representative sample.

b. A second study could evaluate the extent to which the above recommendations were implemented and a further study could evaluate the impact of the recommendations on the everyday experiences of staff in the HSF.

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Endnotes

[i] Designated groups is a term used by employment equity legislation. This group includes all black staff, women and disabled staff.

[ii] In South Africa, it is common for most academics of any race or gender classification not to reach professorial level. Concentration of professorships in relation to total number of academic staff is relatively small.

[iii] Development posts are posts used as a mechanism under equity policies to provide postgraduate training to black academics.

[iv] Learnership is a new contractual relationship between employers and the Department of Labour. It came into effect in October 2001 and ends in 2006. In this contract employers are encouraged to give staff time off for further professional development/study at higher learning institutions. The direct benefit to the employer is a tax deduction of R25000.00 per person on entry and on completion of study.

Chapter 7: Conclusions and Recommendations

"Let today embrace the past
with remembrance
and the future
with longing."
Khalil Gibran, The Prophet

Other than broad macro-level analyses (Kotter, 1996), relatively little work has been done on developing models of organisational transformation at institutional level informed by empirical research. This project has been amongst the first of its type to address this issue in a systematic way, drawing on a wide base of disciplines, and surveying a varied range of participants. Despite the varied methodologies, certain common themes emerged from all the sub-studies in the project.

- Black students experienced various levels and manifestations of discrimination while at UCT. By acknowledging this discrimination, UCT will enable recognition of their experiences to take place so that reconciliation may be possible.

- Despite experiencing hurtful discrimination that adversely affected their learning opportunities and careers, black alumni still generally recognised many positive aspects of their training, including the presence of outstanding individuals who acted consistently in the best interests of their students, irrespective of their race. Many black alumni retained a level of loyalty and

goodwill toward the institution which enabled them to express strong support for UCT's transformation process.

- Given the historical context, as an institution, UCT could be simultaneously opposed to apartheid as well as reinforcing apartheid's discriminatory practices. This explained many of the ambivalent or contradictory views expressed within and between individuals reflecting on UCT's past.

- An enabling environment, that recognises diversity and that values all members of the University Community is critical to transformation. Exclusion took place not just in the academic field but also in social terms, and the latter was as powerful in replicating disadvantage and discrimination. For this reason, it is critical to build an ethos that values all staff and recognises their human potential into all teaching, research and service in the faculty, along with structures, policies and practices that enable those most at risk to discrimination to develop successfully in their careers. In particular, mechanisms that foster an institutional culture more affirming of all individuals, and nurturing of women, black and disabled staff, should be priorities for future institutional change.

- Human Rights and respect for dignity should become a central part of the Faculty's activities. Moreover, reconciliation will be best acknowledged through concrete actions that promote human rights and diversity and counter

discrimination and prejudice. For many alumni, practical progress in this regard will be the most important marker of reconciliation.

However, it is also clear that the research conducted under the Reconciliation Process generated considerable resistance, particularly from white staff and alumni, whose disengagement took many forms, ranging from indifference to contempt. Notably, there were also black alumni who voiced open hostility to the process of reconciliation, and were suspicious of attempts at reconciliation seen as false and lacking real redress. Nonetheless, there were many respondents whose participation reflected a willingness to grapple with issues of transformation, and the breadth of the research has placed transformation firmly on the Faculty agenda, in a way that will be difficult to displace or ignore in future.

Recommendation to emerge from the Research

1. Equity policies

a. Issues of Transformation such as recruitment and retention of black staff must be a standing item on Faculty Board's agenda. Equity polices must be reviewed to assess their implementation and to refine appropriate implementation.

b. UCT should lead discussions and debates on definitions of merit, mentoring, nurturing so that these terms can be re-examined and redefined in the new context of

redress and equity. It is also important that the definitions are disseminated and specific steps are taken to implement them.

c. Transformation should become a responsibility not only at Faculty level but also at the level of divisions and departments. HODs and senior academics should be held accountable for the implementation of equity policies. Training to support Equity Policies should draw on the findings of this research in providing empirical basis for the intended objectives of the policy strategies.

d. Student intakes and admissions policy should be consonant with ongoing student support and mentoring practices to ensure black and female students are not disadvantaged in the course of their progress. Active participation of students in the planning, monitoring and evaluation of these programmes is critical.

2. Institutional and Organisational culture

a. Diversity should be addressed at a level where working and social relationships can better incorporate and value cultural differences. This may take the form of workshops to create awareness of cultural differences as well as people's behaviours and feelings and how these affect other staff members; policies that mandate professional and respectful interpersonal communication and interaction between staff members of different rank and cultures; greater awareness of the role of social gatherings as opportunities for staff to meet new members and to break down isolation.

b. Many of the university's operations require participation in activities that force choices between commitments to family and personal life, and to academic activities. Wherever possible, such requirements should take into account women's family responsibilities (e.g. review meeting times; conference commitments; teaching times, etc.) This recommendation is applicable to men as well who take equal responsibility for parenting.

c. Disability should be elevated to a core consideration in planning in the Faculty. For example, parking and physical structures that accommodate disabled staff must be planned for.

d. Human Resource procedures and policies, particularly relating to handling of grievances, should be reviewed and adapted to ensure sensitivity to issues of race and gender discrimination.

3. Recruitment and Retention

a. Nurturing and mentoring programmes for under- and postgraduates are critical to developing young academics. These programmes should include not only academic aspects but a holistic view of the difficulties and opportunities experienced by students. The post-graduate curriculum should be reviewed with the aim of making academic and scientific careers attractive to black post-graduate students. Senior black professional staff should be recruited to create role models for black staff and students.

b. In appointments there should be clear criteria for selection, which are known to all the candidates. Posts should be advertised for a sufficiently long period to ensure a wide net to recruit staff from the designated categories. Procedures should be in place to ensure that appointments comply with Employment Equity policies, and that such policies result in effective implementation. Selection and recruitment procedures should address more criteria than just those mandated by legislation:

- To take account of a candidates' history and experiences.
- To prioritise equity considerations, especially if candidates have the potential for development and whether they can be nurtured into posts.
- To consider qualities such as hard work, ability and family circumstances.

c. The Transformation Office should explore more short opportunities for developing black professionals such as fellowships or learnerships[i].

4. Career Progression and Support

a. Formal orientation, nurturing and mentoring programmes for new staff should be developed to allow for individual growth and professional development. Such programmes should include all staff (including white and/or male appointees) as they have similar needs for development, and their inclusion would reduce stigmatisation and stem perceptions of favouritism. Such programmes should aim to be flexible, adapted to local context and to the particular staff member, and avoid patronising

black and women staff as passive recipients by enhancing their active participation and responsibility in learning.

b. The faculty should invest in research and development of a mentorship program that is able to balance support with enhancing the agency of mentees, in ways that avoid stereotyping, and will be sensitive to the racial and gender imbalances existing in the faculty already. Senior academics and HODs should participate in these programmes and share experiences on their own career progression and be prepared to talk on how they were mentored, their fears and expectations and how they overcame hurdles in their careers

c. Active steps towards mentoring in departments include:

- Inform staff of conferences, seminars and other public places in which to present their research and assist staff in accessing this information.
- Inform and advise staff of funding for conference attendance and research.
- Introduce publishing opportunities and advise staff on how and where to publish their research.
- Introduce staff to networks and offer meaningful opportunities for participation within these networks.
- HOD's and senior researchers should AS POLICY, routinely undertake sharing of funding opportunities with junior staff and collaborate on projects to develop research expertise.

d. Leadership and management training should be instituted for staff from the designated categories and how to mentor staff. HODs should be trained in management skills, as many of them are academics with very little management experience.

e. Workshops should be held for staff to explain application procedures for ad-hominen promotions, merit awards, performance appraisals and new posts. The ad-hominem process needs to be demystified, be made more transparent and staff need to be informed where to find the information to encourage more applications from black staff.

f. Time spent on the activities listed below should be considered in the evaluation of performance reviews, ad-hominen and merit applications.

- nurturing and mentoring roles
- work on transformation committees and issues
- departmental work which improve the functioning of departments
- duties that go beyond the average expectations of lecturers such as welcoming visiting lecturers and ensuring that they have a positive experience

5. Resource Issues

a. The faculty should review and, as appropriate, adapt the procedures relating to development and strategic equity posts in the context of promoting Employment Equity. In particular, attention should be paid to the relationship between development

posts and permanent posts, and career pathing. ; accessing funding for development posts; incentives to promote such posts

b. Other mechanisms requiring resources include replacement funding for black and woman staff whom intend to further their studies; better financial incentives and paid study- leave for staff who wish to upgrade their skills; enhancing the working environment by providing attractive, comfortable and welcoming social spaces

c. In many departments, particular staff perform multiple roles with huge teaching, research and clinical responsibilities. This raises the difficulties of staffing and posts, and the need to ensure enough posts to enable development to take place.

Future Follow-up

As a result of the research, a Special Faculty Assembly was held on 9th May 2002, at which the Faculty acknowledged its history, both of perpetuating discrimination, as well as enabling individuals to resist apartheid, and committed itself to redress of past inequalities through programmes that promote human rights, respect for human dignity and affirm diversity amongst all its staff and students. The Assembly adopted a new Faculty Charter, and a Student Declaration to this effect, and the research recommendations are being fed into the Faculty's ongoing programme for Transformation and Equity.

The research has thus fed directly into concrete steps taken as part of institutional action for redress within the Faculty's Transformation programme. This will be reinforced by the integration of the research findings in revised modules on human rights and ethics to be integrated into the new curriculum, and by ongoing plans in the Faculty to expand Health and Human Rights research and advocacy in the next 5 years.

The intention is also to write up the findings on the history of the Faculty as a Faculty publication that will be used to ensure that injustice and abuse of human rights do not recur and that graduates are able to learn from this past. The process at UCT is not taking place in a vacuum and could make a significant contribution to human rights teaching at other institutions grappling with transformation (Baldwin-Ragaven, 1998).

At a national level, transformation remains the most important task of reconstruction in post-apartheid South Africa, the need for which was most clearly highlighted in the work of the TRC but remains at the forefront of many different institutional programmes in South Africa. The dissemination of the research findings is therefore likely to lead to ongoing interactions with a range of organisations, in the health sector, in the higher education field, and in broader social transformation. Ongoing networks are likely to be strengthened and new opportunities for additional links established. Opportunities exist to link to international human rights networks some of whom already have collaboration with South African partners, such as the joint project between UCT and Physicians for Human Rights around developing guidelines for health professionals working in

situations of dual loyalties. The research has also generate a database on past and current black staff and students from UCT, galvanised the involvement of black alumni in Faculty activities, and has facilitated the assembly of literature on transformation as it affects the health sciences.

Notably, the view that human rights is a new arena for the development of health professionals is not a parochial concern unique to South Africa, but part of a growing international movement examining what professional responsibilties exist for health workers in relation to human rights (Fox, 1999; Hannibal and Lawrence, 1999, BMA, 2001). This project's findings therefore have considerable resonance internationally.

The challenge facing the faculty is to see the extent to which it realises its objectives in shifting teaching and research practices, and the identification and removal of obstacles based on discriminatory practices in the Faculty. The impacts of this institutional change should not only be seen in increasing numbers of black under- and post-graduates gaining access to appropriate training opportunities, and increasing development and retention of talented black and female academics, but also in consequences for the quality of care provided to users of our health services, and in changes in our institutional culture. What is therefore needed is the development of robust indicators of Institutional Transformation that will enable evaluation of the programme's success in the future.

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