# Re-imagining the doctor-patient relationship in an African context:

# A transformative educational perspective

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# DECLARATION

I, *Tasleem Ras,* hereby declare that the work on which this dissertation/thesis is based is my original work (except where acknowledgements indicate otherwise) and that neither the whole work nor any part of it has been, is being, or is to be submitted for another degree in this or any other university.

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# ABBREVIATIONS

| | |
|---|---|
| BPS | Biopsychosocial |
| CHC | Community Health Centres |
| CT | Cape Town |
| DPR | Doctor-patient relationship |
| FM | Family medicine |
| GP | General Practitioner |
| MHH | Medical and Health Humanities |
| MOOC | Massive Open Online Class |
| SA | South Africa |
| TL | Transformative Learning |
| UCT | University of Cape Town |
| USA | United States of America |
| WEIRD | westernised, educated, industrialised, rich or developed |

# ABSTRACT

Clinician-patient relationships are central to health care, health systems and medical education. Current educational practice of doctor-patient relationships emerged from an episteme rooted in a biomedical understanding of disease, having epistemic and pedagogical roots in Global North contexts. The thesis offers an analysis of clinician-patient relationships that includes medical ethics, communication skills, and the development of the widely accepted (in Family Medicine) Biopsychosocial model of the clinical consultation.

Using a South African clinical postgraduate Family Medicine training programme as a case study, this project answered two central research questions: (i) How do students learn to navigate relationships with patients in this training programme? And (ii) Can we develop an educational model of doctor-patient relationships based on local experiences? Mezirow's transformative learning theory, Mbiti's conceptualisation of Ubuntu as an African philosophy, and Foucault's thoughts on structural power provided a conceptual framework.

**Aim**

The project aimed to understand the process of student learning about the doctor-patient encounter and to develop a model for teaching about the doctor-patient relationship.

**Methodology**

A qualitative longitudinal case study was conducted, drawing data from postgraduate students, educators and patients. Data was collected from educational, clinical and reflective activities, and analysed thematically using an inductive approach.

**Findings**

The key themes describe students' learning in relation to critical self-awareness, contextual awareness, the dialogic nature of learning, and the impact of transformed perspectives. Patients valued that their patient-hood and person-hood were validated, and educators highlighted the theme that vulnerability has pedagogical implications. A new perspective of power dynamics in the clinical encounter is described and an Ubuntu-inspired episteme and pedagogy is synthesised from the findings.

**Conclusion**

This decolonial project provides evidence and proposes a model for incorporating an indigenous philosophy (Ubuntu) into mainstream health sciences education. Recommendations are made for educational and clinical practice, as well as future research.

# CHAPTER 1: INTRODUCTION

## 1.1 Background

The relationships between doctors and patients are central to health care. In South Africa (SA), given the complex post-apartheid [1] reality of a wide gap between economic classes(1) and the multi-cultural nature of SA society, doctors and patients in the public sector almost invariably come from different socio-economic, and often linguistic, cultural and racial backgrounds. These complexities raise sociological questions of the nature of the doctor-patient relationship (DPR), and pedagogical questions of how this subject is approached educationally.

Current teaching in health sciences education focusses heavily on developing effective communication skills as a means of improving the quality of the relationship between doctors and patients. Good communication skills have a proven positive effect on building relationships and improving the experience of the encounter between doctor and patient, as well as improved clinical outcomes for the patient(2). However, good communication is only one aspect of building relationships with patients. Recently, health educators in the Unites States of America (USA) and Europe have identified that while communication skills are an important technical skill for doctors to have, a deeper existential way of being with the patient needs to be explored within the context of Health Sciences Education(3).

The evolution of the pedagogy of the DPR in Family Medicine has been influenced by Western scholars from within the discipline of Psychiatry. Michael Balint(4), Carl Rogers(5) and George Engel(6) were among the earliest twentieth century authors who wrote about the need for doctors to see patients as integrated beings (the 'patient-centred' approach), and to have an integrated approach to the somatic, psychic and social issues impacting on wellness. This Biopsychosocial model was adapted by North American scholars(7) into the teaching of Family Medicine and wholly incorporated into the SA model(8). In addition, the Cambridge-Calgary model(9), a pedagogy of communication skills, developed as a collaboration between colleagues from the Universities of Calgary and Cambridge, was also incorporated into SA pedagogy(10). The humanistic essence of these models holds intuitive attraction for general practitioners (GPs), who more than most of their medical colleagues, have to

[1] *The term 'apartheid' refers to the official policy of racial segregation and consequent unequal resource allocation that dominated South African legislation from 1948-1994. The first democratic elections in 1994 resulted in the disbandment of apartheid laws. I refer to the post-1994 period to date as the 'post-apartheid' era*

develop a deep understanding of their patients' experiences of their illnesses. It must be said, however, that while these models were developed and tested in English-speaking Westernised contexts, a critical evaluation of the DPR has not been done outside of this context.

The fields of medical anthropology and medical sociology have also yielded profound commentary on the psychosocial nature of the relationship between the doctor/health system and the patient/society being served. As early as the 1970's, anthropologists recognised that cultural contexts influence beliefs and behaviour related to health and illness, requiring that medical curricula are cognisant of this diversity (11). Cultivating a meaningful relationship between doctor and patient is a mutually beneficial endeavour(12), that needs a focus on compassion and social responsibility. The culture of medical practice that focusses on technology at the expense of attentiveness to the patient should be actively challenged(13).

A key distinction between the high and low-middle income economies of the world is the relative scarcity of resources. In healthcare delivery, this is abundantly apparent. In the SA Public Health sector, in my experience as a clinician and clinician manager, clinics are overflowing, doctors are over-burdened, and patients are ravaged by multiple social problems that have a direct and devastating impact on their health. While aspiring to political democracy, SA has seen a widening of the gap between the rich and poor who occupy the same geographic space, but are divided by power, wealth and access to opportunities. What does this mean for the DPR? If what characterises the doctor-patient interaction is possibly a reflection of broader society's class struggles, the discourse of the clinical encounter between these two protagonists(14) can serve as a commentary on the coming together of privilege and poverty.

Clinical encounters in the context of a hospital, where patients are mostly seriously ill with biological pathology that is measured and impacted by the medical team; being nursed, clothed and fed, and in relative isolation from their social environments, vary significantly from the context of community-based care. In the community-based context, socio-economic realities thrust themselves (or possibly more accurately, are inseparably woven) into the encounter between clinician and patient and have a much stronger bearing on the evolution of the DPR. It is in this point of primary contact, which is community-based, that the clinical discipline of Family Medicine (FM) (elsewhere referred to as General Practice) operates and evolves. Family Physicians as FM practitioners are often the first point of contact when a person feels ill and, given the sociocultural dynamic that informs patients' health "explanatory models"(15), are often required to navigate these complexities in the search for a diagnosis. In the SA context, these Family Physicians, who receive four years of postgraduate training after their basic medical degrees, are additionally required to provide mentorship to clinical teams,

manage clinical services, provide clinical governance support to health facilities and engage proactively with the communities being served.

In relation to the current discussion on DPRs, the questions that arises for teachers of FM in SA are essentially this: (i) How can we ensure that FM graduates, expected to work as clinical leaders on the district health platform (the first meeting point of the individual, the community and the health system), are able to establish effective relationships with their patients that take into account the uniqueness of this African context? And (ii) What are the specific lessons of the doctor-patient encounter that need to be incorporated into a pedagogy that seeks to inform and transform students' perceptions of their own relationships with patients? These questions are considered against a backdrop of a triad (doctor-patient-educator) who co-exist within this space of multiple possibilities.

Using aspects of Transformational Educational Theory(16), this study critically explores the experiential learning of postgraduate clinical students of FM by confronting them with two issues in the doctor-patient encounter: (i) the manifestations of the power-knowledge dyad as described by Michel Foucault(17); and (ii) Ubuntu, or social inter-connectedness as described earlier by the Ugandan scholar, John Mbiti(18) and subsequently by other African educational theorists(19–21).

The contribution that this study makes is in proposing a model for teaching about the DPR from a humanistic, decolonial perspective. The key findings demonstrate patient-participants' manifestations of agency, the impact of humanising the clinical encounter on the mental health of doctor-participants, and the educational potential of utilising an indigenous knowledge system to develop a framework for the DPR. Ubuntu is posited as a source of a humanising episteme and critical pedagogy that could animate medical education and stimulate widespread discussion about the relationship between indigenous knowledge systems and modern medical education.

## 1.2 My Personal Narrative

I was born to black working-class parents in the Apartheid era, a few years after District Six in the centre of Cape Town (CT) was declared White, and thousands of families forcefully removed from their homes and transferred to the sandy expanses of the Cape Flats on the outskirts of the city. My aunt's household in District Six, where I was cared for in my early childhood years while my mother worked at a city hospital and my father as a builder for a large construction company, was one of the last to be demolished, despite their rigorous protests.

These protests were to imbue my family and social life throughout my primary schooling in the Bo-Kaap and my secondary schooling in Athlone on the Cape Flats during the 1980's and early 1990's.

Political education was experientially achieved. By the time I reached University of Cape Town (UCT) in 1993 as the second university student of my extended family (my older brother preceded me by two years), my commitment to social change by transforming social structures informed my student activism as a member of various political structures on campus.

These considerations directly impacted my career choices after qualifying, when I chose to work in communities in need as a primary care physician. I formalised my commitment to this field by completing specialist training in FM at UCT in 2009. My appointment as lead clinician in Delft, a deprived community on the North Eastern urban edge of CT's Metropole, gave me insight into the tensions that exist between two communities, each heterogeneous in their own right: that of the poor, largely uneducated, entirely black community struggling to emerge from the persistent effects of Apartheid's legacy; and the community of health workers, young and educated, more affluent and racially diverse, with aspirations as diverse as their backgrounds.

The sense of dis-ease that characterised the young health professionals while at work, and the sense of betrayal pervasive amongst patients towards these young doctors, indicated to me a serious dysfunction in what should be a healthy, meaningful and productive relationship. This informed my motivation to pursue this project.

# CHAPTER 2: A LITERATURE REVIEW

## Relationships that heal

Much of what has been written in the field of DPRs has its origins in Western psychosomatic medicine. The dominant themes relate to understanding how physical and psychological manifestations of disease are linked, the key role that communication skills play in the medical environment in understanding this link and its incorporation into medical education, and a growing interest in teaching empathy within Health Sciences curricula. A reading of the available literature reveals an opportunity for re-imagining the pedagogy of DPRs beyond the technical skills of good communication and empathic behaviour, into an as yet untapped space of assisting students to critically evaluate and consciously engage their interactions and relationships with their patients.

## 2.1 Doctor-Patient relationships in Family Medicine

The centrality of the relationship between the doctor and patient in healthcare is undisputed. At the turn of the twentieth century, William Osler is famously reported to have stated that "*the good physician treats the disease; a great physician treats the patient who has the disease*"(22). The nature of this relationship is influenced by many factors, and from the perspective of medical epistemology, very notably the rise of specialisation in medical knowledge(23), which swung the focus of the medical encounter strongly in favour of understanding disease from a biomedical perspective, as opposed to an understanding of disease from the perspective of the patients' lived experiences. The epistemic changes impacting on the DPR were also demonstrated by the French historian-philosopher, Michel Foucault (1926-1984) (17). He described the developments in medical knowledge at the end of the 18$^{th}$, and beginning of the 19$^{th}$ century: as knowledge of anatomic pathology and physiology advanced over time, disease came to be seen and classified in terms of the measurable and observable changes and pathology in the body. The person carrying the disease, the patient, relegated to being merely the vehicle for this disease. While this thinking dominated the 18$^{th}$ and 19$^{th}$ centuries, the 20$^{th}$ century saw a meteoric rise of laboratory medicine that expanded the ability of the medical fraternity to diagnose accurately before death, with recent developments in medical genetics allowing us to detect diseases even before they are manifested in the body(24). As this world of disease expands deeper and deeper into chemical and biological laboratories, the patients' experience of illness has diminished in importance. The patient has merely become a vehicle that transports the disease into the clinic or hospital(17).

In response to these developments, and in an attempt to rekindle the deep connection that doctors and their patients had previously shared, the latter half of the twentieth century witnessed a concerted

effort to re-conceptualise the nature and pedagogy of the DPR in General Practice. What emerged from these efforts were concepts of *'Patient-centred' medical care* and the '*Biopsychosocial model'* of the DPR. This next section will explore the key issues that emanated from this project.

### 2.1.1 The Biopsychosocial model, patient-centred care and communication skills

The term 'biopsychosocial' was coined by George Engel (1913-1999), an American psychoanalyst, who had devoted much of his professional life to ensuring that psychosomatic aspects of illness be incorporated into mainstream medical education(6). Reflecting on the perception that doctors were more responsive to laboratory results than to their patient's experience of illness, and the subsequent frustrations felt by both these protagonists when faced with a psychogenic illness with no measurable or observable biomedical pathology, he proposed that simply appealing to compassion and goodness of the doctor did not answer patients' psychological and social needs inherent in this cohort of patients. A model that formally included competency in addressing psychosocial aspects of disease could solve this educational dilemma: this birthed the Biopsychosocial (BPS) model of patient care that has profoundly impacted the conceptual thinking around the DPR within the discipline of FM. Based on General Systems Theory originally developed by the German biologist Ludwig von Bertalanffy(25), the BPS model perceives patient experience in the context of a continuum ranging from microbiological processes through to physical and psychological experience of illness, and then extends to perceiving how the illness impacts on the patient's relationships and functioning in their immediate and extended contexts. Systems theory explains that each individual component affects other components in the system, and thus a biological process in the liver would impact the body, causing pain and jaundice, which impacts the person's ability to work, which impacts the family if this person is the breadwinner, and if the illness is prolonged, the impact is felt at the person's place of work, and then in the wider economy. Foucault's description of the modernist 'medical gaze' of the individual doctor as he engages with the disease of the individual patient would have to undergo a transformation if doctors are to perceive their relationships with patients within this expanded paradigm. George Engel was not alone in this call towards a more expansive model of the DPR. Prior to the publication of this model, other psychoanalysts had developed the notion of 'patient-centred' healthcare.

Across the Atlantic, psychiatrists were developing a concept that elevated the importance of the patients' experience of illness when considering a comprehensive diagnosis. In the context of his own practice, the Hungarian turned British psychoanalyst Michael Balint (1896-1970), while working at the Tavistock Clinic in London, sought ways of facilitating for General Practitioners (GP's) an improved ability to diagnose and treat their patients with psychological issues overlaying the biomedical

complaints(4). He suggested ways that GPs could become more aware of their own involvement in their patients' problems, and how they could manage their emotional and verbal responses in a way that encouraged symptom resolution. This represented a sharp move away from the traditional view of the doctor as an objective expert casting his gaze over the passive patient as he sought the origin and natural pathway of the disease, a model that had survived since the Renaissance(17). Emanating from Michael Balint's initial work in the 1950's, Enid Balint (1903-1994) developed a concept which she called 'patient-centred' care(26). Working with a group of London-based GP's who were skilled in psychotherapy, she explored their ability to use multiple short interviews (10-20 minutes) to impact on psychological issues affecting how individual patients in their respective practices experienced illness. Their conclusions were that in the cut and thrust of general medical practice, the GP has to allow the patient to decide what services s/he wants the doctor to render. The patient thus becomes the architect of their own use of medical services and expertise, while the doctor must exhibit a heightened responsiveness to the expressed and unexpressed needs of the patient. A third key figure from the discipline of psychotherapy is that of Carl Rogers (1902-1987). Using a 'client-centred' approach not dissimilar to the 'patient-centred' approach described by Balint above, he outlined three cardinal characteristics that any therapist ought to develop: unconditional positive regard for the client; an empathic attitude; and emotional congruence within him/herself(5). It must be noted that Rogers' conclusions, like those of his colleagues mentioned previously, were drawn from his own practice of psychotherapy, within a particular worldview of what constitutes a human being: one rooted in ensuring that the individual is able to actualise his/her true nature *as an individual person* and live in harmony with this realisation.

The preceding discussion dealt with the epistemological development of the more egalitarian DPR as it is framed in the 'patient-centred' model, and the systems theory-guided Biopsychosocial model. I will now briefly discuss how these developments found its methodology in FM as a distinct discipline, and certain pedagogical developments that emerged subsequently.

The Canadian professor of FM, Ian McWhinney (1926-2012), based at the University of Western Ontario, is widely accepted as being a forerunner in the formalisation of General Practice/Family Medicine as it exists today. His "*A Textbook of Family Medicine"*, initially published in 1981, translated the theories outlined above into a clinical method of FM that forms the basis of a large part of the theoretical foundations of the discipline(7). Based on the experiences and insights of a SA GP (Stanley Levenstein) working with a group of Canadian GPs, a method of conducting the clinical interview, based on an understanding of the doctor's agenda and the patient's agenda, was developed and formulated into a patient-centred clinical method(27,28). The approach was further expanded by the introduction

of a technique of summarising the outcome of this method into a standardised format, the Three Stage Assessment, which incorporates biomedical, psychological and environmental/social issues into a comprehensive assessment of the patient's illness experience(29). The BPS clinical method in FM can be summarised into six components(30), tabled below (Table 1).

While the important pedagogical work of conceptualising the clinical method was being carried out in North America, a collaborative effort between colleagues from the Universities of Calgary (Canada) and Cambridge (England) was producing a system of communication with patients that complements the BPS model of the medical consultation(9). Communication is viewed as a skill that can be taught at both undergraduate and postgraduate levels, across a range of clinical disciplines. The authors present empirical data in support of the claim that communication skills, as a core clinical skill for all health professionals, has multiple benefits for the DPR. These are: producing a more effective doctor-patient encounter; improved clinical outcomes for the patient; improved job satisfaction for the doctor; enhanced collaboration between doctor and patient; and decreased complaints about clinicians. In addition, the authors claim that the principles of good communication can be implemented in various cultural contexts, and have spent considerable time advising faculty in diverse parts of the world.

The convergence of the McWhinney group's work on the BPS clinical method and the Calgary Cambridge group's communication skills provides a comprehensive framework for the teaching of a clinical method in FM that has been widely accepted across the world. It can be summarised in the following table:

| McWhinney group: components of the clinical method | Calgary-Cambridge group: communication tasks in the consultation |
|---|---|
| 1.Exploring the disease and the patient experience | 1.Initiating the session |
| 2. Understanding the whole person | 2. Gathering information – including exploring patient's perception |
| 3. Finding common ground | 3. Providing structure to the interview |
| 4. Incorporating prevention and health promotion | 4. Building the relationship |
| 5. Enhancing the doctor-patient relationship | 5. Explanation and planning |
| 6. Being realistic: managing time and resources | 6. Conclusion/closing |

**Table 1: Key characteristics of the McWhinney and Calgary-Cambridge consultation methods**

The BPS model, as a vehicle to achieve patient-centred care, is philosophically critiqued by Butler and colleagues because of its roots in the analytic tradition, which is itself grounded in Cartesian mind-body dualism(31). This position of mind-body dualism which has shaped modern medical innovations and practise, is iterated in the BPS model by keeping the biological, psychological and social domains distinct, though interrelated, with the biological taking pre-eminence, and the psychosocial approached through this lens. The result is that psychosocial problems are somatised by offering a plausible biological explanation. They offer an alternative interpretive approach, that proposes a process of meaning-making of suffering as the key task of the clinical encounter. By focussing on "embodied experience" of symptoms (suffering), the practitioner is able to side-step the "awkward dance of collusion around somatised illness…"(30, p221) that is required when biologically unexplained symptoms are explained from psychosocial perspectives. Notwithstanding this critique, the BPS model remains the mainstream model being taught in FM curricula, given its proximity to the centuries old hegemony of the biomedical model.

From an educational perspective, while the BPS model and good communication skills provide the doctor with a platform from which to identify and address patient complaints holistically, and a formal method of assessing students' competencies has been developed(32), issues impacting on students' attitudes towards patients, and on a deeper level how they construct meaning in these encounters, are not explicitly addressed here. It is widely believed that students learn values and attitudes from their experiences as part of clinical teams (the informal or hidden curriculum), rather than from formal teaching in classrooms(33). Given the myriad of factors that could potentially impact this type of situated learning, it becomes an educational imperative to develop within students the ability to be self-aware and be able to critically reflect on their experiences within a particular framework. This imperative was addressed by three distinct strands, which are unified under the banner of professionalism: teaching of medical ethics and professionalism; attention to professional identity formation; and the need to cultivate empathy among medical students.

### 2.1.2 Ethics, empathy and professional identity: a quest for humanistic medicine

The need for an ethical framework that addresses challenges in modern medical practice was addressed by Tom Beauchamp and Jean Childress in 1979 when the first edition of the "*Principles of Biomedical Ethics"* was published(34). A comprehensive system of ethical reasoning was presented, based on four principles: respect for individual autonomy, justice, beneficence and non-maleficence. In a SA context, Keymanthri Moodley expanded and contextualised this approach, adding some local flavour to an otherwise Western text(35). However, the basic framework is left intact, and finds significant synchronicity in post-apartheid SA law. This dominant status has been challenged by African

scholars who question the validity of individual autonomy in an African context, where communitarianism (Ubuntu) is the traditional world view(20). This is an unfinished debate, and as the current situation stands, communitarianism is not included in the SA medical ethics or professionalism curriculum. In relation to the DPR, the ethical framework provides principles that should guide the development of the relationship but is often only explicitly referred to when clinicians are experiencing difficulties in decision making. It remains an external structure that guides practice, rather than an internal world view that assists clinicians in finding their place in society. In the context of a post-Apartheid society, critical voices have been raised regarding the incorporation of human rights into the medical curriculum, with London and colleagues lamenting the conflation of bioethics with human rights, resulting in the "sublimation of human rights within bioethics teaching"(36, p1269).

Empathy has been defined as a cognitive process involving the understanding of another's experience of suffering, the ability to communicate this, bolstered by an intention to help(37). Using this definition, a decline in empathy was demonstrated in American medical students as they traversed their medical studies. This finding ushered in a series of studies elsewhere in the world which either corroborated [in Iran(38)], or refuted [Australia(39) and Japan(40)] the original discovery. Attempts at incorporating empathy into the formal curriculum met with some success(41). Defining a socio-culturally specific approach with an understanding of empathy that goes deeper than a cognitive process is probably needed to take this debate forward(42). In addition, as the current debate does not place empathy within a specific conceptual model of the DPR, the default is the biomedical model, which relegates empathy to the level of a skill to be learned and deployed when needed, not as a manifestation of a state of being in relation to other human beings. Within western literature, there have been some publications challenging the dominant materialistic perspective. Jeffrey, in a longitudinal case study of undergraduate medical students in the USA (121), showed that student self-perceived levels of empathy, and their own realisations that contextual issues impact on this phenomenon, supports the socio-cultural perspective. Marshall and Hooker (122) present an intriguing proposal that critiques the Cartesian view presented in the biomedical literature and propose a model for studying the embodied experiences (and identity construction) of the "emotional geography", including empathy, as it manifests in the doctor-patient relationship. This model lends itself to incorporating emotions in conceptions of the DPR, which presents an interesting and important challenge to educationists.

The key role that educationists play in the process of identity formation of young health professionals is becoming more apparent. It is now well accepted that identity formation is an ongoing process that is deeply affected by the teams and social structures young professionals operate in, wherein they

often assume multiple roles, depending on the situation and task that is demanded of them(43). This issue has not been addressed in the formal curriculum, leading to a suggestion that while current medical curricula across the world have focussed strongly on ways of doing (technical competence), a pedagogy of a way of being (identity) needs to be developed(3). This impetus has used psychological theories of behaviour and identity construction as a basis for understanding the psychological changes being brought about, and herewith exposes its colonial roots: the perspectives from indigenous knowledge systems are not embraced in the mainstream health sciences education literature. These perspectives may represent a valuable pathway to exploring how health sciences education can expand epistemologically to incorporate diversity into its knowledge system.

### 2.1.3 Perspectives from the Medical Humanities: context and behaviour matters

Before exploring styles in the production of knowledge that the medical world generated in response to the challenge of this widening rift between the healer and the sick patient, it is useful to consider the important contributions made towards understanding this phenomenon, particularly in the fields of sociology, anthropology, and what has now been termed the Medical and Health Humanities (MHH).

With the failure of modern medicine to develop the tools to understand patients and their behaviour, medical practitioners have borrowed from these disciplines tools with which to develop a deeper understanding of their patients' lived experiences(44). One such general practitioner was Cecil Helman, who after studying at UCT, left SA to pursue a career in London as a GP, and subsequently, as a medical anthropologist. In approaching an understanding of the doctor-patient interaction from both these disciplines, Helman makes the astute observation that within the medical curricula too much emphasis is placed on cognitive ability (the 'head'), at the expense of developing the ability to navigate emotional issues with patients (the 'heart')(12). This represents a missed opportunity for allowing empathy and social responsibility to define the relationship. While empathy has obvious benefits for the patient, the potential benefit to the doctor when a patient returns that empathy is hardly considered.

Abraham Verghese, a Professor of Internal Medicine at Stanford University, considers the culture within USA medical institutions where the patients are secondary to the clinical data that is being generated by the myriad tests they are subjected to, and advocates for a return to a type of medicine where doctors make meaningful connections with their patients(13). Students are exposed to institutionalised cultural factors in their learning-practice which has a profound effect on their professional development(45). Perceptions and professional identities are shaped by these social and cultural forces, beyond the reach of health professional educators.

An appreciation of the experience of the ill person is hardly taught in health sciences education, yet it is a powerful way in which to understand the illness, and an important step towards healing(46). Importantly, understanding how ill people interact with their healers holds immense value in the evolution of the DPR(47), offering insights that challenge the notion of doctor-dominated power dynamics in the relationship. Efforts to enhance the humanistic dimensions of health sciences education has seen the international MHH movement reach SA shores, as documented by Reid(48) and Pentecost et al(49), who describe progress made in incorporating MHH into medical curricula in SA, while Tsampiras critically explores institutional dynamics that impact its incorporation into a health science faculty(50). Hooker and Noonan observed that the medical humanities are grounded in a set of assumptions that emanate from a Western epistemology(51). These assumptions are often uncritically accepted by scholars in the field. Theory was translated into practice when Reid and Levine hosted a Massive Open Online Class (MOOC), examining aspects of MHH at UCT, that attracted participants from across the globe. Their reflections suggest a clear distinction between MHH in the Global South and North, with the former represented as being "more interdisciplinary and embodied, rooted in traditions of oral narrative, song, dance and movement rather than exclusively in text"(52, p344).

The teaching of health sciences must therefore develop within the health professional a level of self-awareness that allows critical engagement with cultural forces within medical teams, and appreciates the depth of experience that patients bring into the medical encounter.

## 2.2 Rationale for a critical evaluation of doctor-patient relationships in an African context

The development of the BPS model, a patient-centred approach, the excellent work being done in teaching communication skills, the post-modern ethical principles, the rising star of empathy and a renewed focus on professional identity formation may indicate a desire within biomedicine to reclaim its humanity that has progressively been eroded by the relentless march of technology. While SA health and health science education systems have inherited much of this historical-sociocultural baggage of the Western biomedical episteme, an opportunity exists in post-apartheid SA to attempt a re-imagination of how we can forge long-lasting and meaningful relationships with our communities and patients. The end of Apartheid represents a significant break in continuity with the narrative of Western epistemic hegemony and presented an opportunity for inserting some foundational African assumptions into our pedagogy. This is seen in a report published by the erstwhile Minister of Education, Prof Kader Asmal, in 2001, that set out a values-based framework for educational reform

in SA(53). This framework explicitly aligns itself with the principles of “Democracy, Social Justice, Equality, Non-racism and Non-sexism, Ubuntu (Human Dignity), An Open Society, Accountability (Responsibility), The Rule of Law, Respect, and Reconciliation” (50, p7), all of which represents a stark departure from the inherited apartheid frameworks.

While the extent to which these principles have been realised is debatable, the questions that are pursued in this project are aligned: Are we able to radically transform our students’ perceptions of themselves in relation to their patients in a way that promotes cohesion and enhances the quality of their interactions? Can we achieve this by confronting students with the reality of their own use of power in encounters with their patients? How do patients exercise agency in their search for meaning in their relationships with clinicians? Utilising the triadic relationships between patients, doctors and educators, this project represents a serious attempt at answering these questions in the ongoing quest of making health sciences education directly relevant to the social context in which we operate.

## 2.3 Conceptual Framework: Transforming Perspective by analysing aspects of Power and Ubuntu

This project was framed by Transformative Learning (TL) theory as described by Jack Mezirow(16). Within this framework, students reflect critically on their experiences with patients by focussing on issues of power(17) and Ubuntu(18). A transformative educational approach aspires to deep learning that impacts the students’ world view. Appreciating the existence of Ubuntu provided a socially relevant context for this learning to take place, while analysing power dynamics allowed the students to evaluate how inequality impacts their practice.

### 2.3.1 Transformative learning theory

Acknowledging the work of critical theorists such as Paulo Freire and Jurgen Habermas in shaping his thoughts, Mezirow’s theory posits that adults learn when they experience disorienting dilemmas, followed by critical reflection and discourse, leading to transformed attitudes, beliefs or paradigms.

According to this theory, the central task of learning is constructing meaning based on experience of the world. New learning must involve the disruption of a previously held explanatory model of a particular experience. This leaves the person feeling disoriented, as their world view has been fundamentally challenged. To resolve this disorientation, the individual starts reflecting critically on the previously held assumptions. The ability to reflect critically on personal experience requires a certain level of self-awareness that allows the student to separate the experience from the self. The student then evaluates several different explanatory models in an attempt at reformulating meaning

for this dilemma. Once a new perspective has been tentatively reached, the individual tests it in a group of people who have undergone similar experiences. This social discourse in a safe group allows refinement of the perspective, re-integration into society and a re-negotiation of relationships from this new perspective. This learning is referred to as 'deep learning' as it fundamentally transforms the learners' perspective of the studied phenomenon, and not the more superficial technical skills required to achieve competence at a given task. This deep learning lends itself to the phenomenon of the DPR.

The tasks associated with this type of learning includes the assimilation of new technical information, depending on the learning needs demanded of the particular dilemma. Probably more importantly, it involves the development of skills that facilitate ongoing learning and autonomous thinking, providing the potential for the student to be involved in knowledge production, and offers an opportunity for a more expansive world view(54). In addition, an understanding of the link between cognitive and emotional functions that arose from neurobiological and behavioural studies suggest that TL theory incorporates both domains and does not view critical reflection or discourse as exclusively cognitive processes(55). This is especially important when one considers that most disorienting experiences have explicit and strong emotional motivations and consequences. Central to the learning, therefore, is explicit resolution of the affective as well as the cognitive dilemma.

For the purposes of this study, which explored deep learning involving a perceptual shift, TL theory was the most comfortable fit, catering for emotional, intellectual and existential learning domains. Because of its constructivist nature, it allows the researcher and learner to explore the underlying reasons for phenomenon occurring, and construct meanings for these occurrences(56). Social learning theories are very useful for medical education, particularly in explaining the acquisition of new knowledge, skills and behaviour and how they relate to social context(57,58). However, these theories do not easily lend themselves to exploring deep perceptual shifts. Social cognitive theory as described by Bandura(59), for example, posits an interplay between the individual, the environment and behaviour, and proposes a dynamic explanatory model based on this continuous interplay. Disappointingly, from the perspective of examining deep learning as demonstrated by shifts in perspectives or worldviews, the almost exclusive focus on cognitive and behavioural aspects of learning means that these theories are not suited to the type of enquiry this study demands, as learning is described as cognitive, not paying sufficient attention to the emotional and existential components. On the other hand, Lave and Wenger describe Situated Learning Theory (SLT), wherein learning is socially situated as the process of gaining knowledge, skills and behavioural adaptations that allows the student to move from legitimate peripheral participation to becoming a core member of the community of practice(58). Situated learning theory is useful in describing the motivation for learning,

the process of learning, and the process of identity formation. Identity formation necessarily comprises a perception shift and this may lend itself to this study, but this theory does not offer the structured process of deep perceptual learning from experience that TL theory does.

Two other theories worth mentioning, that embrace cognitive and emotional dimensions of learning, are Actor Network Theory (ANT) and Cultural-historical Activity Theory (CHAT). Originating from social sciences, ANT posits that social engagement takes place in the context of a "heterogeneous network" consisting of human and non-human actors who are not inherently more powerful or weaker than others, with power derived from the dynamics that typify the network (119). Educationally, this would suggest that learning and meaning-making is situated within this network. Inherent in (but not exclusively so) the relationships that constitute this network have human characteristics: cognitive and emotional drives that weaken or strengthen bonds. The inclusion of non-human elements allows ANT to explain the evolution of the DPR in relation to the seismic technological advances described earlier. CHAT covers a wide range of human interactions including health sciences and education (120). Similar to ANT in that it includes non-human actors, CHAT introduces the concept of mediation between the subject and the object, which manifests in increasingly complex ways through different levels of society (120). Learning becomes a collective social activity, generated by the multiple interactions that characterise social life.

While ANT and CHAT would have provided a suitable framework for describing the learning process between antagonists and their contextual mediators, I preferred TL theory for the structured description of deep learning, which lends itself, in a deductive manner, to the data analysis process.

### 2.3.2 Power in the medical encounter: The doctor, the patient and the medical gaze

The current practice of Western biomedicine, with its biomedical focus rooted in rationality and the materiality of the physical body, is based on a socially constructed relationship between the doctor, the patient, and the disease. What Michel Foucault, the French philosopher, called the 'medical gaze' is, in the context of a discussion on power in the medical encounter, in fact a description of a relationship wherein the patient is a near passive recipient of the doctor's perceived powers of healing, is essentially unchanged since the early 1800's(17). This skewed relationship was further entrenched by the development of the pathological sciences: anatomical and chemical, with ever increasing levels of medical speciality and expansion of the traditional triad forming Foucault's 'clinic': doctor-patient-disease. In this model, the disease entity assumes its own ontology, to be studied, analysed and vanquished, the desire for which emanates from a charitable, humanitarian desire of the doctor(15). This may not seem problematic when initially encountered, but it holds two immediate challenges.

Firstly, the 'humanitarian' doctor is always in a dominant position, which marginalises the patient in activities of power. Secondly, as the battle between doctor and disease entity rages intensely, the patient, objectified as the vehicle of the disease, is frequently forgotten. The twentieth century witnessed the explosion of laboratory sciences that rapidly assumed a central role in the diagnostic and therapeutic processes. It is not only the individual doctor who wields power in this unequal relationship, but also the entire world of medicine that has passionately embraced the technological revolution(7). The voice of the suffering patient is silenced by the cacophony of machines.

Power, by virtue of the medical knowledge generally inaccessible to the public, has traditionally been vested in the doctor and medical institutions. Waitzkin notes that in the twentieth century, doctors have been one of the most influential professional groups in influencing family life in the USA(14). He contends that the ideology that informs macro-processes in society also informs micro-processes in the interpersonal interaction between doctor and patient. In post-Apartheid SA, this notion assumes great significance given the massive gaps in economic power between social classes and the radically different social realities that doctors and their patients in the public sector inhabit. Discourse in the medical encounter can be influenced or shaped by dominant ideologies in society. Waitzkin borrows from the work of Jurgen Habermas to make the point that when domination and ideological hegemony manifests in social and interpersonal relationships, distorted communication results. In contrast to this unidirectional view of power flow in the medical encounter, Ainsworth-Vaughn uncovers how patients use rhetoric to exercise personal power (agency) in the discourse with their doctors(60). The implications suggested here are that the exercise of power by patients manifests cryptically in medical encounters. In analysing this discourse in the medical encounter between doctor and patient, insights into the dynamics of power in the relationship can be uncovered. This analysis offers students an opportunity to critically evaluate their own practice.

The case has already been made of SA's persisting Apartheid-era socio-economic inequalities(1). In primary care facilities of the public sector health system, the encounter between an educated, economically mobile doctor and an uneducated, impoverished patient is a direct reflection of these inequalities. Analysing the discourse of power in this context could provide insights into how power is accessed and utilised in the relationship between doctor and patient. As an educational tool, this analysis of power may disrupt the students' assumptions about their role in maintaining or challenging social constructs in their own learning, in their practice of medicine, in their participation in the politics of medicine, and in their 'meaning perspectives'(16), or paradigms. When this analysis is done within the framework of a particular paradigm, it may have a constructive influence on their personal and professional development. In Africa, Ubuntu offers such a paradigmatic opportunity.

### 2.3.3 Ubuntu as an African epistemology

According to oral traditions that emanate from the pre-colonial era, African communities have existed in a form of communitarianism: personhood is conferred on the individual in relation to the community in which he finds himself(18). In Southern Africa, the Nguni people use the word *Ubuntu* to describe this collective humanity, while it is called by different names in various parts of the continent. Although the first writing on Ubuntu appeared in the late 1880's, when it was initially only described in terms of a human quality (compassion, kindness, mercy), the notion of Ubuntu as an African humanism is particularly strong amongst revolutionary postcolonial African writers such as Kwame Nkrumah, Julius Nyerere, Kenneth Kaunda and others(19).

It is neither centred on the individual, nor utilitarian, but rather a way of being that centralises the relationship that individuals have with each other, and to society at large. The destinies of the individual and society are inextricably linked. Doing 'good' to others, in this context, directly benefits the subjective. This effectively breaks down the barrier between 'self' and 'other'. In this interconnected world, the notion of 'goodness' emerges from that which promotes the establishment of harmonious relationships. Gade quotes the Zimbabwean journalist, historian and author, Stanlake Samkange, on Ubuntu as "*the attention one human being gives to another: the kindness, courtesy, consideration and friendliness in the relationship between people; a code of behaviour, an attitude to other people and to life, is embodied in Hunhu or Ubuntu"*(19, p8).

The educational potential of this African world view lies in the moral values that permeate good human relations(21). Venter writes in the context of educator training in SA, highlighting the need to use principles rooted in social interconnectedness in designing curricula, although she does not provide specific actions to corroborate this statement. Letseka(61) argues that Ubuntu as a moral theory has direct implications for public and educational policy, given its focus on an interpretation of common understandings and meanings. This would manifest as values of compassion, caring, kindness, altruism and respect. Ubuntu as an epistemological source of the above values has been explicitly included in educational policy for SA(53). In health sciences education, this potential is quite obvious as it pertains to the relationship between educators, student-clinicians and patients. Ubuntu offers a locally relevant episteme that recognises the centrality of the relationship between these human beings. In addition, it offers an opportunity for health science educators to move beyond the vexing debate of the biomedical versus the biopsychosocial clinical method. The practice of Ubuntu would mandate that clinicians recognise the whole person that is the patient, which, if translated into effective pedagogy in our context, could produce health professionals who see themselves and their patients as being part of the same 'community of healing', sharing a common purpose of relief of suffering for members of

this community. In this paradigm, by being part of the healing process of the patient, the doctor would also improve his/her own sense of wellbeing.

Ubuntu is not without critique from contemporary perspectives. Matolino and Kwindingwi criticise the SA government and political elite for using Ubuntu as a means to achieving public support, and observe that the metaphysical aspirations are far removed from the social and material realities(62). They juxtapose the term foregrounded in State policy, “Batho Pele” (People First), against the phenomena of poverty, inequality and poor service delivery that characterises much of poor South Africans’ experience. Their critique is not so much of Ubuntu as about those in positions of political and economic power who profess to practice its principles. Similarly, Yang and Tuck call for the recognition that “decolonization is not a metaphor”, in the sense that the language of decoloniality, which could include the renewed aspirations of indigenous philosophies like Ubuntu, should not be co-opted into entrenching the colonial paradigm that perpetuates prevailing hierarchies(63). From a feminist perspective, Ubuntu in educational policy in Zimbabwe has been critiqued by Simba as entrenching male-dominant practices(64). She argues for a new understanding of Ubuntu that is presented as a framework for social encounters, creating a space for multiple perspectives and transforming power dynamics. In a disconcerting attempt at re-interpreting Ubuntu in a secularised manner, Metz denies the underlying spiritual dimension, connection with the ancestors, diluting the potential existential impact, possibly in an attempt at making Ubuntu palatable to a non-African audience(65).

These approaches are useful insofar as they offer perspectives removed from the essentialist one offered by Mbiti. In particular, the feminist approach in challenging power structures and opening social encounters to multiple, oftentimes competing, voices, challenges Mbiti’s essentialism in a constructive manner. At the same time, given the paucity of African literature on the subject as it relates to health sciences education, awareness of the neo-colonial tendencies that could manifest is vital for emerging African scholarship, especially in relation to entrenched hierarchies and when catering to non-African (predominantly Western) audiences.

The current educational model, rooted philosophically in liberal individualism with its emphasis on individual rights and autonomy, has informed pedagogy in health sciences education to date. An Ubuntu-based evaluation of relationships as represented by the medical encounter offers African educators an opportunity to re-imagine the DPR from a fresh perspective.

### 2.3.4 A Transformative Pedagogy through the lenses of Ubuntu and power

Transformative learning as described by Mezirow is premised on the notion of a disorienting dilemma(16). The opportunity for this lies in deep reflection on the encounter between clinician and

patients. The disorientation occurs when long-held perceptions are challenged either by direct experience, or when the meaning of an experience is challenged in processes of introspection and critical reflection. The educational process plans to exploit the latter form of disruption of the students' perceptions of the DPR. By reflecting on their encounters with patients, the process of introspection and critical reflection, deepened by discourse with fellow students and educators, could produce TL and the construction of new meaning.

The proposed framework for this process of introspection, critical reflection and discourse was built on the principles of Ubuntu and power, as outlined above. This framework informed the students' interrogation of their own worldviews, their experiences with their patients, and provided a framework for them to resolve any disruptions to which they were subjected.

This framework, composed from three seemingly competing perspectives, may seem counter-intuitive to some: Ubuntu in its essentialist pre-colonial understanding, supports tribal hierarchies that promote social harmony in a specific context. Foucauldian power analysis stands in stark contrast to these invested social hierarchies, fundamentally challenging them. Mezirow's critical theory posits an individualistic perspective of learning that also seems at odds with the collectivism that Ubuntu aspires to. Taking this into account, I have been at pains to step away from the essentialist nature of Ubuntu, grounded in its historical origins, and rather embrace a modern conception of a renegotiated social contract comprising its lofty ethico-emotional ideals. Similarly, I draw a distinction between the Foucauldian method of analysing power critically while not fully embracing the strong critique of all hierarchy – a critique to understand rather than to transform. And finally, while Mezirow's western individualistic approach may seem at odds with an African communitarian one, when one considers that the construction of the Ubuntu collective relies entirely on the uniqueness of the individual, these approaches become complementary. This in no way seeks to minimise the tension that exists at the point where the individual synapses with others to form a collective – it is precisely from this tension that discourse facilitates the production of new knowledge.

# CHAPTER 3: METHODOLOGY

The phenomenon that is explored in this study is the doctor-patient encounter in the context of a postgraduate clinical training programme in Family Medicine, where student learning about the DPR is facilitated within a TL approach. Learning, in this instance, is understood to be the process of the making of new meanings, which is a characteristic of deep learning(16). For Mezirow, the process of making meaning is to "become critically aware of one's own tacit assumptions and expectations and those of others and assessing their relevance for making an interpretation"(66). Students analysed and critically reflected on their own encounters with patients repeatedly over a period of ten months, with data generated by their process of learning during this experience. In addition, the actual interactions between students and patients were serially observed by the researchers. The novelty of this study lay in three aspects: the context of the medical encounters within a society that has deep socioeconomic inequalities that is mirrored in the DPR; the use of Ubuntu and power as conceptual co-ordinates to guide critical reflection; and the application of TL theory in developing this approach to learning about DPRs.

## 3.1 Aims and objectives

This project had two broad aims: firstly, to understand how the doctor-patient encounter was influenced by student learning using a TL approach; secondly, to develop a model of teaching about the DPR in an African context. The objectives to achieve this were, to

1. Explore the process of student learning (meaning-making) of the DPR in this context;
2. Gather feedback from patients of their encounters with doctors (student-participants);
3. Explore the perceptions of educators of their students' learning processes and;
4. Synthesise an approach to teaching about the DPR in an African context

## 2.3 The context

This study took place within a postgraduate training programme in FM in CT, SA. The students were all qualified health professionals (all but one were doctors), studying toward a *Postgraduate Diploma in Family Medicine (PG Dip)* for nurses and doctors, or a *Masters of Medicine (MMed, Family Medicine)* for doctors only. The PG Dip is a two-year part-time programme, while the MMed is a four-year full-time Professional Masters' degree. This study took place during the first year of study, when these two programmes are joined in teaching/learning the theoretical framework of FM. Teaching takes place one afternoon each week, with practical and workplace-based assignments and assessments taking place within the clinical environment in which students are working. These clinical environments are public sector Community Health Centres (CHC) and District Hospitals in urban working class areas of

CT, which serve communities from the uninsured population, at risk of poverty, unemployment and crime(67). The student-participants in this study were qualified medical doctors or nurse practitioners in clinical practice, mostly employed by the State (one was self-employed), with access to medical insurance, and therefore are not at similar social risk as the populations they are serving. For many, it was the first time that they encountered some of the social challenges that were presented. The 'macro' reality of social inequality was 'micro' manifested in the medical encounter between doctor and patient.

The theory that forms the basis of the classroom-based sessions is a combination of the Principles of FM described by McWhinney(7) that includes the patient-centred clinical method, an approach to Family-oriented primary care, Community-oriented Primary Care, and ethical issues relevant to Primary Care(35). The academic year commences in February and ends in November, with a mid-year break of about three weeks. Summative assessment is in the form of written and oral presentations. Formative feedback, based on student performance in clinical encounters, reflections on video-taped clinical encounters and participation in group discussions, is provided on a continuous basis by lecturers.

Formal group reflection sessions, scheduled to take place every two months, were included in the timetable to ensure that adequate opportunities were available for reflection on experience, a vital component to the learning process.

## 3.3. Study design

This project took the form of a qualitative longitudinal case study. A longitudinal design was used because the study attempted to capture change in perception over time, which required multiple measurements of the same phenomenon at various moments in time(68).

### 3.3.1 Study participants

The population being studied to address the objectives stated above included three groups: first year postgraduate students undertaking FM training at UCT; patients who were consulted by these students during the course of the year; and educators (lecturers and supervisors) who had direct contact with these students.

All first-year postgraduate students were invited to voluntarily participate in the study. The inclusion criteria applied were registration as a first-year postgraduate student in FM and willingness to participate in the study. Exclusion criteria: not willing to participate; student deregistering from the

course; student not in first year. As the annual intake is limited to fifteen students per year, this was deemed to be the maximum size of the group eligible for participation.

The second cohort was that of patient-participants. Students engaged with patients in varied types of encounters for the duration of the data collection phase. A convenience sampling method was used to invite patient-participants to be part of the study. The inclusion criteria we applied were: willingness to participate; able to speak English, Afrikaans or isiXhosa; available for a brief interview either in person at the clinic or telephonically; mentally competent; over the age of 18 years; must have had a recent (less than 24hours) consultation with a student-participant; or caregiver of a cognitively impaired patient. The exclusion criteria were: no recent consultation with a student-participant; refusal to be part of the study; unable to converse in English, Afrikaans or isiXhosa; cognitive impairment with no competent caregiver present; and/or under the age of 18 years.

The third cohort of educators were purposively recruited for their active involvement in teaching and supervising postgraduate students in FM at UCT. This included those providing classroom-based teaching as well as clinical supervisors at the health facilities. These educators had varied lengths of experience and training in medical education generally and postgraduate FM training in particular, but all had similar clinical backgrounds in FM. All of the invited educator-participants played a role in supervision, formative or summative assessments of students at this level. Some would have fulfilled all three roles. The inclusion criteria for this cohort were: active involvement in some aspect of teaching or assessment of postgraduate students in FM at UCT; willingness to participate; and availability for the focus group discussions. Specific exclusion criteria were: not willing to participate; no involvement in teaching or assessing PG FM at UCT; and not available for focus groups.

As this was a qualitative study, the key strategy to determine adequacy of the dataset was saturation. Insofar as a fairly small population was being studied, and it was anticipated that most participants would accept the invitation to be part of the study, there was a reasonable amount of confidence that the data would accurately portray the experiences and processes of these participants. The definition of saturation that was used in deciding whether it had been reached, is the one proposed by Saunders and colleagues of 'inductive thematic saturation'(69). This is reached when no new codes or categories emerge from the dataset already collected and guides the researcher in deciding when to stop the analysis process. Implicit in this definition is that sample size is dependent on saturation. A potential pitfall is the departure from the original intent of saturation first described within grounded theory, which was to decide directly on the need to collect more data, which Saunders and colleagues call 'theoretical saturation'. This is particularly true when trying to ensure that all outliers are included in

the dataset, and the researcher pro-actively seeks new participants to expand the theory generated from the data. However, given the narrow inclusion criteria for all the cohorts, this does not apply to this study as data was collected from all the possible participants, with potential outliers already included in the dataset.

### 3.3.2 Data generation

Data collection and analysis depended on the respective objectives being addressed, with qualitative data (documents, individual interview transcripts, group discussion transcripts, direct observation notes, video-taped clinical encounters) being analysed thematically.

To address the questions in the first objective, that of exploring student learning, a number of data sources over a period of 10 months (the 2019 academic year) were used to achieve the key outcome, which was to develop a theory of learning about the DPR in this context. In this phase of the educational process, students were required to interact with patients on three levels: one-on-one clinical encounters (consultations) in the health facility; interaction with the family of a patient in the form of a home visit; engagement with community structures in the geographic area of the health facility as part of a community-oriented primary care module.

The first point of data collection was from the clinical encounters in the health facility using participatory observation methods. Direct observations between each student-participant and a patient at the health facilities, at which student-participants worked, were conducted on three separate occasions: the beginning of the project, at 6 months, and at completion of the project. Documentary data consisted of field notes of direct observations and a validated quantitative observation tool(9) (Appendix 1 – Cambridge-Calgary). Any patient willing to be part of this observed encounter was invited to be a study participant (convenience and purposive sample). In my dual role as clinical supervisor and researcher, I sat in on the consultation, assessed the student-participant's performance using the Calgary-Cambridge rubric, and recorded field notes. Quantitative data from the Calgary-Cambridge tool was entered onto an Excel spreadsheet and used to provide formative feedback to the student, and was not included in the research dataset. The research data collection was clearly distinct from the educational data collection, as described in more detail in Table 2 below.

The second point of data generation was from semi-structured group discussions at 3 monthly intervals wherein student-participants critically reflected on their own encounters with patients, families, communities and the health system, and feedback received from their clinical supervisors. Again, assuming the dual educator-researcher role, I convened and facilitated these discussions, which were audio-recorded and transcribed.

Thirdly, at the completion of the academic year, students were required to present individually, in any format, an interpretation of their learning in relation to patients and communities, providing an explanation of their rationale, and submit a written report. These presentations and written reports were used as supplementary material to explain some of the findings from the observations and focus group discussions (see Table 2).

To achieve the second objective, gathering feedback on, and exploring the patients' perception of their encounters with the student-participants, individual semi-structured interviews were conducted. Two trained research assistants were employed to conduct the semi-structured interviews with the patient-participants. One was an Afrikaans-speaking female in her 30's of Caucasian descent, a teacher completing a Master's degree, who conducted interviews in English and Afrikaans. The second assistant was an isiXhosa-speaking lady in her 50's of African descent, a qualified social worker, who conducted interviews in isiXhosa and English. The English version of the questionnaire had been developed with the specific objective in mind and piloted during the proposal development phase of the project. Each of the assistants translated the questionnaire into Afrikaans and isiXhosa respectively, and each translation was independently reviewed by someone proficient in Afrikaans/English and isiXhosa/English. The translated questionnaires were piloted after the first training session where role-modelling and collective reflection was used as a training technique and reviewed at a second training session. The flow of this data generating process was: the patient was approached in the waiting area of the clinic and the research project explained in detail in a private room. Thereafter, the patient and student-participant engaged in the clinical encounter. Immediately after the encounter, the research assistant interviewed the patient (and escort, where applicable) in a private room.

Besides basic demographic details, a quantitative validated tool(70)(Appendix 2) measuring closeness between the doctor and patient was administered, and some open-ended questions based on the above tool were asked verbally (Appendix 3), and audio-recorded while the interviewer also made handwritten notes. The research team reviewed the handwritten notes and audio recording together to decide on the accuracy and reached consensus on any changes that needed to be made to the notes. The audio-recordings were translated into English and transcribed into document format using MS Word.

The data for the third objective, to explore the experiences and perceptions of educators as described above, was generated in the form of a series of focus group discussions (discussion guide - Appendix 5) within the first 3 months, and at the end of the academic year. These preliminary findings of the

data analysis from the student and patient cohorts were presented to the group. In the light of this data, educators were asked to critically reflect on their own experiences and perceptions of the learning, teaching and assessment processes. This data specifically did not include actual grades and academic performance of the students, as the emphasis was on the reflective learning of educators. The audio-recordings of the discussions were analysed as described in the following section.

### 3.4 Data quality assurance

In qualitative research, the need for rigour in ensuring data quality is important to proactively deal with criticism that may arise in relation to the trustworthiness or reproducibility of the data, among other risks. To pre-empt this, Lincoln and Guba's trustworthiness criteria as described by Nowell and colleagues(71) were used**.** This approach ensures that four key criteria are attended to: credibility, dependability, transferability and confirmability.

I attempted to establish credibility in the data by three key mechanisms: firstly, by directly observing the data generating processes, I was able to ensure that the participants' perspectives as recorded in the data texts were in keeping with their experiences; secondly, because data was collected from multiple sources for the patient and student cohorts, I was able to apply triangulation between the data sources; and thirdly, in the educator and student cohorts I was able to ask them to check the data (member checking) after I had performed a preliminary analysis.

Dependability is an important construct as it would allow future researchers to reproduce the study and either confirm or challenge its conclusions. To this end, the data collection tools, process of analysis and the generation of the key findings are made explicit. Additionally, all references to the raw data in the text are clearly marked, allowing any reader to engage easily with the raw data should they wish to explore a particular extract in more detail.

Although ensuring transferability is a difficult outcome to achieve in qualitative research due to great variability in the contexts in which research projects take place, I provided a detailed description of the study site, participants, my personal perspective, including a reflexive passage, that would provide a reader the opportunity to evaluate the transferability of these findings into their context.

The final trustworthiness criterion is confirmability, which is dependent on the three preceding criteria being achieved. Given the attention paid to ensuring that the preceding three criteria were adequately met, this threshold is also passed, with the concluding implication being that the dataset, analysis and findings can be deemed trustworthy.

## 3.5 Data analysis

Thematic analysis of the qualitative data was applied, as this facilitates uncovering of the process of meaning making, an educational principle that is essential to the student-participants' learning(72). The choice of this mode of analysis was also influenced by the need to be flexible in the analytic process, as the analysis was performed from a Critical Realist perspective, involving the critical exploration of both individual and social constructs that influenced the generation and interpretation of the data, informed by a perspective that "*is both explanatory within a particular set of conceptual relations and potentially transformative of those relations*"(70, p31). This approach facilitated the identification of phenomena that had transformative potential within the social reality (educational and clinical encounters) being studied by focussing attention on existential domains that were actual, empiric and real. The 'actual' refers to a reality that exists, even though the participant is not aware of it; the 'empiric' reality exists, and participants know it exists; the 'real' incorporates both 'actual' and 'empiric', and the structures that facilitate relations between phenomena. A Critical Realist paradigm is also sensitive to the power inherent in these causal or transformative phenomenon. Thematic analysis therefore affords the space to exercise these critical activities in generating the descriptive and interpretive findings, both of which are key to this project.

Inductive and deductive approaches were used when engaging with the dataset. A deductive approach facilitated the description of the process of student learning in relation to Mezirow's TL theory by applying this lens during coding, categorising and generating themes(74). While describing the process, the empiric data also tested the applicability of TL within the context of the study, reinforcing the utility of a deductive approach. The inductive approach synchronized with the flexibility of thematic analysis in facilitating the generation of descriptive and interpretive findings for those parts of the dataset related to the experiences, perceptions and meaning-making.

In engaging and analysing the dataset, the six-phased framework proposed by Braun and Clarke(75) was followed. Phase one involves the researcher "familiarising" with the data, by repeated listening to the audio-taped interviews and group discussions, multiple readings of the transcribed texts, while recording initial thoughts contemporaneously in the form of informal notes. In phase two of the data analysis, extracts from the data tests are coded, ideas that present themselves are listed, and seemingly inconsistent codes and extracts documented. Reviewing these codes, and categorising them when they were similar, allowed themes and sub-themes to be generated, which captured the common ideas proposed. An Excel spreadsheet was used to collate the data extracts, which were clearly labelled indicating their data-point of origin. Each extract was coded on this same spreadsheet, with each code being assigned a specific colour, and some extracts having more than one code. The

generation of themes from these codes, and their categories, represented phase three of the analysis framework. A theme was defined as a central idea or concept that typified the codes within a particular category. Field notes, student submissions and informal notes (from phase one of the analysis) assisted the process by providing context to the extracts and making meaning of participant statements. Phase four involves finding coherence between themes, allowing the mapping of themes in a way that prepares for entry into phase five, which is the fitting together of themes into a model that is representative of the raw data, and communicating a cohesive interpretation of the data. The final phase is the writing of the report into the current format.

## 3.6 Reflexivity in the data generation process

At this point, it is appropriate to insert myself into the research process. In so doing, the language that follows will describe the process from a first-person perspective, making explicit my role in the interpretive phase. This process requires a high degree of reflexivity to protect the integrity of the data. My triadic roles of programme convenor-clinical supervisor-researcher placed me in an extraordinarily powerful position in relation to the student-participants. This presented an ethical challenge to me as a researcher, who did not want to influence the data generation process too strongly, and as an educator responsible for assessing and grading the students. I recused myself from all summative assessment processes for the duration of the study in order to minimise the educational risk that the research process may have influenced me as an examiner. While this was pragmatically useful in that it addressed the perception that a formal reflective process may influence assessment practice and hence mitigated perceived risk to the students, in reality reflective practice is a necessary process for any educator, and even if performed informally or cryptically, it influences pedagogical practice. Oftentimes the formal ethical review will correctly and appropriately consider certain theoretical issues, but some issues presented in fieldwork cannot be anticipated, as they are embedded in the relationships between researcher and participant(76). In this instance, although I had recused myself from the examination, this represented a departure from the ‘real world’ of the student-educator relationship and may have skewed the performance of the student while being observed. A manifestation of this dilemma is presented by a psychoanalyst, Sally Swartz, reflecting on weighing the benefits of clinical research intertwined with clinical practice, against the risk to the therapeutic relationship(77). The proposed solution lies in a high level of reflexivity on the part of the researcher/clinician (in my case, researcher/educator), which is honestly reflected in the data production process, while protecting participant confidentiality – the focus is more on the subjective experience of the researcher than the objectivity of the participant.

Developing this higher level of reflexivity was wrapped up in the process of iteratively engaging, either singularly or collectively with my supervisors, with the data and searching for meaning that was novel to my thoughts and biases. This meant that I had to identify my own thoughts on an issue, and while it proved impossible to separate them from the analysis phase, it became a conscious effort to remain true to the text when extracting the codes. I anticipated this process of simultaneous deep engagement with my own thought processes and the richness of the text, would impact and possibly transform my own perspectives as an educator and clinician, though this was not the focus of the study.

## 3.7 Ethical considerations

This study conformed with the ethical guidelines pertaining to protection of confidentiality of all participants, as described by the Declaration of Helsinki(78). Although this project involved research in Health Sciences Education, and is not medical research per se, the ethical principles relating to autonomy of participants, protection of privacy and confidentiality, and minimising harm were directly applicable to all participants.

The study proposal was submitted to UCT Human Research Ethics Committee for evaluation and received formal approval (HREC reference – 484/2018). Approval was also obtained from the Provincial Research Committee of the Provincial Department of Health, Western Cape Government, SA. Finally, as this research involved students, formal approval from the Department of Student Affairs, UCT was obtained.

In particular relation to student participants, the risk was minimised by:

- Informed consent: Ensuring voluntary participation in the study, with full disclosure being made at the commencement of the programme, and at every instance of data collection. My role was fully explained to student-participants before commencement of the project. Voluntary participation was emphasised repeatedly during the data production process and participants were reminded that they could withdraw from the study at any point, at no cost or risk to themselves.
- Only data captured from voluntary participants was used as research data. As no students opted out of the study, there was no need to remove any part of the focus group discussion in the post-transcription phase.
- There was a strict delineation between research data and academic data for grading students. Research data only pertained to the process of learning and teaching, and did not involve the

collection of any academic or clinical data (grades from summative assessments, clinical information from the clinical encounters) generated by the any of the participants.

| Research data | Academic performance data (written or audio-visual) |
|---|---|
| Direct observation of clinical encounters | Presentation of Biopsychosocial assessment of a patient |
| Individual in-depth and quantitative interviews | Discussion of an ethical dilemma |
| Group reflective sessions | Report on a family meeting |
| Reflective journal | Report on a community-based project |

**Table 2: The distinction between research and educational data**

- As discussed above, I recused myself completely from all summative assessments related to any of the course components. However, by virtue of my responsibility as programme convenor, I retained administrative and governance responsibility to ensure that final grades were collated and submitted via institutional processes, and for quality assurance processes. Full disclosure in this regard was provided to all student-participants at the commencement of this project.
- To further mitigate risks, three senior academics in the department that houses this academic programme were approached to form a panel that was directly accessible to student-participants should they have felt negatively impacted in any way due to their participation or non-participation in this study. No students approached this panel with any queries or concerns in this regard.

A risk to patients who were asked to provide feedback on a clinician's performance in a clinic that they regularly attend, was anticipated in the form of a fear of victimisation and may therefore not feel safe in providing honest feedback. To mitigate against this risk, I recruited a non-medically trained research assistant who conversed in the patient-participant's home language to conduct the semi-structured interviews. Attention to confidentiality was consistently applied, and prior arrangements were made with facility management to ensure that the interviews took place in a private area of the health facility.

This data is being stored electronically on a password protected device that is not used in academic administration of the programme and that is only accessible to me. Involvement or non-involvement in the study did not carry any rewards or penalties for any of the students.

As the data generated from the student and educator cohort was generated in the form of focus group discussions, anonymity was sacrificed. Confidentiality of the discussions was ensured by asking participants to sign non-disclosure agreements in addition to the informed consent agreements. This data, once transcribed, was also anonymised in the reporting process.

# CHAPTER 4: RESULTS - A description of the actors and the process

## 4.1 Participants

In this short chapter, a profile of the study participants is presented. The sampling technique, desired sample size and criteria for inclusion and exclusion were discussed in the preceding chapter. Three distinct cohorts were recruited into the study: students, patients and educators.

The final number of students who were enrolled was twelve (n=12), representing the entire group of first-year postgraduate students in the FM programmes at UCT. The sample participating in the study constituted all those who 'opted in', with no student 'opting out'. In total six registrars (specialists in training, registered in the MMed) and six Diploma students were enrolled. Most students were female (8/12), in the 30-35 years age group (7/12), working in the state sector (9/12) and had a minimum of 5-10 years clinical experience after initial qualification (7/12).

| Designation | Practice context | Gender | Age | Years in practice |
|---|---|---|---|---|
| Registrar | State – hospital | Male | 40-45 | 10-15 |
| Registrar | State – hospital | Male | 30-35 | 5-10 |
| Registrar | State - clinic | Female | 30-35 | 5-10 |
| Registrar | State - clinic | Female | 30-35 | 5-10 |
| Registrar | State - clinic | Male | 30-35 | 5-10 |
| Registrar | State - hospital | Male | 30-35 | 5-10 |
| GP | Private - clinic | Female | 40-45 | 10-15 |
| GP | Private - clinic | Female | 40-45 | 10-15 |
| Nurse practitioner | State - clinic | Female | 40-45 | 15-20 |
| GP | State - clinic | Female | 30-35 | 5-10 |
| GP | State - hospital | Female | 30-35 | 5-10 |
| GP | Private - clinic | Female | 50-55 | 25-30 |

**Table 3: Profile of student-participants**

The strategy to recruit patient-participants, described in the preceding chapter, yielded a total of twenty-five (n=25) patients. The average age was 51 years, with the youngest being 24 years and the oldest 81 years. IsiXhosa was the most frequently chosen language (10/25), followed by English (9/25) and Afrikaans (6/25). Most patients (19/25) were presenting to the health facility for their usual appointments to attend to a longstanding (chronic) medical problem. Of those patients who provided this information, most had a secondary education (11/25), one had a tertiary qualification (1/25), four only had primary education (4/25), while one had never attended school. Most patients were employed (9/25), some were retired (5/25) and three were unemployed. Eight patients (8/25) did not report data on education levels or employment.

Of the thirteen educators who met the study inclusion criteria, five accepted the invitation to participate, with the only reason given for refusal by the remaining eight educators being their unavailability due to clinical workload. The composition of this group was one Professor and four Senior Lecturers.

## 4.2 Data collection

A total of twenty-five (25), twenty-minute clinical consultations between student-participants and patient participants were observed by me at five different primary care facilities. During these consultations, I made notes on the interactions, verbal and non-verbal, between the participants (research data), and recorded a score on a communication skills rating tool (educational data). Immediately on conclusion of the consultation, two activities happened separately, and in confidential spaces: I provided feedback to the student-participant on his/her performance in the consultation; and the research assistant conducted the ten-minute semi-structured interview with patient-participants, in a language of their choice. These interviews were audio-recorded, transcribed verbatim, and then translated into English. The English transcripts were used as raw data for the analysis, with field notes and recordings providing clarity and contextualisation where this was needed. This process, though clearly planned, was challenged by the noise in the busy clinics, the pressure from patient-participants to finish the interview so that they could collect their medication, and in one instance, the interruption of an interview by a staff member needing to access a cabinet in the room.

By contrast, focus group discussions with student-participants were held on campus, in a quiet seminar room, and continued uninterrupted for one hour. I facilitated three of these discussions, placed strategically at key intervals during the ten-month academic year (month 3, 6 and 10). As these sessions immediately followed a two-hour educational seminar, we had the full quorum at all of them of all twelve student-participants. As the first session happened in the third month, students and I had ample opportunity to bond as a group, and the discussion in the focus group flowed easily. As is usual

in group discussions, some members were more vocal than others, and employed my experience and training as a small group facilitator to ensure optimal involvement. Students seemed to enjoy the opportunity to reflect critically on their experiences, as the curriculum did not mandate reflection as standard pedagogical practice.

The educator cohort proved to be the most difficult to access, mostly due to their very busy workload. That only five were able to join the two discussion groups is notable, with the predominant reason provided for not attending being that they could not break away from their busy teaching and clinical workload for a two-hour discussion. This was in the pre-pandemic era, where online meetings were not yet in vogue, which may have facilitated better attendance. While the protocol called for three educator-participant focus groups, we ended up with two, placed at month 7 and month 11 after the data collection period had commenced. The final session was cancelled as COVID-19 was upon us and all research activities were placed on hold. Notwithstanding this, the data was deemed adequate, as saturation was reached in the second session. Both educator-participant focus groups were facilitated by me, which placed me right at the centre of most data generation activities.

## 4.3 Conclusion

This chapter describes the participant cohort and the process by which they were engaged. Some areas of interest are highlighted, in particular, the context-related issues in data collection from patient-participants, the full engagement of student-participants, and the issues around availability of the educator-participants.

# CHAPTER 5: RESULTS - Suffering: an opportunity for enhanced connectedness

## 5.1 Introduction

This chapter describes data that emerged from the direct observations of student-patient encounters in primary care clinics in CT, and the reflections of patients and students on these experiences. We proceed from the assumption that the encounter between student (clinician) and patient is a central social node in the health system, without attempting to marginalise other important social dimensions of modern health systems such as professional teams, referral pathways and communities (professional, cultural or geographic). Some interpretations of these findings are presented, and an attempt is made at placing the outcomes within an educational context, given the central position that the clinician-patient relationship plays.

In approaching this data, I have used Mbiti's essentialist conceptualisation of Ubuntu that defines who the African human being is biologically, socially and spiritually, who constitutes the community that is integral to this identity, and the multiple processes by which this human-ness is actualised(18). To make sense of this in a post-apartheid SA context, one has to acknowledge the radical and violent departure from this essential nature that has been thrust upon African communities. An attempt is made to observe, interpret and analyse the present day encounters between student and patient from this somewhat tortuous critical perspective, which could be described as operating from a historical realist perspective.

The themes that emerge and presented in this chapter, from this descriptive and interpretive process, were: the validation of patient-hood; the validation of personhood; and finally, opportunities for finding purpose and making meaning. As this is a project focussed on medical education, we develop and propose some thoughts about the relevance of the findings to a new imagining of African medical education.

## 5.2 Patient-hood is validated by attending to suffering

This theme refers to the expectation that patients had of clinicians (student-participants) in terms of the medical problem that had necessitated the consultation. When students responded to the patients' discomfort by listening, examining, and being comprehensive, the "patient-hood" was validated. The idea of patient-hood, as proposed by Duran, is a socially constructed role for an individual who has biomedical vulnerability or suffering as essential characteristics, and whose meaning is dependent on being in a constant relationship with a doctor(79). An additional layer to this

concept is provided by Duran, who typifies patient-hood as a role an individual accepts due to the presence of symptoms which is real to them, whether or not they are medically explained(80). In this theme, the validation of patient-hood manifested as the doctor paying attention to the suffering of the patient in various ways, resulting in an enhancement of confidence and trust in the doctor. The various manifestations are presented below.

### 5.2.1 Being examined

Patients have certain expectations of their doctors. Probably the most common recurring statement relates to the perceived comprehensiveness of their encounters with doctors. This patient responded to the comprehensiveness of the experience when the doctor examined him, using the term 'check' to indicate being examined.

> *"I can say most of the time when I come to hospital I didn't get the time (for) doctor to check me for everything. It was just (previously) to ask me the questions and writing. But when I attend (this) doctor they check my body, ask everything, so I'm happy with it."* [Patient interview 1:1-004]

A high value is attributed to being examined, as evidenced by the words 'everything', 'all', 'even', 'thorough', as demonstrated in the excerpts below. When it happened to the satisfaction of the following patient, the outcome was that she felt 'confident' in the service, a necessary precursor for 'trust' as we shall see later.

> *"It's the way he treated me… he told me all that I needed to hear, even for my high blood pressure. Today he even examined my eyes, something that is not normally done. That's why I chose this score…. But today I felt I was given a thorough examination… I felt confident about my health and treatment"* [Patient interview 1:2-001]

Being comprehensive, and wanting to know more about the patient's condition, was seen as being committed to his health by this disabled man, who had suffered irreparable brain damage in a motor vehicle accident some time ago. In response to being asked why he had previously answered that he felt the doctor had done a good job, he replied;

> *"She told me to lie on the bed and examined me; she also asked me other questions as well. And also gave me my next appointment and that I should bring her the letter that I got from Groote Schuur Hospital so she can thoroughly examine me… so she can put me on treatment. So she can see the accident I was involved as to how much damage it caused in the head."* [Patient interview 2:4-003]

The suggestion in these instances is that when a doctor aspires to being comprehensive and showing interest in developing a fuller understanding of the patient's problem, it is motivated by an interest in the patient's wellbeing. This seemed to be a departure from many patients' previous experiences. Using past experiences where she felt her suffering was not addressed as a point of reference, this patient remarked

> *"Because he actually came towards me and felt my leg… touches it and asked me how it felt. I am not used to that, because not every doctor actually comes to you and ask you while at the same time feel where you say the problem is. … 'what is the problem?' and 'what can I do for you?'… but this one actually came and touched me."* [Patient interview 3:2-001]

The meaning of being touched (examined) by the doctor is not immediately apparent in these excerpts. However, the value that this physical act holds in validating the patients' discomfort/pain is quite apparent. This idea of physical contact as a synaptic connection between patient and student at the point of the pain is intriguing in its possibilities.

### 5.2.2 Being heard

Patients expressed appreciation for when they were heard. This patient described a continuum of comprehensiveness that included being given the opportunity to 'explain', being heard and 'understood', and finally being 'helped'. What flowed out of this process, for this patient, was a recognition that the student performed in the 'best' way. Belief in the validity of the process led to belief in the promise of a good outcome, which proposes a formula for nurturing trust.

> *"He did everything… I explained to the doctor and he understood me, and he helped to the best of his abilities."* [Patient interview 1:1-002]

Another participant goes even further, placing high value in suggesting that when the doctor 'hears', it is an opportunity for meaningful connection, and that 'knowing' and 'understanding each other' is a desirable outcome.

> *"We get to know each other and to understand each other, which is very important… and they always ask how I am and how is my health doing and how I am getting on."* [Patient interview 1:1-003]

Several patients expressed the importance of being heard by relating previous experiences when they felt they were not being heard. One patient, when asked what she did not like about some of her encounters with doctors implied that she felt marginalised by their inattention, stating:

"*They don't ask you what are you feeling. They just do things and rush, rush… but this one takes time."* [Patient interview 1:1-006]

The centrality of suffering and pain is common to the patient experience, and a means of interpreting the doctor's commitment to helping. This middle-aged woman, in responding to a question about what she perceived to be a 'good doctor', responded,

*"They pay attention to what you're saying, examine the part that you say has pain and must be understanding."* [Patient interview 1:4-001]

Ignoring the pain and suffering without acknowledging or responding to it in the clinical encounter detracts from the validation that the patient seeks.

"*Some doctors… I reserve an appointment and come here to hospital then I see doctor and say Doctor, it's very tender, I have a pain. Because they ask you: 'Do you feel anything?' then you say: 'Yes, I feel something'… maybe I have a pain in my chest. Then he just writes it down and then there's no checking!"* [Patient interview 1:1-004]

Foregrounding the patient's narrative and experiences of the illness became the focal point of the consultation for this patient, around which everything else revolved, including the reflection on previous experiences.

*"I feel like with some doctors, say for example you tell them that you have a pain and the doctor won't even touch you to see where the pain is. Like he will just ask you where the pain is "Oh you have a pain. Okay." I experienced that the last time I came here, I had a back pain and lower abdominal pain. They only took a urine test and didn't even tell me to lie down on the bed to properly examine me. Today when I told the doctor that they had told me that I have urinary tract infection, I then asked him what are the causes and he told me and then told me to lie on the bed so he can check and then he found that the pain was still there even though I took the antibiotics. I told him that I could still feel the pain…"* [Patient interview 2:5-002]

When the pain that is causing suffering is validated, the patient feels understood and validated in the sick role, and is able to fully justify their patient-hood. The doctor becomes an ally in this process. This may represent a step towards developing trust: when the patient believes that the doctor believes her story, and has an intention to help, trust is earned.

*P: She made me feel safe, like I can talk to her about anything and to be honest with her during our conversation.*

*I: Did the Doctor do anything that you liked or made you feel good?*

*P: She treated me in a humane manner. Other Doctors and nurses don't normally do that. I felt safe with her. And then I could talk to her like honestly.* [Patient interview 4:2-002]

The validation of patient-hood emerges from the practice of suffering-focussed storytelling by the patient, while the student responds by listening and touching, motivated by an intention to help. In the clinical encounter, these become the necessary requisites for building confidence, creating comfort and fostering trust.

## 5.3 Personhood is validated

While patient-hood is an important construct within the clinical encounter, the human being who is suffering also responds, positively to recognition and acknowledgement, and negatively to being ignored or marginalised. For some patients, the role of patient is sufficient, but for others, it appeared that something more was needed, as described below. I describe this as a validation of personhood. When one considers this from the perspective of Ubuntu, then it is apparent that the person is the first to be acknowledged, before the clinical problem. The data that follows describes patient reactions to being recognised and acknowledged, which, for the purposes of this discussion, is termed a validation of personhood.

### 5.3.1 Ways of doing and being

Patients reported that certain actions or manner of actions generated positive emotions within themselves. While this may seem an obvious finding when two human beings encounter each other, the specific actions or mannerisms that evoke these emotions within this context are made explicit. While the emotions are not always explicitly explained, they are expressed in the words that patients use to describe the doctors' actions and their responses. Their assessment, beyond the *acts* of doing, includes the *ways* of doing and the *ways of being*.

*"…The doctor that I've just seen is a wonderful doctor… for the way the doctor treats me... speak very nicely to me... make me feel good… ask how I am and how is my health doing and how I am getting on.* [Patient interview 1:1-003]

It seems the act of touching evokes an emotional response, understandable when one considers that this localises and further validates the suffering, as alluded to above.

*"…he actually came towards me and felt my leg… touches it and asked me how it felt. I am not used to that, because not every doctor actually comes to you and ask you while at the same*

*time feel where you say the problem is. They always ask what is the problem and what can I do for you, but this one actually came and touched me. …I felt good about that."* [Patient interview 3:2-001]

The following patient describes her reaction to the attention paid by the student during the consultation. What is remarkable is that she could only speak a smattering of English (the post-consultation interview was conducted in Afrikaans), while the student is from another country, and can only converse in English. Despite this significant language barrier, her positive response suggests a subjective experience more focussed on *how* he performed, rather than on *what* he did.

*"P: I chose that circle because, yho… because it feel like the first time that I had a doctor examine me like he had and the way he spoke to me, the way he asked me the questions I was not even afraid to answer the questions.*

*I: How did you make the decision that the doctor is that close to you?*

*P: I made the decision because he, like I just said. The way he spoke, the way he looked me in the eye, even the way he touched me you know… Comfortable? Yes, he made feel very, very comfortable."* [Patient interview 1:3-001]

In addition, it seems that the patient assessment of doctors' attitude was rapid and intuitive, rather than slow and deliberate, based on a set of criteria. Although not articulating the pathways of the emotional response, these patients easily made causal relationships between their emotional experiences and doctors' ways of doing/being.

*''Because it was how the doctor treated me when entering the room. From there on it was just a good relationship between me and the doctor… The way he treated me through the whole appointment… For me, he did everything perfect. I wouldn't ask that he does something different, everything he did was perfect. And I was satisfied with the services… Some doctors… It is just you are a patient, they treat you and you go. They don't go that extra mile to make you feel comfortable."* [Patient interview 1:2-002]

*"P: Yes, he made me feel goo… I was comfortable.*

*I: What made you feel comfortable?*

*P: I didn't hide anything, because of the way he asked me."* [Patient interview 1:5-002]

*"…when she asked me if I feel comfortable with her then she quite understood… She made me feel safe, like I can talk to her about anything and to be honest with her during our*

*conversation… She treated me in a humane manner. Other doctors and nurses don't normally do that. I felt safe with her. And then I could talk to her like honestly."* [Patient interview 2:4-002]

Patients clearly identified and responded to the ways that students performed tasks, their ways of doing, and in their manner of carrying themselves into the encounter, their way of being.

### 5.3.2 Builds trust

Trust is not something that is inherent in the DPR. It is earned, and for the following patient, was conditional on the student being attentive and responsive to the problem at hand.

*"The things that make a good doctor is to give the patient the time. When he gives the patient time and ask everything, it is good, and they must follow the answer of the doctor."* [Patient interview 1:1-004]

Performing certain acts within the consultation that reflect the gravity of the patient's concerns engenders confidence in the doctor's decision-making.

*"It's the way he treated me… he told me all that I needed to hear… even for my high blood pressure. Today he even examined my eyes, something that is not normally* done. *Yes, because of this thorough examination I felt confident about my health and treatment. Before him, we were complaining about how we are treated here, there was one time that I even decided to stop coming because of this poor treatment."* [Patient interview 1:2-001]

Validation of the patient's humanity (personhood) by virtue of ways of doing and of being nudges the relationship towards confidence, trust and comfort. This is less apparent in the time spent with patients than it is in the way of engaging with the patient. From this perspective, a short encounter grounded in a paradigm of validating personhood could be more meaningful than a longer encounter grounded only in compliance to the technical rules of the system.

## 5.4 Caring for the carer

From the student perspective, a similar theme arises: suffering (or its imminence) is an opportunity for the student-clinician to traverse the distance between self and other. Dr A, working in a small community-based facility, had a startling realisation that she was not far removed from the risks that her patients are exposed to.

*"…it struck me that should my father not have medical aid this is the facility that he would probably go to. And I looked around one day and I sort of saw how certain patients were being*

*treated and it did not sit well with me that my own family member might be subjected to the same level of care we're giving some patients… and that really bothered me."* [S-FGD 1:179-183)

Dr S learnt a similar lesson when contemplating the impact that a meaningful relationship with a patient had, as she found an ally for her own wellbeing. She worked in a very busy clinic treating patients with HIV and TB. Every day was booked full, and any distraction that needed time to attend to was viewed with irritation. So, it was a surprise that, when she experimented with proactively seeking a more meaningful encounter with her patient, she found solace from the intensity of her work in an unexpected place.

*"I sat and I just spoke with her and I'm like, but why... just why, because she was also, she walks with a walker. And I asked her, but see… why? and then because I had seen her for a long time and because she knows me, she told me that when she found out that she was HIV positive she tried to commit suicide. She drank some type of acid, had a partial bowel resection and because of that she can't absorb Vit B12. They found it out only when she had spinal atrophy from B12 deficiency and that's why she's in a walker. And because of that she has to get her Vit B12 injection. And that just blew my mind. I was just... and went from thinking this woman just wants her B12 injection, to this complete like opening up and she had never told anyone. She has a file this thick, no-one knew. And now that I know that about her and now that she'd shared something very personal about herself to me, I felt like I'm much closer to her and I feel like I can understand her so much better. So, when she comes to me on a Friday, we are now also... she will say, phew doctor, you are having a very busy today, don't you think I must go put the kettle on?* [S-FGD 1:384-395]

### 5.4.1 Finding peace

Being aware of their own emotional vulnerability and humanity was also characterised in a positive light, as described by the following participant, narrating how she allowed herself, and benefitted from, opportunities for more compassionate interactions with patients who needed higher levels of empathy. She freely borrowed from her own intersectionality in ways that benefits her patients.

*"I think for me it is just accepting that I am human and I will react emotionally if I am confronted with an emotional kind of situation… that it will happen and I am okay with, because I am human, and most of the time I deal with children or young adults and they will remind you of my own kids and I will say to them: I am a mother and I am a doctor but a mother as well. I will give a patient a hug or let them lie on my couch if they are very stressed and for*

*me that is okay, and I think it is part of caring. I think that is part of being a doctor and showing you care and knowing someone cares."* [S-FGD 3:342-350]

The ability to step past barriers to meaningful connection held some consequences that students had not anticipated.

*"The reason why we want to do it (enhanced relationships with patient) is simply because practising the other way was essentially what led to burn out for a lot of us to different degrees because you just give out instructions and they come back a month or three months later and it is still the same thing, and you give out more instructions. …we were not listening then to understanding the patient… We were listening to give solutions and your blood pressure is high and let's give you this tablet or this…"* [S-FGD 3:47-56]

Mitigation against burnout was certainly a surprising finding, as the highly stressed system and working environment was often blamed. Yet, while the context had not changed, the perspective had, and in searching for deeper meaning, the negative impact of this context was significantly diminished. Early in the project, this participant had already anticipated that the possibility of a more humanistic way of being and doing could have a positive impact on her wellbeing.

"*I think for me personally it would contribute to prevention of burnout because I feel like if we just operate like robots and diagnosing patients, making diagnoses is not really making a connection with someone, it takes away from what it means to be a health professional."* [S-FGD 1:99-102]

Later in the project's timeline, when students had actually had an opportunity to experiment in their workplaces with new ways of being with the patient, Sr A, working in a high crime, impoverished area related how her clinical encounters are a redeeming aspect of her day:

*"And that is nice. It's a nice fulfilling thing. Also, it's... was saying that it's lonely sometimes. If you're the only practitioner, it's lonely because you don't get to speak to anyone. You just feel like you're working, working, working. And if you're actually speaking to your patients like a person and not just a patient then you are less lonely because you're actually speaking to people all day."* [S-FGD 3:132-136]

In addition to the prevention of burnout as described by his colleagues, Dr C describes a feeling of 'peace' when he was able to facilitate a patient making a decision about starting Insulin for her uncontrolled diabetes – a departure from the norm when he would usually make the clinical decision, impose it on the patient, and then carry the emotional burden of that decision.

*"So all I did today was to explain to her everything. I empathised with her… But since we are now starting her on insulin, I explained everything in terms of she would have to learn how to give it, it's a lifelong thing, she's got chronic kidney disease, she is not a candidate now for replacement therapy... I just explained everything I could remember about and honestly by the time I finished, I felt at peace, like, she can choose to discharge against advice, I would honestly have no problem. She knows everything and I actually got an interpreter to make sure that everything is... in Afrikaans… that's why I can empathise with this nodding because I was at peace, I was like, aah. And she decided to stay. It was almost an anti-climax. So, I get that thing about the peace. Sometimes I still feel like I make a lot of the decisions because I am guiding you towards what I want you to decide. So, I still feel like, it's still like my decision but with your participation as a patient. But in this case today was purely hers. I must let go."* [S-FGD 1:331-334]

Letting go of the desire for control, and hence the paternalistic responsibility for the patient's wellbeing, was a liberating experience for this student. It was not an abdication of professional responsibility – he had still facilitated an informed decision but had additionally taken a conscious personal decision to respect the autonomy of this patient. That moment of peace enjoyed in the frenetic environs of an acute hospital was appropriately savoured.

### 5.4.2 Finding meaning

Beyond burnout and peace, students found meaning and purpose. This was found in the ordinary activities that they had been engaged in for many years previously. The changed perspective, dealt with in detail in another chapter, held enormous benefits for them. As one student related,

*"As I'm saying I got to see the difference [inaudible] So right now the relationships are now more based on a personal basis, as in actually trying to see a human being, not just another patient that needs to be finished quickly."* [S-FGD 1:28-60]

Finding meaning in clinical work, for Dr Z, meant rediscovering the ability to make a difference in her patients' lives. Her work no longer was a series of transactions, typified by endless queues and just going through the motions to get to the end of the working day. She had become an agent of change in her patient's lives.

*"P: So that connection, those few minutes that I'm with each patient, that relationship is quite important even if it's for a short period of time, but actually feeling like you might be actually making a bit more of a difference than just treating someone, but actually talking to someone*

*like a person for those few minutes. It helps the day also go quicker for me. It's not ... it makes the work a bit more meaningful.*

*F: So, it gives you more meaning to your work?*

*P: Yes, to what we're doing because, yes, it can get really depressing if you're just going through the motions and doing stuff, it just feels like it's a queue of people who never... just treating numbers.* " [S-FGD 1:104-111]

Connected to this search for meaning was the desire to do good, a reflection of the intentionality that the student brought to the clinical encounter. This intentionality drove the engagement beyond the mere technical and transactional, to a realm of meaningful engagement for Dr R, who reflected on her experiences of doing a home visit in an informal settlement:

*"So, this forced me actually to focus on this guy as a person. It's also like a lot of the tools that we have, we can give lots of recommendations about clinical things, but this actually forced me to think, how can I make this person's day to day life better? Which I find really difficult. I think we've spoken about it before. We can all just write down a plan for her to do social work with. This was actually you seeing what this person's life is like."* [S-FGD 2:147-155]

Dr N described her intense emotional responses when her intentions aligned with her engagement with her patients – the connection with the patient's suffering was instant and acute.

*"F: So how did you cope with patients whom you don't get on well? So, you said that you connect with their pain.*

*P: Yes. It's understanding… that… the reason why they are angry, or the reason why they're irritable is because they're in pain. I mean, I had one student who came in and walked in and sat on the chair and pushed as far back from me as possible, and I thought 'Oh my goodness, what is going to happen in this consultation?!' But I think, you know, I started talking and I felt like crying and I'm thinking, shame, the amount of pain... and it's like immediately I was thinking of an animal with a thorn and that is now wanting to bite and bark. Yes, for me it's understanding. No-one is... they are who they are because of their experiences."* [S-FGD 1:421-429]

This rather intense emotional response, granting the student an ability to make a deep and meaningful connection with this patient, nevertheless holds some risk of being overwhelmed by that which is beyond her control, similar to the frustrations with the overwhelming issues in a health system that

are beyond her control. The possibility of sustaining this type of intense, meaning-generating practice could only be possible if the practitioner herself finds support, existential, material and moral. In the context of the clinical encounter, the search for meaning is potentially perilous.

## 5.5 Conclusion

The themes presented in this chapter describe the validation of patient-hood, the validation of personhood, and the impact of enhanced engagement between students and patients. Central to all of these themes is the idea of suffering, which is the foundation for the illness experience as proposed by McWhinney(23), and Helman's explanatory models(15), and when applied to the clinical encounter, offers to be the bridge between the student-clinician and patient.

Suffering, the desire for relief, and the ability to help are what forms the foundation of the clinical encounter. From the patient's perspective, this encounter is valid when it validates the suffering in whichever way they interpret it. This means that the attitude shift from disease to illness, as described by many before, is the focal point of meaning production for the patient. When suffering is foregrounded, the encounter represents a space of holistic human engagement, and when it is marginalised in favour of efficiency or cost savings, the meaning is reduced to a materialistic biomedical endeavour. For medical educators in particular, this holds profound implications epistemologically, where the overwhelming weight of data that informs the medical curriculum comes from the biomedical sciences. And it is in this moment that Ubuntu comes to the fore. Sindiwe Magona, the SA novelist, in her novel about rural life under apartheid and its many challenges, describes how death and grief leads to solidarity between villagers based on knowing the 'other', understanding suffering based on personal experience (validating), and responding in a manner that holds meaning to the recipient(81). Discovering or shaping the educational practices that can facilitate the development of the ability to identify and respond appropriately to suffering is the first challenge for medical education.

# CHAPTER 6: RESULTS - Disciplinary power, agency and vulnerability

## 6.1 Introduction

Power was raised as a central theme by all participant cohorts, although in various manifestations and from differing perspectives. This chapter describes my key findings (themes) that emerged from the data collected by direct observations, individual interviews and group discussions. Because this project is premised on the notion that the student-patient encounter is a central element in the process of educating health professionals, I conclude by proposing a schema for analysing the power dynamic in the doctor-patient encounter from an educational perspective.

In considering the student-patient encounter, I propose that power is a phenomenon that cannot be ignored when trying to learn about, and gain deeper insight into, student-patient relationships in a context of significant social inequality. When applying an interpretive educational lens to this data, we can propose appropriate opportunities for future practice in medical education.

Three key themes were identified, which will be elaborated and discussed in greater depth. The first applies to the notion of patients as critical agents in the face of a powerful health system. This is especially important when we consider that the discourse of 'empowering patients' presupposes that they are disempowered to begin with. The second key theme relates to manifestations of agency of actors within the system (doctors and educators), who are often far removed from policy or decision-making, yet are required, by virtue of their positions, to make decisions. And finally, we deal with the vulnerability experienced by doctors and educators, as they consider changing power dynamics in their respective relationships. When applying an educational lens to this analysis we propose that three distinct, observable nodes of power emerge. These nodes of power can assist the educational project pedagogically with the phenomenon of the student-patient relationship and its microcosm, the clinical encounter: decision-making; actions that flow from these decisions (implementation); and accountability, that oversees decisions and actions.

## 6.2 Patients as critical actors

Patients exhibited remarkable and exciting ways of powerful actions in the clinical encounter that point toward power sharing possibilities. This manifested as acts of evaluation, accountability and shared decision-making.

### 6.2.1 Acts of evaluation

Mr M (a pseudonym), a 66-year-old man, came to the outpatient clinic of his local hospital on the outskirts of CT. He is financially dependent on a state old age pension, having worked as an unskilled

labourer for most of his life, marked by an education that ended before high school. His interview after a routine visit for his multiple diagnoses revealed that he had clear expectations of the outcomes of the encounter, evaluating the doctor's performance against how these expectations were met:

> "*He did everything that I wanted the doctor to do… I explained to the doctor, and he understood me, and he helped to the best of his abilities... We wanted him to draw blood, and the doctor did that to see if he could find anything else that might be wrong."* [Patient interview 1:1-002]

The attention to expectations is important, insofar as they draw attention to Mr M's ability to formulate and clarify them independently of professional assistance. The belief in the authenticity of the expectations is strong enough that they become a measure of the success of the encounter. The interpretations of the signs are drawn from their respective world views, and therefore holds a measure of authenticity. As such, Mr M's expectations emanate from his worldview, drawing its evaluative power from that.

Patients used their past experiences with medical professionals as a point of reference when evaluating the current encounter. The context of the observations for this study were not what doctor or patient was used to, disrupted by the presence of an observer (me), and because he was being observed as an educational activity, may have influenced the performance of the doctor-role in this encounter. While this may have been the case for the doctor, my disruptive presence and the potential influence was not lost on the patient, with an astute comment:

> *"I would like for it (a high rating) to him, because of previous experiences with doctors… to speak honestly this was the best service that I got. I don't know why, because he was maybe… he was being observed a lot. But to me he did everything good… Since I've been coming to this hospital, it was the first time now ever to be treated like that by a doctor."* [Patient interview 1:2-002]

Commenting on a past experience at the clinic that his blind 78-year-old mother attends, Mr A, her son who was accompanying her on the current visit, stated quite emphatically that

> *"We are different people with different personalities, some of us keep (remember) the faces of the people that have mistreated us."* [Patient interview 2:5-003]

He justifies his position:

> "*Some doctors just examine for (the) sake of doing so. They do not pay attention to you, they examine and then write down your prescription and then they tell you to go to the pharmacy. Some doctors do that, they don't check you properly…"* [Patient interview 2:5-003]

Previous experiences, concretised in patients' memories, cannot be negated by policies or excuses, and play a significant role in building perception, which provides for some degree of predictability for future experiences. This is especially important when one considers the vulnerable position a sick person is in, not sure of the severity or extent of the illness, or the impact it could have on their lives. Such perception becomes an important anchor to evaluate current experiences and predict potential outcomes. In this way, lived experiences become integrated into the patient's explanatory model of her illness, providing some level of meaning to the current experience.

Evaluating the doctor's attitude was based on a rapid semiotic observation of the doctors' manners and performance of certain tasks during the encounter. Patients were remarkably articulate in justifying their comments about the doctors' performances. Mr W, a 54-year-old man, encountering this doctor for the first time, was emphatic in his praise:

> *"There is nothing that I would like for him to change. I didn't see anything wrong with what he was doing. I saw that <u>he was passionate about helping people</u> and not someone who was just passing time."* [Patient interview 1:2-001]

The initial statement is qualified by an observation of the doctor's passion, made all the more valid by the patient's subjectivity of being at the receiving end. It might be true that previous experiences had lowered the bar for him in terms of the expectations about doctors' passion and commitment, but his ability to discern the intentions of this doctor semiotically was significant. This close, analytical observation within the short clinical encounter wherein he was the object of scrutiny belied his lack of formal education… he had not progressed beyond primary school, and still works as an unskilled labourer.

### 6.2.2 Acts of accountability

A consequence of this evaluation of attitude is found in the level of trust (or mistrust) or confidence (or lack thereof). Trust and confidence, important to the medical profession and the individual practitioner, seems not to be an automatic characteristic of the DPR, but is conditional on how the doctor is perceived.

Ms F, an unemployed middle-aged lady, attending the hospital with an acute problem, laments the absence of certain characteristics in previous experiences with doctors, and presents the conditions necessary to earn her trust:

> *"The first thing I don't like about doctors is, you tell them there's something wrong with you and they examine you, everything goes so quick. And then they just give you the outcome. You don't feel like you are properly examined… He has to be patient with you, and you have to trust him when you coming to his office or room. When he begins to speak to you, that trust must be immediately there."* [Patient interview 1:3-001]

This concept was echoed powerfully by Mr S, a 42-year-old man with uncontrolled high blood pressure.

> "*(Laughing)… Yeah… Some doctors… when they walking past the passage that we sit in, they just walk past us like we are just nobody. You know what I mean… yeah (laughing)... They have to make you feel comfortable, make you feel safe around him. If he does that you know that you can trust him with the medication that he has given you."* [Patient interview 2:4-002]

The patient clearly has the power to give or withhold genuine, trust-based engagement in the clinical encounters, making decisions not so much as a consequence of the social structures that give power to the doctor, but rather as a result of the semiotics of the individual interaction that emphasises their humanity. This observation clarifies that reciprocity exists within this dynamic, as in other human engagements, challenging the conception of the patient as passive recipient in this exchange.

### 6.2.3 Decision making

Patients were explicit in their desire to be part of the decision-making in the consultation, citing their autonomy as the key reason. Mr S, the man with uncontrolled blood pressure quoted above, clearly wants to be able to choose the most acceptable option for himself. His comment below should be read in tandem with his previously quoted expression of being made to feel like a "nobody" while sitting in the waiting area.

> *"I think you have to be part (of decision-making). You see the thing is… when he prescribes you medicine, he must explain what is it for. So, I think it is necessary for you to be part, you must give a choice of whether you want to drink it or not. And he must listen to you when you say no. For example, I was drinking Pharmapress and it didn't make me feel good. So, I had a choice to say no these pills are not good for me but there are some other doctors told you: "no it's the only pills we have here you have to drink it otherwise leave them there." So, I do think that they have to give you a choice."* [Patient interview 2:4-002]

Ms A, a 30-year-old mother of a 6-year-old autistic boy, bringing her son to the hospital for a routine assessment, is equally emphatic about being involved in decision-making. Her response suggests that she regards this as normative practice, something that is not really up for negotiation.

> *"I: Okay. When you see a doctor, do you want to be part of making decisions? When you come to a doctor do you want to be part of the decision making…*
>
> *P: Yeah, I think I would if it is something that I feel comfortable with if it is going to help me. I think it is supposed to be like that, nobody makes decisions about you and you (are) not comfortable with and you don't want to do it. So yeah, I think so…"* [Patient interview 2:5-002]

It is in understanding the patients' semiotic skill that we may unearth some of their analytic ability. Though the empirical data at hand is not sufficient to reach any conclusions in this matter, an acknowledgement may stimulate some future research. In our study, patients come from suburbs with high levels of gang and interpersonal violence, with the threat of injury or death ever present. A semiotics of survival may have evolved from early childhood and translated into how the clinical encounter is 'read', rather than only as a medical encounter. Important as this observation may be, it is interpreted with caution so as not to reduce or limit the entire life experience of the person to the context he or she lives in.

In contrast to what has been described as a power imbalance between doctor and patient, what emerges from these observations of patients are an image of a critically engaged person, exhibiting power in terms of the expectations and evaluations of performance, level of engagement, and reciprocity. The power dynamic between doctor and patient is nuanced, with multiple axes, and manifest cryptically. In none of these actions are patients passive, as described by Foucault's 'medical gaze'. However, my observations of these encounters did not easily reveal these manifestations of agency, suggesting that within the encounter they are suppressed, to be exposed in the reflective interview afterwards, and likely in the adherence to the doctors' recommendations in the days, weeks and months that follow. Could this possibly explain Mr S's uncontrolled blood pressure? James Scott's analogy of onstage-offstage performances that typified peasant-landowner engagements in his study, seems to be mirrored in the performance of compliance within the encounter (onstage), not followed through when in the reality of the patient's life (offstage)(82). It is when patients are in the reality of their own lives that the decisions made in the clinical encounter need to assume a dominant role. While often acknowledging the doctor as the medical expert, the decision to reciprocate with trust was, at least partially, based on an evaluation of the worthiness of the doctor to be granted this trust.

The implications for medical educators could be captured in the following questions, which will be discussed later, with the working assumption that engaging with the patient's agency is a useful experience: how can we engage with the patient's agency as an educational resource; what is needed to awaken a consciousness of this agency within students; and what are the potential consequences of embracing patient agency in this way?

## 6.3 The struggle with vulnerability

Clinicians working in SA's state-funded health sector are especially vulnerable to burnout and associated mental health challenges(83). The student-participants, all independent clinicians, were aware of their own mental health vulnerability inside their facilities, and vulnerability to crime outside the facility. The context in which the following data was generated is a formal course dealing with the psychosocial dimensions of clinical care, wherein students were expected to apply new theoretical constructs in their clinical encounters in the clinic, and had to visit a patient's home in the community, something which none of them had done before. The data was generated in a series of reflective discussions they had within this course.

Sr A is an experienced clinician working in an area notorious for its high crime and substance abuse rates. As such, the patients she consults with face complex challenges, even if their biomedical complaint is seemingly simple. She describes how her desire to offer a holistic service cognisant of the patient's vulnerability and based on an ethic of care, worked against her as she felt manipulated by the patient. She had made a conscious decision to be more caring and inclusive but felt taken advantage of when the true intention of the patient was exposed.

> *"I think the inherent scenario that the patient needs something from me... that we are here to do good and to satisfy the needs that the patient has, and that the patient is coming to you as a vulnerable being and without any hidden agendas or for any other reason... So yes, I'm answering that. So, from inside that is why I'm here. I care so therefore I am here. So, I'm here to satisfy that. ...I come there (here) with wanting to satisfy the need and you would believe that the patient is going to take chances... <u>And then sometimes it makes you feel like, was I that gullible</u>?"* [S-FGD 1:152-156]

Self-judgement based on matters beyond the clinician's control was a source of distress, with solutions not readily available. This participant, Dr D, a few years out of medical school, and in the process of establishing herself as a clinician in a community-based facility, acknowledged that she was not being kind to herself by self-imposing expectations that were beyond her power to achieve, in the attempt to provide high quality care in a resource limited context.

*"I try to do the best that I can which is not always the kindest thing for myself, or for those around me because I think if we try to keep up really high standards in the resource limited settings, and resources not just in terms of things, but mostly in terms of time, and I think this is a recurring issue for everybody, it's really very difficult. …And I really feel like most of us, we do do our best, but often I just feel like we're not reaching the standards that we should be… and that… it's a very difficult thing for me to balance."* [S-FGD 1:183-189]

In an environment where the patient's rights are foregrounded and held up as an institutional ideal, the health worker feels marginalised expressing disempowerment, fatigue and depersonalisation.

*"I often feel that the patient holds the key to the power, and I just sometimes feel like I'm just a cog in that wheel, just having to keep on working and working."* [S-FGD 1:237-238]

These rather intense feelings of vulnerability, whether it is at the level of engaging with the individual patient, dealing with systemic resource challenges, or the dominant institutional culture, points to a perceived lack of agency within the larger structural issues that dominate. This brings to mind Michel Foucault's idea of 'docile bodies', subjected to disciplinary power and stripped of individual agency and ambition, where every moment and action is pre-determined by the demands of structural power(84). Clinicians working in the contexts we have described are subject to this structurally imposed powerlessness, at the mercy respectively of patients' desires and systemic deficiencies. It seems there is a relentless struggle to surface from these almost oppressive forces, to find some sort of self-knowledge and expression amidst all the angst. The struggle is not *against* vulnerability, but rather *with* vulnerability, in the sense that it seems to be an unavoidable component of working in this fraught space.

One of the tasks designed to enhance clinicians' understanding of the patients' home context was doing a pre-scheduled home visit. This process generated strong feelings of vulnerability. Dr C, a tall imposing figure on ward rounds and in the clinic, usually knowledgeable and confident, relates his apprehension.

"*My predominant feeling at the time I was going was apprehension because I was going to (a high crime area)… in this case it wasn't my patient inviting me… like, what am I walking into?… Are they going to see me as an intruder that doesn't speak Afrikaans… By the time I was knocking on the strange door, and... The nearest police station wasn't that close, so ...*" [S-FGD 2:43-53)

This speaks to the obvious issue of personal safety in communities with high levels of interpersonal violent crime, but also the diffusion of the power of the clinician by stepping out of its context. He

considers his position an outsider, unable to speak the community's language. The image of 'knocking on a strange door' is a powerful metaphor for his anxiety and uncertainty, for the unknown.

Despite the vulnerability, Dr Z, a doctor working in a practice in a working-class community, connects with the response she received when doing the house visit.

> *"…yes, our workplaces are our comfort zones. And then going out there, it's a very vulnerable thing, like you are exposed. But the good thing about the experience is that the patients all seem to feel special that they were singled out… Compared to the conveyor belt system… So that personal touch helps to buffer the...* (trails off)" [S-FGD 2:170-172]

Dr B, a foreign African doctor doing his training at our university, visited a patient in one of the poorest informal settlements in CT. At the time, he was working at a community-based HIV clinic, a context well known for strict adherence to clinical policies and protocols. Describing his sense of vulnerability as 'exposed', he reflected on his home visit experience,

> *"And I felt out of my comfort zone because the patient had the assumption that doctors know everything, and they would start asking about everything. Like the structure of the house, how to make this better... That's why I felt like a foreigner. Exposed. And I think the system works for us, not for the patients. More suited to us."* [S-FGD 2:320-323]

### 6.3.1 Mitigating vulnerability

While much of the expressed vulnerability was anticipatory, that is, the participant expected some negative experience, their actual experiences with patients were overwhelmingly positive. Dr S, also a young doctor in the nascent years out of medical school, met up with her patient, a refugee from a neighbouring African country, living in an informal settlement.

> "*I was thinking to myself, why did she respond so overwhelmingly, like where did this come from? I mean she took me to her house immediately. I didn't even have the chance to plan the visit. And I was wondering to myself, why this immense... She was so grateful for me* [S-FGD 2:91-99)

And later, when considering the reasons for families' responses to the home visit, she remarked:

> "*I think it might just be that Ubuntu thing. Most of us walk in there looking like a puppy, waiting to be whipped or something, so it's like, please don't hurt me. I think it might just be, just being the host this time. Maybe they are trying to show us how we should be doing it."* [S-FGD 2:337-339]

Once again, the imagery of a puppy, helpless and lost, brings home powerfully the message of dependence on the patient that this activity provoked. With the changing of the context from clinic to community, the power shifts discernibly between doctor and patient.

Reflecting on the unexpectedly positive experiences, participants suggested that vulnerability may be a worthy price for the enhanced sense of caring felt by patients. Stepping out of the clinician comfort zone with the express intention of providing care becomes an act worthy of its consequences, feeling vulnerable becomes a price they are willing to pay.

Dr Z, in trying to answer a question about why families had responded so positively, answered:

> *"You asked why do you think the families are so welcoming. I think it's because when patients are ill in the family, the families have a burden of care, and I think they're grateful that you're there to witness, give any suggestions on how they can make it better and easier, for the patient and for themselves as well."* [S-FGD 2:352-356]

There is value in patients feeling as if the doctor cares for them. This too, seems to be a price worth paying in embracing their own vulnerability:

> *"And then going out there, it's a very vulnerable thing, like you are exposed. But the good thing about the experience is that the patients all seem to feel special that they were singled out."* [S-FGD 2:171-173]

And

> *"…I'm the only white lady walking or working… You make yourself vulnerable in that sense. But I think most of us have had positive experiences… Because one of the things that I felt, going there, to her, was a sign of caring…"* [S-FGD 2:84-90]

### 6.3.2 Reflections on vulnerability

Being able to reflect critically on their emotions during the home visit and other patient encounters allowed some of the vulnerabilities to be exposed and understood. Referring to a case study that she had written up as an assignment based on an encounter with a particularly traumatised patient, Dr N, who had qualified almost 30 years ago, related her surprise at being so emotionally invested in the experience – this after never having had a similar experience in thirty years of being in clinical practice. Engaging reflectively with experiences that touched them deeply led to enhanced awareness of their own emotional reactions.

*"This year now with my last case I cried so much and already in my assignment I wrote it there. I am even tearing up when I think about this patient, but I am finding I am wondering and asking myself should I be crying over my patient. So, I think if I tell you guys the story you will cry. It is human but I must be careful… Do we become too emotionally attached or involved with the patient when we expect them to trust us and we trust them? Does it affect my judgement?"* [S-FGD 3:298-308] *(great data!)*[2]

Self-awareness and the ability to reflect in-action mitigates the emotional vulnerability somewhat. In the next quote, the participant links this vulnerability to our humanity, and how being aware of this assisted her in dealing with certain situations.

*"…and then it makes it easier to handle those things because you acknowledge your own humanity, and you understand there is a part of you invested in this process. So, in those situations when you manage to use that perspective it is much easier handling the emotions. When you don't, of course it is a bit rougher but still all in all it is a more rewarding experience."* [S-FGD 3:330-336]

When asked if this vulnerability was worth the effort, the same participant responded by comparing her current practice to her previous practice, which she characterised as a quasi-industrial process.

*"…rather like the conveyor belt system because at the end of the day there is that hollow feeling and even though you pushed through the numbers… but you just drained from that."* [S-FGD 3: 338-340]

Being aware of their own emotional vulnerability and humanity was also characterised in a positive light, when participants agreed that it allowed them to identify opportunities for more compassionate interactions with patients who needed higher levels of empathy. They freely borrowed from their own intersectionality in ways that benefitted their patients, as indicated by the following powerful excerpt.

*"I think for me it is just accepting that I am human and I will react emotionally if I am confronted with an emotional kind of situation… that it will happen and I am okay with, because I am human, and most of the time I deal with children or young adults and they will remind you of my own kids and I will say to them: I am a mother and I am a doctor but a mother as well. I will give a patient a hug or let them lie on my couch if they are very stressed and for*

[2] Researcher's note

*me that is okay, and I think it is part of caring. I think that is part of being a doctor and showing you care and knowing someone cares."* [S-FGD 3:342-350]

This awareness suggests that the social power conferred by the profession and the health system is not sufficient protection against the ever-present existential threats: being under-resourced, overwhelmed by the sheer volume of work, and the uncertainty of facing complex situations on a daily basis, leading to 'moral injury', a state of being characterised by powerlessness and "loss of faith in the goodness of the world and humanity", caused by the witnessing of, but inability to prevent, suffering of others(85). Patients became key mitigators of doctors' vulnerability, and so necessarily enter the power equation, foregrounding the context of the observation as a core element in understanding the power dynamic.

### 6.3.3 Supervisor vulnerability

Clinician-students were not the only participants experiencing vulnerability. Their supervisors similarly voiced some discomfort with the idea of a shifting power dynamic that would make them more exposed to scrutiny by their students. In a discussion on the home visit presentations of their students, the supervisors clearly identified specific moments when they questioned themselves, and reflected on their own performances as compared to their students. Dr K, new to her hospital and its community, had the following concern:

*"…from a Coloured doctor's point of view, I am kind of fearful going into a white person's house and doing a home visit. Most of my patients there are all over eighty. You know the whole ward is full of eighty-year-olds and I am just thinking to myself senior students did that and maybe I should do something similar…"* [E-FGD 2:180-184]

That vulnerability inherent to the medical profession, dealing with multi-layered, and multi-textured forms of trauma, is obvious, and one way of dealing with it is in dark humour. The following excerpt from the discussion among the educator group demonstrates an aspect of this.

*"…It does need the student to be critically self-aware, which is not something which intuitively comes to all. Some people get it, some people don't.*

*P: Is that where transference and countertransference comes in?*

*F: Yes. And that's where the vulnerability lies. People don't want to carry stress home.*

*P: You shouldn't have done medicine if you don't want to carry the stress home. [Laughter]"* [E-FGD 1:882-892]

Describing her process to understand why she struggles with some students and not with others, Dr J reflected on her uncertainty in the educational engagement. This uncertainty raises more questions than answers, and she is unable to reach a conclusion to these thoughts.

> *"Whereas a registrar that has... It could even be a fourth year that is quite weak... the dynamic is further apart and there's a lot more teaching, lot more guidance that's needed. So, I'm reflecting on my own power within teaching. How does that change, depending on where the registrar is at... And is it good or bad? There are times when it's needed, if they're that low, there is a need for being more directive. Is there? I don't know. I need... It's a reflective process..."* [E-FGD 1:1192-1196]

Further in the discussion, Dr J's uncertainty is highlighted again, and echoed by her colleagues, this time in relation to being observed by a registrar (student). The nervous laughter punctuating the middle of her statement underlines this vulnerability, which is then followed up by another stressor - that of being part of a system with significant time limitations.

> *"Do we allow the registrar to sit in with us if we have the time to do that? Do we want them in there? [Laughs]. Because we're also pressured. So, the exam model of a consultation, the last time I did that properly was... You know it's not always every day that I'm doing that. Because I'm also pressured for time…"* [E-FGD 1:1282-1285]

Dr E, an experienced senior clinician and educator of almost 30 years, also raised a similar concern when thinking about the opportunities for role modelling in the workplace. She laments the lack of time for this type of teaching in a primary care context. It appears that she does not have the power to change this situation, and attributes blame to unequal distribution of resources across different levels of the health system.

> *"How is she supposed to learn the skills I have? Because I only critique her. She doesn't get to observe. She gets to observe how I facilitate meetings, but not my consultation skills. You're right, it's something that I haven't thought about before. And that's part of the inequities. Joint appointees in this building have a lot more time. And potential interaction that's not perfect, than joint appointees out in the community who are alone."* [E-FGD 1:1356-1362]

To summarise the preceding section, vulnerability was experienced due to inflexible systemic structures and processes, when participants engaged in contexts beyond their comfort zones, was surprisingly mitigated by patient responses, and was seen to be a reflection of their own humanity.

## 6.4 Actors in the system

While we have thus far concentrated on the interactions between students and patients, the context of the health system, which is also the learning environment for these students, needs some attention. It is clear that the students entered this programme with some beliefs about their role in the encounter with patients. How these ideas were challenged by their experiences is discussed below. As Dr C stated:

> *"Initially I must say the relationships with the patients were mostly the traditional relationship, like the healer and the healed. That was, after starting this course then I got to realise about the power dynamics and everything that come with that. That relationship was initially based on having to study and then having that... I think there's something that all doctors suffer from at some point. It's called an imposter syndrome... So there comes that fear that you have (are) not enough and then you tend to compensate by wanting to be in total control of the discussions with the patient. Like you are the medical authority."* [S-FGD 1:15-21]

But this 'traditional relationship', native to the current system, has its challenges. Dr N articulated this by identifying that the unavailability of enough time with the patient is a major pressure point, and that the pressures of the health system detract from what she regards as 'good medicine'.

> "*So, I think for me it's, in terms of the relationship with the patient it's, you know… I'm learning to try to communicate better… to try and build that relationship with them so that they benefit. And when I say partner, it has always been from a point of me being the one who knows everything in terms of their health, and dishing out information, and whether they're not checking to see do they have some information, I think they probably don't or it doesn't matter if they do, not checking... So, I think doing this course has helped me. We did a lot of this stuff early in our training, but through years of practice one sort of, yes, forget and time pressures and all other reasons that we find not to practice good medicine. So, I think it has helped in looking at, with all the other modules that we'll be doing, and sort of be reminded of how to be a good doctor or healthcare worker."* [S-FGD 1:86-94]

In addition to the lack of time, continuity of care seems unattainable in the busy, urban clinics these students find themselves. Dr R summed it up:

> *"…with the work I'm doing at the moment in the clinic I'm not always seeing my same patients again, so there's a big lack of continuity of care."* [S-FGD 1:102-104]

### 6.4.1 Humanity and agency

Doctors are not immune to the emotional pressures felt by patients. Working in a primary care clinic that is fully booked for weeks in advance, Dr S rationalises her own emotional response to the systemic pressures, stating that she is considering quitting this job to pursue a better quality of work.

> *"And the bad relationships that I've had is people at the clinic saying," I've been waiting so long… I was before this one…" and then they're angry and… (then) I will also be angry and irritated and then you start off on a bad foot... I think time is just such an important thing. So, my whole idea is moving to something different where I can set aside a certain amount of time for patients so that I can have the relationship and so that I can have that indepthness that we all want and gratify so much to us and the patients. And it's not that you have to quit your job and go do something else to do that."* [S-FGD 1:137-139]

However, in some instances, particularly when one has worked for some time at a particular facility, the chances of building a relationship with patients over multiple encounters is a possibility, though it is a distinct outlier in this dataset. Dr D, the young student working in a community hospital where she cared for in-patients whom she would see daily for the duration of their admission, remarked:

> *"So… I think one of the things a lot of us face, pressure of numbers, especially if people are working in public... and most of the good relationships I've had with patients are patients that I've had a nice amount of time to spend with them to be able to develop that relationship, as well as the continuity of seeing them again.* [S-FGD 1:128-131]

She was able to find a space within this highly pressured system to engage with her patients, allowing for the development of 'good relationships'. However, the context of her work differed from others in that she worked at a hospital, while others worked in day clinics, with no in-patient care.

Making the effort to find meaning in the encounter represents an active decision and follow through by the student and not something that happened by default. Dr Z describes a qualitative difference that she experienced by changing the focus of her conversation:

> "*So that connection, those few minutes that I'm with each patient, that relationship is quite important even if it's for a short period of time, but actually feeling like you might be actually making a bit more of a difference than just treating someone, but actually talking to someone like a person for those few minutes. It helps the day also go quicker for me. It's not... it makes the work a bit more meaningful."* [S FGD 1:104-107]

These opportunities for meaningful engagement were a result, not of system design, but of the student making an active decision to engage deeply with a patient and finding the space within the system to

implement this decision. This phenomenon suggests that intentions and agency could align to produce an outcome at variance with the systemic pressures. While admirable, the question of sustainability of such actions come to mind, and subsequent questions of resilience. For how long can these students swim against the tide in a quest for finding meaning in their work?

### 6.4.2 Educating towards agency

The struggle for self-expression by students was recognised by educators. The health system strategy for improved efficiency in terms of diagnosis, management and rational (read: cost-effective) use of resources has ushered in the concept of clinical governance, an ongoing process that sets standards, monitors and evaluates actions and processes aimed at achieving these standards, and makes recommendations for system improvement based on these findings. One of the vehicles for the effective implementation of clinical governance is the implementation of clinical protocols, effectively systematising and standardising clinical decision-making, though Dr S accepted that they should not be blindly implemented:

> "*I wouldn't agree that protocols remove decision making. The protocols just give you the broad guideline. With this... for tonsillitis you need to use this antibiotic, but that doesn't personalise it to that particular patient."* [E-FGD 1: 695-697]

This position is provided by a senior clinician who is able to argue and justify his decision to deviate from the protocol, whereas Dr J reiterated that a junior doctor is unable to express him/herself in this manner, as they don't have the authority/power in the system to do so.

> "*But I think that in 10 years the difference would be because they're then consultants. An MO*[3] *in 10 years' time, they've still got a fear of (being) the victim. Because by moving into a different space in the system, you get (a) better perspective of the system, and how you can have agency."* [E-FGD 1:540-543]

Continuing with this theme of enhanced agency as a result of a changing perspective of the system, Dr J substantiated her statement by providing an example.

> "*I think it also comes back to the point about knowing the system, and if... where they can think a little bit out the box. You want free drugs? This is the option… but are there other options? They must just… while they're still stuck in that work, work, work, this health system's crippling me... But once they can rise above that and say, but are there other options? If I was in private,*

[3] MO – Medical Officer

*what could I do? If you had a little bit of money, what does it cost, and can it make this person's life better? Maybe that comes with time and experience."* [E-FGD 1:695-711]

While this example of Dr J's would not be universally applicable to all patients in these poor communities, the point she makes regarding the ability to 'rise up' and see new perspectives and options is worth exploring in more detail. This will be done in a subsequent chapter.

Educators also identified that the institutional norms, as indicated by the language used to promulgate and implement policies, left no room for dissenting voices, imposing limitations on expression of individual agency by the students. Dr T, who had worked in the health system for almost fifteen years before joining academia, remarked that:

"*I was just going to say, just to, it goes with "I'm the victim of the system thing" comes through in a similar way. So, it's less that the protocols remove the decision making, but it's the way in which the protocols are introduced, framed, and difference by those who... so, for instance, why did you deviate, you mustn't deviate from the protocol. It takes away any sense of agency from someone like the medical... It's the use of... or the way in which they are disseminated and...* [E-FGD 1:715-723]

This prompted Dr E to emphasise the point that clinical governance processes were complicit in silencing dissenting voices.

*"That message also sort of drowns under clinical governance. Because the bigger message of clinical governance is adherence."* [E-FGD 1:731-743]

Linked to clinical governance, and probably driving it to a large extent, is the evidence-based medicine movement, which is embedded in modern medical epistemology. Dr E offers an opportunity for critical engagement and enhancing self-perceptions of power among students by employing principles of evidence-based medicine to grapple with the structural power manifested by clinical protocols.

"*I'm thinking again about the point about protocols, and victim of the system, powerlessness. The conversation that we often have about evidence-based practice which anticipates, if not protocols, at least guidelines. And I wonder how, in that teaching-learning moment where we talk about it, we like to think that when we talk about evidence-based practice, we talk about the last step where it is still possible for you to be evidence-based, when you are not following the guidelines or following the evidence. And how strongly you make that point versus follow the evidence and therefore follow the guidelines, and therefore follow the protocols. And how*

*that can be balanced out if it is in fact the environment in which we put it across in the curriculum."* [E-FGD 1:1024-1033]

In a similar way that we saw patients as critical agents, we see students emerging as critical agents within the system, looking for opportunities for self-expression and to find meaning. Educators could be willing participants in this search, by facilitating a learning environment that encourages dissent and critical reasoning in the curriculum and pedagogy. What implications does this hold for medical educators, who themselves are bound by institutional norms and policies?

## 6.5 Conclusion

This chapter has detailed the unpacking of the patient as a critical actor in the clinical encounter with the doctor. This empowered person challenges the view that in a society with stark economic inequality, that considerations of power are necessarily binary: the powerful and the powerless. This empowered patient engages in evaluative actions, is deeply perceptive of the semiotics of the encounter, and makes empowered decisions about that over which they hold sway: their humanity. They do this while all the time acknowledging that structural power is skewed towards the doctor and walk on this uneasy path of re-establishing the limits of trust each time they encounter a new doctor, which is an all-too frequent occurrence.

Based on the empirical data, a new model for observing and analysing power dynamics in the clinical encounter, and possibly in the health system, is proposed. It is comprised of distinct nodes: *accountability*, which recognizes that this evaluative process holds immense power of expectations, that shapes the emergence of new perceptions and behaviours; *decision-making*, that is only possible when one has access to resources, in this instance, knowledge being the predominant factor; and *implementation*, which asserts that a decision made in isolation of a consequent action loses its value in the material world, and so clinician and patient need to collaborate to ensure that decisions made in the encounter have life outside of the encounter.

# CHAPTER 7: RESULTS - Transformative learning: dilemma and dialogue

## 7.1 Introduction

This chapter outlines the learning process as described by students as they grappled with new challenges and changing points of view in their encounters with patients. As part of the course activities that informed the generation of this data, they were tasked with presenting summaries and reflections of clinical encounters with a patient to the lecturer and peers within the framework of McWhinney's foundational assumptions of FM(7). These encounters could have occurred in the clinic, the patient's home, or any other space suitable for a consultation. The findings were arrived at deductively, using the analytic frame described below. We conclude by presenting some principles that could facilitate transformative learning about the DPR in medical education.

In the analysis, I draw on the work of Mezirow wherein he develops TL theory as an adult learning theory that describes changing perspectives of students in one (or more) of three domains: "frames of reference", "points of view" or "habits of mind". This change is stimulated by a life experience that causes sufficient discomfort to be regarded as a "disorienting dilemma". The disorientation, which has a strong emotional component, forces the student to critically examine the underlying assumptions (epistemic, socio-cultural or psychic) that led to this situation, validating the experience and critique by engaging in discourse with others who have had similar experiences, exploring new imaginings of how the world could be and the social roles needed to make this a reality, experimenting with these new roles, and finally integrating the transformed perspective into life. The usefulness of this approach to medical education is that it is premised in concrete experience linked to a particular context, has an unavoidable social dimension, and requires the student to be fully engaged in the formulation and experimentation of new perspectives.

In brief, I found that there was clear evidence of disruption, representative of Mezirow's disorienting dilemma, learning from critical reflection, formulation of new imaginings of how things could be, and lessons learnt from concrete experience that resulted in discernible shifts in perspectives. While the scope of this study could not investigate how comprehensively these new perspectives were integrated into students' work or the longer-term consequences of such integration, the data as presented here tells a compelling story.

## 7.2 The Disorienting dilemma

Mezirow's first phase is termed a "disorienting dilemma", an experience that fundamentally affects the person, that has a strong emotional component, causing significant life discomfort. In our study, this was represented in two concrete experiences: student engagement with patients once they had

been sensitised to the power dynamic and the humanist dimensions of the clinical encounter; and the second was when they visited the patient at home, stepping out of the comfort zones of their health facilities, and into the discomfort of their patients' contexts.

### 7.2.1 The humanist realisation

After having spent a few years building a practice in a community to which she was a newcomer, Dr Z described her realisation that building the DPR does not necessarily only reside within the ambit of the doctor's responsibility.

> *"I think for a relationship you need willingness from both parties also. It's the willingness on the part of the doctor to reach out to the patient and to accepting the patient as well, not just from the patient, but from the doctor as well. That's what we're learning also, it's a mutual thing."* [S-FGD 1:59-61]

This recognition of patient agency, where the patient needed to be an active partner in the pursuit of a more meaningful DPR, resonated with other student participants also grappling with new ways of viewing their patients. Dr N, who graduated medical school more than twenty years ago, reflects on her practice prior to starting the course in relation to her current thinking, identifying gaps in her prior appreciation of the human experiences of the patient.

> *"…me, a doctor and the patient were sort of in a partnership to get that person better. But I think the way I was going about it, what I've learnt, or what I've been reminded of is probably not the right way. So, if we (now) talk about caring for the person, the individual, the context, where they are coming from… sometimes I wouldn't consider things like that."* [S-FGD 1:77-80]

These sentiments are echoed by Dr S, working in her busy HIV clinic in an impoverished community.

> *"And I'm seeing my patients now more as people than patients or problems, and now I've started to… (trails off) just kind, that there's kind of this change of how I interacted with my patients. Because if you are just kind, that's like 25% of your job done, really."* [S-FGD 1:172-175]

Part of this humanistic engagement is appreciating the psychosocial complexity of patients' lives, integral to the practice of FM and the BPS model of the clinical encounter. This realisation, for Dr N, seemed to represent a threshold moment in her approach to understanding the complexities that patients deal with.

*"… before I started this course, for me you know, it was very important to have that relationship with the patient… But I think the way I was going about it, what I've learnt, or what I've been reminded of is probably not the right way. So... if we talk about caring for the person, the individual, the context, where they are coming from, sometimes I wouldn't consider things like that. So... it would… look we are here as partners in trying to get you better, but it wasn't considering that if it's someone who is not adhering to taking their medication, I was: 'Why are you not taking your medication?' But it's not probing further to understand why they're actually forgetting. I mean, why would they forget to take their medication knowing that, say ARV's, if they don't take it, they're not going to get better, or there's a possibility of them dying. So… it's not just a fact that they're forgetting. It's why. So, are they, when you look at the family, look at their household, is it because they haven't disclosed, being afraid of being rejected by their partner or by their family?"* [S-FGD 1:73-86]

Hearing about the psychosocial challenges that patients experience sensitised students to this reality, but being witness to it first hand, with the sensual experience of being in that context during the home visit, proved to be an even more powerful experience. This 'being in' the patient's context is a disruption of the students' perspective, necessary for the transformative process. Evidence of the disruption is found in narratives describing emotions experienced during the visit, witnessing the patient's poverty (compared to the clinician's privilege), the value of first-hand knowledge of the patient's context, and personal growth that emanated from the experience. Dr S remembered the discomfort of a lack of personal space, a radical departure from the clinic.

*"…And that's how we talk, and now we were sitting on the same couch. At first it was a little uncomfortable, because we were quite close together... It's a small couch... [Laughter]… if you're sitting next to someone and your legs touch, it's a bit of an infringement of your personal space…"* [S-FGD 2:292-300]

At another point in the discussion, she relates how this experience had changed her point of view of her own circumstances.

*"I think also, the terrible poverty that a lot of us have seen. I mean, you know it's a shack and you know it's bad, but I think if you go there, I came out and I was just so grateful for every little thing that I have. I remember having a fight the previous day with my partner about something, and then coming home and saying, listen, that's absolutely nothing. Let's not even bring it up. In comparison to what some people have to go through and what some people*

*don't have. Every time that it happens. You get so humbled when you see it."* [S-FGD 2:157-162]

Similarly, Dr D identified the process from knowing by hearing to knowing by experience, the latter eliminating any romance or uncertainty about the experience of patients.

*"It's tough for our patients. You think you know, but being there is a completely different reality, and they come and tell you, but it only goes as far as your imagination. Then seeing how (the patient) lives, that her house is flooded six months of the year, it makes how they live real, and the difficulties that they have so real."* [S-FGD 2:379-382]

The final word on this disruption that the transforming learner must experience is left to Dr M, a relatively quiet member of the group, whose excerpt suggests a transcending of barriers and the uncovering of a common humanity as the most important learning step at this point.

*"… even though you know when you have the folder in front of you, you have his name, surname everything, there's almost an anonymity about your patients in terms of who they are… seeing them in their own space, it really changes how you see them as people… Just thinking, 'What is this person's story?' That is what has changed for me having gone to see someone in their own environment. Just like I am a person with a story and a history, our patients are more than just a set of diagnoses and [inaudible40:01]. That is the biggest thing that I have learnt."* [S-FGD 2:472-481]

While this new humanistic experience of engaging with patients within the clinical encounter was certainly useful, opening new levels of understanding of the patients' experiences and thereby creating an opening for the development of a new point of view for students, the strong emotional content that is required for deep learning that is needed for transforming perspectives came from direct experience of the social realities patients face. When tasked with critically reflecting on the power dynamic in the clinical encounter, this emerging point of view was further expanded.

### 7.2.2 Considering power

When the conversation and reflections started focussing on the power dynamic, we were able to move further along this pathway of disruption, as students started engaging critically with their own performances in the clinical encounter. There were glimmers of this criticality in the early data being generated, as stated by Dr C:

*"…it's something I never consciously thought about before until it was now mentioned in doing these teachings and I now realise that, oh yes, there is actually (a) power dynamic there… So, I*

*don't think most of us ever consciously thought about the power dynamic until now that we read about it, and then now started looking at it retrospectively to see..."* [S-FGD 1:203-205]

This new level of awareness of the power dynamic as manifested in shared decision-making is corroborated by Sr A, the facility manager who runs two health facilities.

*"It's funny though. six months ago, I would have said I make the decisions 95% of the time. But now, it's like we make the decisions and its really treatments now for my patients and it becomes more of a discussion… I feel there's more equal power in relationships now versus before, and more of an understanding that the decision actually lies more with the patients than it does with me. I can make recommendations, but that's also, it gives you this ability to sigh this big sigh of relief that you actually aren't responsible for the decisions. It's actually: 'Here, take this information, think about it and you tell me.'* [S-FGD 1:297-309]

Dr D had reported seeing manifestations of the inequalities in the power dynamics in her workplace that she had noticed before, with the criticality of her observations being reinforced by her experiences in the course.

*"I think one's seeing an abuse of doctor-power... you see how the same doctor treats someone who is in a position of privilege, who they feel is educated… like, to litigate should they make a mistake, versus the same doctor treating another patient who they deem to be not as educated, more accepting and a paternalistic approach will work for this patient. I've seen that and it bothers me… So, I think once you've seen it you become more aware of it and it challenges your own perception, and definitely this course as well. We explored the dynamics of it, but I think if you've seen it, it doesn't leave you."* [S-FGD 1:216-222]

Following the theme of how power manifests differently to the critical eye, Dr C also describes the 'becoming aware' of power dynamics as a threshold moment.

*"…when you see a patient being treated differently by a doctor, we notice that… but I don't think most of us have thought of it in terms of power dynamics. We think of it in terms of this patient is getting a raw deal because of coming from the wrong side of the tracks. I never honestly articulated those thoughts, like: 'Oh, this is a powerful figure, or this is a powerless figure coming together.' So, it was an eye-opener for me to hear about that here."* [S-FGD 1:254-258]

The expansion in point of view to include the power dynamics, not only in the clinical encounter, but in the broader context of the health system, constituted a break from previous perspectives that the

humanistic element could not achieve. Being aware of how power manifests represented a significant opportunity in how the DPR could be perceived differently, but still seemed to be in the realm of cognitive reflections, not generating the intensity of uncomfortable emotions that is demanded of deep learning that transforms perspectives. Something more was needed.

### 7.2.3 Vulnerability

Out of these reflections on the existence of the power dynamic, Dr R takes us even further along the pathway towards a "disorienting dilemma" by inserting herself into the situation, as she imagines her own family's vulnerability to the power plays in the health facility.

> *"…it struck me that should my father not have medical aid, this is the facility that he would probably go to. And I looked around one day, and I sort of saw how certain patients were being treated and it did not sit well with me that my own family member might be subjected to the same level of care we're giving some patients and that really bothered me."* [S-FGD 1:179-183]

When the student starts inserting herself into this space of vulnerability, it becomes quite uncomfortable as Sr A found when she opened herself up to a patient, whose needs she thought she understood, only to later come to realise that she may have been manipulated.

> *"I think the inherent scenario that the patient needs something from me... that we are here to do good and to satisfy the needs that the patient has, and that the patient is coming to you as a vulnerable being and without any hidden agendas or for any other reason... So yes, I'm answering that. So, from inside that is why I'm here. I care so therefore I am here. So, I'm here to satisfy that. ...I come there with wanting to satisfy the need and you would (not) believe that the patient is going to take chances... And then, sometimes it makes you feel like, was I that gullible?"* [S-FGD 1:152-156]

This position of vulnerability is further entrenched when one considers the conditions in which these young doctors are working: high volume of patients coupled with insufficient resources, and a systemic demand for high levels of efficiency. Dr Z summed it up, using an industrial metaphor that seemed to emphasise her vulnerability to being de-humanised:

> *"I often feel that the patient holds the key to the power, and I just sometimes feel like I'm just a cog in that wheel, just having to keep on working and working."* [S-FGD 1:237-238]

The home visit, as alluded to in previous excerpts, stimulated significant personal vulnerability. Not only was the student outside of her 'safe space', but the threat of personal harm due to the high crime rate in these areas could not be excluded. This was articulated by Dr S:

"*I think we do feel out of place. I think that's one of the big things. You're out of your comfort zone. You don't know exactly where to go or what to expect. It actually makes you vulnerable. You're not... We've often talked about how the doctor, or the clinician is in this position of power at the clinic, because you're sitting behind your desk and people are coming to you. That power play… I think if you're going to someone else's place, especially in a community that you don't live in, you feel out of place."* [S-FGD 2:77-82]

This encounter in the patient's home evoked a level of discomfort that moved them to deeper personal reflections, as reported by Dr L, who had worked in many different places before coming to this course.

"*I felt a bit awkward initiating a home visit… this time I felt very awkward, because I was initiating the home visit, rather than being asked by either the patient or someone who knows the patient and is caring for the patient, to visit the patient. So that for me was just very awkward."* [S-FGD 2:28-31]

The social vulnerability expressed by Dr L as 'awkwardness' is further captured in the following excerpt wherein Dr C describes his very palpable apprehension at visiting the patient's home in an informal settlement, far from the nearest police station.

"*My predominant feeling at the time I was going was apprehension, because I was going to (a high crime area)… in this case it wasn't my patient inviting me… like, what am I walking into? Are they going to see me as an intruder that doesn't speak Afrikaans? By the time I was knocking on the strange door, and ... The nearest police station wasn't that close, so...*" [S-FGD 2:43-53]

Vulnerability was not only experienced due to personal safety issues, or the awkwardness of the encounter in an unfamiliar space but spoke directly to the idea that the doctor in the clinic is supported by the system's view of doctors as knowledgeable and powerful. Dr B, taken out of this context, finds himself unable to change this mindset, feeling that the patient is asking him to solve their complex problems, which highlighted his lack of power in this situation (though, it is highly probable that as the patient's first language was isiXhosa, and Dr B's was Arabic, that much may have been lost in translation).

*"And I felt out of my comfort zone because the patient had the assumption that doctors know everything, and they would start asking about everything. Like the structure of the house, how to make this better... That's why I felt like a foreigner. Exposed. And I think the system works for us, not for the patients. More suited to us."* [S-FGD 2:320-323]

It is in this sense of vulnerability, the acuity of the discomfort as it relates to the specific experience, that we find the promise of deep disruption, as students bridge the physical and intersubjective gap that separated them from their patients. As students made sense of their experiences, particularly considering what their emerging points of view and newfound vulnerability could hold for their practice, essentially making meaning of their perceptions of suffering, critical reflection became an essential tool in this process of learning.

## 7.3 Critical reflection

There were two broad areas of critical reflection that dominate this theme: self and relational-contextual awareness. Mezirow's approach to critical reflection as a key component of TL evolved significantly over two decades, from defining it as a "critical consciousness" of how one sees oneself and relationships in 1981, to differentiating between "non-reflective (habitual or thoughtful, without reflection) action" and reflective action in 1991, where reflective action focusses on content (what happened), processes (how did it happen) and premises (why did it happen), and finally, in 1998, as reflections *on* underlying assumptions (objectively) and *of* assumptions (subjectively)(86). For the findings that follow, I used a definition derived from Mezirow's collective work, wherein critical reflection is considered as the students' individual and discursive process of engaging with experiences, interpretations of these experiences, and exploring the underlying assumptions that influenced the experience initially and subsequently.

### 7.2.1 Critical self-awareness

Before making assumptions about her patient's identity, Dr N found that it was useful to step away from her usual habit, which was to believe her first impression, and thereafter make a more considered assessment based on the actual experiences that the patient narrates.

> *"For me, it's that first impression before getting to know the person... And then the instinct is to sort of, you know, take a step back in myself, but then you know, but then when you get to understand why they have become the person that they are, understand what they've been through, the pain and usually there's lots of psychological trauma that leads to... that's getting to know the person"* [S-FGD 1:406-409]

Sr A narrates her early thoughts on her own response to engaging critically with her own practice, indicating that she learnt from this reflective process. The following excerpt describes a process of learning wherein she is the subject and the object of the educational process, with the context of this self-reflection being the peer group.

*"So, I think for me it's, in terms of the relationship with the patient it's, you know, I'm learning to trying to communicate better to try and build that relationship with them so that they benefit… So, I think doing this course has helped me. We did a lot of this stuff early in our training, but through years of practice one sort of, yes, forget and time pressures and all other reasons that we find not to practice good medicine. So, I think it has helped in looking at, with all the other modules that we'll be doing, and sort of be reminded of how to be a good doctor or healthcare worker."* [S-FGD 1:86-94]

The act of reflecting on their personal principles that motivated students' clinical work provided an opportunity for critical engagement with their own beliefs and assumptions. Dr Z, joining a discussion theme on what motivated participants to care for patients, stated

*"…personal values... for me it's just the simple thing of brotherhood. That whatever walk of life you come from, whatever race, whatever religion, we are all human beings and it's just that sense of shared humanity or interacting with another human being"* [S-FGD 1:192-194]

Additionally, students articulated a deep awareness of the power that their roles as clinicians conferred on them. The following excerpts, emanating from one of the participant's experiences where a patient refused to have a medical procedure because the doctor in the hospital did not have a stethoscope. For that patient, the stethoscope was a symbol of competence and authority, integrated into the professional identity of the student.

"*They're not just power symbols, they are also identifying symbols. For example, the stethoscope. Most doctors in our hospital wear a stethoscope around their neck and one doctor had left hers on the desk and then went to go lumbar puncture a patient, and the patient refused. It's like, you're not a doctor, I want a doctor."* [S-FGD 2:195-198]

"*The power is [inaudible 17:00] in the symbol. You can't take it away.*" [S-FGD 2:209]

Sr A describes the community reaction when she drove her official, marked, vehicle to a patient's home.

"*Then people start... 'ooh, there's the car coming in.' And 'that car is very powerful'. 'That white GG car'. 'You must watch out for that car'*." [S-FGD 2:352-353]

That power is symbolised in artefacts commonly identified with the clinician identity, in the form of the branded clinic motor vehicle just alluded to, the doctor's stethoscope or the nurse's uniform. The participants were fully aware of the implications that these symbols carry.

The value of assuming the identity seems, in this exercise, to be one of facilitating access to the patient, and protection, rather than exerting power.

> *"…in terms of uniforms… it's this issue about trust relationship and you need to be able to make the patient comfortable and secure. And the patient must believe that you are really who you are presenting yourself to be..."* [S-FGD 2:216-220]

> *"You can also use it for protection. Remember as a student when they used to make us go into the community, they made us put stickers on that said medical doctor, because then the community will accept you better when you're driving into the community."* [S-FGD 2:211-213]

> *"For me, when I'm driving to work every day, it's a stupid thing, but I put my stethoscope on my seat, hoping that if someone tries to smash and grab me, they won't, because she's a doctor. She's here for a reason. I don't know, like its... you hope that the community does see you as someone who is contributing in a positive way."* [S-FGD 2:228-231]

Self-awareness was also demonstrated in the presentation in the preceding section on vulnerability, where students were acutely aware of their emotional reactions to situations they described as awkward, uncomfortable, and potentially risky. This self-awareness was a starting point for a deeper assessment of their own assumptions about their experiences.

### 7.2.2 Critical contextual awareness

The reflection process made explicit underlying assumptions that influenced the clinical encounter, opening them to be critiqued and challenged. Dr C, when asked to consider the power dynamic based on the unequal knowledge, stated:

> *"Initially I must say the relationships with the patients were mostly the traditional relationship, like the healer and the healed. That was, after starting this course then I got to realise about the power dynamics and everything that comes with that. That relationship was initially based on having to study and then having that... I think there's something that all doctors suffer from at some point. It's called an imposter syndrome… So there comes that fear that you have not enough and then you tend to compensate by wanting to be in total control of the discussions with the patient. Like you are the medical authority".* [S-FGD 1:15-21]

This idea is rooted in knowledge inequality, as reflected on by Dr Z. While the realisation that knowing about the power-knowledge axis was probably not new to these students, these reflections made them explicit, and hence the underlying assumptions became amenable to deconstruction.

*"A lot of the time it's knowledgeable and less knowledgeable sort of relationship. Your patient is coming to you because there is something that they are lacking, whether it's information, the ability to prescribe medications, or whatever. There's something that, which is also a power thing again, I think, but there's something that you have that your patient needs from you..."* [S-FGD 1:45-48]

Continuing with the idea that making the power dynamic explicit in the discourse became a key task, Dr L stated in response to the earlier point made by Dr C about the 'traditional relationship'"

*"If the patient is present, there is an implicit consent already that they subscribe to the authority."* [S-FGD 1:25-26]

Unearthing this assumption was important, as it spoke to the understanding of how this may have come about. Dr Z opined:

*"… that (the) power dynamic is different in different areas that you're working in, in different communities and different cultures."* [S-FGD 1:32-35]

Similarly, Dr D interprets her ability to connect with some, and not with other patients, as being directly related to the working context. The space and time afforded her with patients admitted to the ward was much more than those seen rapidly in the emergency centre or outpatient department, where patients have been waiting for some time.

"*I think it depends also where you're working and the type of relationship that you have with your patients. So, it's also, like for me working in a hospital at the moment there are patients that you know for a long time and the relationship… more of an easy-going sort of conversational type relationship versus a patient, if you're working in say like, a day hospital, where you're seeing fifty patients a day and you don't really get to know your patients, then that relationship is very different."* [S-FGD 1:45-48]

This awareness of how the context shapes the encounter and relationship is repeated by this participant, who describes it as a barrier in his workplace. The pressure of providing a service mitigates strongly against the ability to engage meaningfully with patients. This is coupled with a longing for continuity of care, being able to build up a relationship over repeated encounters, which is not always possible within the pressures of the state health system.

*"So, I think one of the things a lot of us face, pressure of numbers, especially if people are working in public... and most of the good relationships I've had with patients are patients that I've had a nice amount of time to spend with them to be able to develop that relationship, as well as the continuity of seeing them again."* [S-FGD 1:128-131]

Dr L adds some more detail to this observation by including the important issue of cultural and language barriers that may impact on the unfolding of the encounter.

> *"…some of it is the contributing factors… the amount of time you're able to give the patient, how well you're able to listen to the patient, and if there are language barriers, culture barriers that prevent you from sort of understanding each other. I think those things have an impact. And then also the focus, either your focus or the patient's focus on disease or the whole person, and how that's led."* [S-FGD 1:68-73]

Despite these pre-existing socio-cultural barriers, the physical movement into the patients' space broke through them, to a certain extent. When the encounter takes place outside of the clinic, as happened with the home visit, the influence of context is even starker, showing up the limitations of the doctor-role outside of the clinic space.

> "*When you're sitting in someone's home, it's got a completely different purpose… I can't write a prescription for a dry floor for your asthma… a house that seals and doesn't allow the wind in… your poverty that's driving your dependence on substances."* [S-FGD 2:244-258]

The context of the engagement also influenced how students perceived their existence and performance within their workplaces. There was a sharper focus on their own intersectionality, and how this allowed, or hindered them from integrating. Dr S, the only white person working at a clinic in an informal settlement, summed this up quite eloquently in describing her experiences as a young, white, female doctor.

> *"Okay. Can I make a slightly racist, slightly feministic comment, and you can't judge me... [laughter]... It's much different in male and female doctors. I found very often that because I'm a female, if a male sees me, he'll treat me much different than he would another male doctor. So, I've often been called 'Klein meisietjie, kan jy 'n dokter wees?' (Little girl, can you be a doctor?) 'Are you old enough to be a doctor?' Like, 'do you even know what you're doing?' Especially by older males… And now, like something that I never thought about... In the clinic where I work, I am the only white person, I'm also the only white person in the entire area, and I don't wear a white coat and I don't wear a name badge and I don't wear a stethoscope, like wear it like a name tag. But everyone knows I'm the doctor, and that's terrible. That's terrible. Like I never thought about it until we did this, and I didn't say it out loud because it's not a very nice thing to say…"* [S-FGD 1:260-269]

The importance of reflection, in private and collectively, was highlighted as key to learning and resolving some of the emotional experiences that participants had in exploring this new way of engaging with patients, with the reflective skills impacting on their lives beyond the professional

dimensions. Although this data emerged much later in the project's timeline, it is presented here to reinforce the significance of critical reflection as a pedagogical tool. Dr S, admitting that she was initially impatient about having to do reflection, as it was not part of how she approached life, had this to say.

> *"So, at the beginning it is hard but really it is one of the best things you can do. Looking at that situation and just thinking; what does this mean to me and why did I do this? and I feel like that was really good. I never used to be a reflecting person but that has been really good for me, and I think it is something I can take not just in my medical life and not just in me being the doctor but just in everything. It is such a good thing to learn."* [S-FGD 3:458-463]

Dr L continues this thoughtful engagement and narrated his newfound ability to reflect in-action, allowing him the opportunity to identify and react to an issue in the clinical encounter as it unfolded.

> *"That moment and action and reaction and that little moment in between and just taking the time to think; why am I doing this and why am I feeling this way. I don't know if you guys were used to feeling like that, but I wasn't. I definitely wasn't… and I think that is very good for a doctor but also for a person."* [S-FGD 3:465-468]

The practice of collective reflection as part of the group discussion in class was an opportunity to resolve and unburden uncertainties that accompany clinical practice, as shown by the following quote from Dr B.

> *"So, these are, like, very practical hints that actually help you every day. We did everything and we heard all about it, but in practice… and then the sessions we had when we came here… it served us really well because the time to become unburdened… It really helped."* [S-FGD 3:503-507]

It is clear that when given the opportunity, the students were able to reflect quite deeply on their own assumptions, their positionality, social roles and personal histories, and how these came to bear on the clinical encounter. Self and contextual awareness becomes difficult to separate when one considers that the mode of acting in the encounter is relational. This relational zone between doctor and patient is now proven, for the student, to be a space for a deep education about themselves as critical actors in an unequal society.

### 7.3 New imaginings

As students engaged each other in the process of group reflections, they often shared ideas about some of their new experiences, and aspirations about what impact these new lessons could have on

their work-life in the future. The ideas reflected the early phase of the project, and the experiences were nascent, based on very little experimentation with the new theory they were learning in the classroom. It was too early to state that they had experienced an actual perception shift, but rather what we saw is a becoming, a process. The following excerpts of their discussions allude to this process. As detailed below, the key imaginings that emanated from these discussions were that the students could find some solace in these encounters, the clinical work would be enhanced and that the benefits of new perspectives could impact their lives beyond work.

In the early stages of the project, when students were asked to imagine what the potential benefits would be from improved relationships with their patients, this participant, seemingly already exhibiting some signs of burnout, spoke directly to her needs.

> "*I think for me personally it would contribute to prevention of burnout because I feel like if we just operate like robots and diagnosing patients, making diagnoses is not really making a connection with someone, it takes away from what it means to be a health professional."* [S-FGD 1:99-102]

Improved relationships, focussing on more than just the biomedical problem, held some promise of mitigating the loneliness of working in a busy HIV clinic for Dr S.

> *"And that is nice. It's a nice fulfilling thing. Also, it's... was saying that it's lonely sometimes. If you're the only practitioner, it's lonely because you don't get to speak to anyone. You just feel like you're working, working, working. And if you're actually speaking to your patients like a person and not just a patient then you are less lonely because you're actually speaking to people all day."* [S-FGD 1:132-136]

Dr C proposed that when interpersonal connections are enhanced, the medical work that flows from this would be more comprehensive, as the exchange of information would occur on a deeper, more honest level.

> *"A good relationship with a patient actually helps the work you do because you are more likely to elicit more of a history, a more accurate history when you establish a good rapport. If you are irritable or already showing signs of being judgemental then the patient is less likely to give you the full history. If you are giving a sermon about smoking and all that they will most likely give you a smaller number in terms of how much they smoke or how much they drink... So, a good rapport does help with the work we do upfront, the mental health aspects, and the aspect I've mentioned."* [S-FGD 1:114-118]

When communication is enhanced within the framework of a better relationship, Dr Z offered that she would trust her own decisions and clinical judgement even more, as the data the interaction would generate would be more valid.

> *"…the first thing that came to mind is obviously trust. But it's not just the patient's trust in you. It (a good relationship) helps you to have trust and confidence in your decision-making that you are getting the best possible information from the patient and then making the best possible decision together in the best interest of the patient."* [S-FGD 1:122-124]

Getting to know about the patient's domestic context by direct experience, as alluded to in a separate chapter, exposed the students' vulnerability, which led Dr Z to conclude that this exposure could impact her life in a meaningful way. The deepening of her humility in the face of life difficulties of another, had the potential to affect domains of her life unconnected to her work.

> *"…humbling on so many different levels. Not only because it brings you down in terms of power play, but just witnessing human interaction on what patients go through is humbling and it expands you as a person as well, not just as a doctor."* [S-FGD 2:508-512]

In considering and appreciating the opportunities for a new way of being with their patients, students developed hypotheses of the potential impact of these new ways. Improved clinical outcome for patients, enhanced sense of wellbeing for students, and learning life lessons applicable outside of their work were seen as the key potentialities. Whether these were actualised, will be presented in the next section.

## 7.4 Experimentation and experience

In compiling this section of the findings, I included student narratives that showed some learning from concrete experiences, rather than the potential of learning based on reflecting on theory or early experiences, as described in the preceding section on 'new imaginings'. Students described these experiences as finding meaning in the encounters with patients, renewed purpose in their work, enhanced wellbeing, and impact beyond work. While most of this data emerged later in the project, there are some instances where the evidence for deep learning presented itself earlier, and so is included here.

### 7.4.1 Meaning and purpose

Dr C, within the first two months of changing his consultation style to be more engaging, respectful of his patient's wishes, and sharing decision-making, narrated that he had already started seeing a qualitative difference in these engagements.

*"As I'm saying I got to see the difference, or I got to realise that [unclear – 02:57]. So right now, the relationships are now more based on a personal basis, as in actually trying to see a human being, not just another patient that needs to be finished quickly."* [S-FGD 1:28-30]

Echoing the positive experiences of these new ways of connections, Dr R reflected that when she makes an authentic connection and helps someone, this mitigates against being bogged down in the mundane, and the potentially destructive impact of being disconnected from this sense of purpose.

*"So that connection, those few minutes that I'm with each patient, that relationship is quite important even if it's for a short period of time, but actually feeling like you might be actually making a bit more of a difference than just treating someone, but actually talking to someone like a person for those few minutes. It helps the day also go quicker for me. It's not... it makes the work a bit more meaningful... Yes, to what we're doing because, yes, it can get really depressing if you're just going through the motions and doing stuff, it just feels like it's a queue of people who never... just treating numbers.*" [S-FGD 1:104-111]

Reflecting on this new sense of meaning and purpose in the encounter, one of the participants reflected on the challenges of time in the integrating newly learned theory into daily practice, and the irresistibility of this transformed practice as a threshold concept, not being able to go back to the way things were.

*"At the beginning when we started, and we learnt about all those things you should be doing in a consultation and what all of us said is: there is not enough time. You can't do all of that in your consultation, and I remember thinking: I am going to have to put all of these things in my consult and how am I going to manage? And now… I feel like I want to put all those things in my consult and how can I manage, and I think from doing it you actually see the benefits of it, and I feel I want to do it. It is not like someone told me at the beginning of the year and I was trying to do it like an exercise, like you have to now try and do this and this like a consult. I think from doing it and seeing the benefit I need to do it."* [S-FGD 3:34-42]

This re-discovered focus on the human dimensions of the clinical encounter, coupled with enhanced reflective ability, allowed participants to identify when the clinician-patient interaction had outcomes beyond the technical. What is meant by this is that for the clinician, application of medical knowledge to a patient's problem is a technical process and can become mechanistic when only the disease is foregrounded. However, when the perspective of the encounter is broadened beyond this technical expertise, the humanistic engagement itself has certain outcomes.

Dr D, working in a busy medical ward relates her experience of how relatively small, humane gestures or actions, can have significant impact.

> "*…from my side I think patience has been one of the things I have learnt… that extra bit of time you can give and just to listen does make a big difference and not only to find out more clinically but also giving the patient peace of mind… knowing that somebody is listening to them, and they have been heard and we are working on the problem."* [S-FGD 1:14-18]

New ways of being with patients led to rediscovering this sense of purpose, rooted in the idealism of youth. Practising in this manner, for Dr S, meant unearthing the innocence that had brought her into medical school in the first place.

> *"I mean when we all started doing a medical career, we did it because we wanted to help. I mean if you ask the average grade eleven pupil why did they want to study medicine and it is because they wanted to help and then after many years of horrible studying and then two years of trying to kill you through internship and then trying to drink your way through comm serve*[4] *just to cope with all of it, you kind of become cut off and your motivation, you lose a bit of that and not just to prevent burn out, but to give job satisfaction and to make you happy about what you doing in life… It makes you happy. It makes you happy to feel like we have helped this person. It makes you happy to have more meaningful relationships with people… this has kind of helped bringing you back to that core and the reason you want to be with people and the reason you want to help people because we are caring people, and it makes us happy."* [S-FGD 3:90-102]

### 7.4.2 Enhanced wellbeing of clinician

An appreciation of the practitioner's vulnerability to burnout, and an opportunity to mitigate this vulnerability through an enhanced humanism within the encounter was an important finding. A recurring theme of an emotional reward for the students, despite the fact that the working environment with its inherent pressures and challenges had not changed, was significant.

Responding to an earlier comment that students, after experiencing the benefits of deeper connections with patients, had transitioned from what was initially an artificial humanistic performance to a way of being that they felt motivated to actualise, Dr R stated:

> "*The reason why we want to do it (practising humanistically) is simply because practising the other way was essentially what led to burn out for a lot of us to different degrees because you*

[4] Comm serve – Community service

*just give out instructions and they come back a month or three months later and it is still the same thing, and you give out more instructions. …we were not listening then to understanding the patient… We were listening to give solutions and your blood pressure is high and let's give you this tablet or this…"* [S-FGD 3:47-56]

The moving away from a toxic practice that led to burnout towards a different practice that enhanced wellbeing was a repeated sentiment from other participants as well. Finding joy and calmness in an engagement with her patients when she transitioned beyond the transactional nature of the encounter was a huge step forward for Dr Z.

"*I think for me it has changed. I think it has made me more relaxed in my consultations definitely… I came into general practice last year and I was also anxious and worrying about did I do the right thing… but I think this year I have definitely been more relaxed… just saying to the person: tell me what can I do for you today? And tell me about your problem, and what has it done to you, and how has it affected your life and how can I sort of help. I think for me that has really… and seeing the patient appreciating the fact that they talk more in the consultation, and I listen and sort of guide, that makes me happy. …I find I prescribe less!"* [S-FGD 3:110-127]

And again, the theme of mitigation against burnout is unapologetically welcomed, particularly as the student's own humanity is reinforced by these experiences, struggling against the 'machine'-like role they have been given in this industrial metaphor of the health system.

"*So… I think it is a two-way street. I am not going to sit here and say I am doing it purely to help the patients. I think we also doing this for helping ourselves. I think for us it is preventing burn out, definitely. If you practice in a conveyor belt outpatient setting all the time, then you yourself start to feel like a machine. So, I think why I did it was it helps me help patients better but also, I walk away feeling I am contributing more than just writing a script."* [S-FGD 3:76-80]

Dr S's experience, narrated in chapter 5, wherein she was able to get to know a patient regarded as a nuisance by other staff members by connecting with the patient's suffering and trauma, relates that at the end of this process, the patient dons the mantle of carer.

"*So, when she comes to me on a Friday, we are now also... she will say "Phew doctor, you are having a very busy today! Don't you think I must go put the kettle on?"* [S-FGD 1:392-395]

Sharing decision-making with the patient, an important node of power in the consultation, and an indicator of the student's approach to engaging with the patient's agency, has its own consequences for the wellbeing of the student. As Dr C narrates, after a long process of teaching this patient and her family about her uncontrolled diabetes, and the implications of each treatment option, including staying in hospital or self-treating at home, he experienced a sense of relief as he let go of the desire to control the outcome.

> *"...I just explained everything I could remember about and honestly by the time I finished, I felt at peace, like, she can choose to discharge against advice, I would honestly have no problem. She knows everything and… I was at peace, I was like, aah. And she decided to stay. It was almost an anti-climax. So, I get that thing about the peace… I must let go."* [S-FGD 2:331-334]

### 7.4.3 Enhanced clinical outcomes

The transformation of perspective in terms of the student-patient encounter and relationship was not limited to the humanistic dimensions. When enhanced levels of trust and communication were established, students found that they understood patient complaints better, were able to negotiate better plans, and felt that patients were more engaged in implementing decisions made in the encounter.

Dr N responded compassionately to a patient who came into her consulting room, angry and aggressive, and was able to 'reach' this patient by focussing on her suffering. While she does not elaborate on the clinical outcomes of this encounter, it is not difficult to imagine that this deep understanding of the patient's trauma will lead to a more favourable outcome than if this trauma is made invisible.

> *"It's understanding that the reason why they are angry, or the reason why they're irritable is because they're in pain. I mean, I had one (patient) who came in and walked in and sat on the chair and pushed as far back from me as possible, and I thought oh my goodness, what is going to happen in this consultation. But I think, you know, I started talking and I felt like crying and I'm thinking, shame, the amount of pain... and it's like immediately I was thinking of an animal with a thorn and that is now wanting to bite and bark. Yes, for me it's understanding. No-one is... they are who they are because of their experiences."* [S-FGD 1:421-429]

When she perceived herself and her patients differently, Sr A was able to adopt a stronger advocacy role within the constraints of the health system. Her experiences with patients who trusted her was that they understood that she had their best interests at heart, even when the resources were not available to satisfy their needs. This led to a situation where the student and patient became trusted

allies. Once again, the outcome of this scenario is not elaborated, but the implications of enhanced collaboration holds promise of co-creation of solutions.

> *"To be able to advocate for your patient without taking or feeling blame or responsible for the defects in the system. …I belong to the system and work for the department, but I can separate at some point. With this patient… because of that trust relationship, because I know there is no department or system or other people in this room when I am with this patient. …you can be honest to say I would love to offer you this, (but) and I know (only) this is available."* [S-FGD 3:410-417]

Being cognisant of the system challenges and finding ways to work around and through them in a bid to establish relationships with patients, holds potential to strengthen this camaraderie between student-clinician and patient. This builds a platform for honest engagement around patients' risk or suffering, as described in the following excerpt narrated by Dr R, who describes her learning from engaging with a patient whose blood pressure was not controlled, despite an ever-lengthening list of prescribed medications.

> *"You may not be able to establish it in your first session but if you get the opportunity to see them the second time and that continuity then they will be able to see who you are and that you are actually trying to help and in most cases that is the time where they open up and they will tell you this tablet didn't make me feel nice and I didn't take it and when they do that and what I have learnt is it is important not to judge, very important because then you have to kind of start over again and I think that is a huge step to trust. A huge first step at least."* [S-FGD 3:204-210]

In response to Dr R's comment above, Sr A elaborated on this idea of authenticity in the encounter, stating quite strongly what she would like to convey to all her patients. Being committed to the patient's wellbeing and thereby earning the patient's trust, is elevated to a station above her own competence and the system challenges. Struggling to rise above the technical puts the patient in touch with possibilities that are not within their immediate reach.

> "*I would like them to feel I have their best interest at heart even if I can't do everything and even if I don't know everything. I will try and help them, or find someone who can, or find something that can, or help them in the way where they need to… but I am there to care for them and I have their interest at heart and I want to help them, whether I can and what I can do it varies but I am there to want to help."* [S-FGD 3:215-219]

Sharing of information between student and patient within this qualitatively different encounter allows the creation of a space where light is shed on previously dark areas, the corners of the encounter that are not normally examined, through shame or guilt or ignorance. The encounter, as a space for the practice of Ubuntu, becomes a moment where deep healing can begin. What this means for the crossing of language and cultural barriers for Dr B, the Arab doctor working in a Xhosa community, is beyond the scope of this study, but nevertheless deserves special mention for the question it raises… can intentionality transcend these barriers?

> "*I mean the patient will come more to you and speaking to you freely and not trying to hide stuff... they trust you more also when you give them advice, that is how it feels so different. …this is when you start to listen to them and when they come to your room, and they feel the difference and they start becoming more open and they start talking more and you get more information… you feel closer, and you feel you are doing something for them."* [S-FGD 3:188-194]

This trust is earned by way of being different – in a way that the patient believes the clinician has their best interest at heart. Being authentic in this moment of purposeful intentionality results in patients investing their trust in the clinician, without having to resort to the artefacts or social constructs that define the power imbalance between clinician and patient.

> *"Now traditionally it is the respected doctor that knows everything… being this authority figure… but if the patients trust you and the patients know you have their best interest at heart then you don't have to put up that. They will trust you because they know you have their best interest… and they trust you inherently like that as opposed to try to win their trust or belief in you by putting up a certain facade. If you are scared that the patient is not going to trust you and not going to believe what you are saying and going to doubt your clinical confidence and maybe being that big bad doctor with a stethoscope is the way that you get them to believe you or have faith in you but if they have faith in you because you have shown them, you care about them then there is no other thing that you have to put off."* [S-FGD 3:383-395]

### 7.4.4 Work enhances life

I have already described the positive impact that could be seen in students' wellbeing, sense of purpose, and in some instances, joy and peace. Added to this is the phenomenon of greater satisfaction at work as a result of authentic relationships based on trust, which carries an optimistic aura despite the many challenges. These findings, on their own, impact positively on the quality of students' lives.

Additionally, Dr S narrated her experiences with encountering patients away from the clinical space, attributing a new dynamic in these social encounters due to the changed dynamic within the clinical encounter.

> *"Sometimes I go to the mall… I will meet some of my (patients) and I always feel proud when they are "Hi doctor!" and make sure they come and greet me, and someone is waving at me from afar, and for me it is part of having that relationship and it doesn't take away the doctor-patient relationship. For me it just means they are trusting, and they are more open about their lives and their health, whatever health problems that they are having, and they find they are more comfortable talking about their problems and they don't feel judged."* [S-FGD 3:356-362]

It may seem mundane and ordinary that patients are recognising their doctor socially in non-clinical spaces. However, when taking the racial, socioeconomic and cultural divisions existent in SA society, the clinical encounter that challenges these barriers spills over into non-clinical life for this student, in deep and meaningful ways, validating her new perspective.

Taking the theme even further than happiness and mental wellbeing, the next passage describes, for Dr Z, a deeper, almost existential validation that comes from knowing that an authentic connection has been made, and that good has emanated therefrom. The participant describes an uncoupling from the socially constructed notion of clinician as powerful figure, and re-imagines herself alongside her patients, allowing herself to exist in that organic relationship, and finding contentment in that.

> *"I would describe more in terms of a humbling experience for me. It is a realisation that there is not much external confirmation required. I don't know if you follow what I am saying. So, the satisfaction is coming from a different source. I don't know how else to put it. So, you don't need to be the authority figure. You don't need to be the all-knowing. You don't need to be the one who is making the final decisions. You are facilitating. You are kind of holding it there and you letting things happen. So, you are holding it there and things are happening, and I am kind of happy that things are happening, that is more important. People are doing their own developments. So, it is a different status is what I am trying to say."* [S-FGD 3:367-374]

## 7.5 Conclusion

This chapter has described in detail the transformative learning process that the students went through in relation to their perspectives of relationships with patients. The longitudinal nature of this project afforded me the privilege of observing first-hand how these shifts and movements evolved, from tentative thoughts, exploring new territory, to robust principles that had reach beyond clinical

work. If, for the clinical practitioner, the lived experience of the patient is sacred ground to be treated with reverence and honour, then to the medical educator, the lived experience of the student needs the same reverence and honour.

Four dominant themes, each held together by some core ideas, have been presented. The first is that evidence of disruption is present quite early in the project. The centrality of critical reflection is the second theme, being the fulcrum of learning in this process, allowing the students to swivel in different directions as they explored new ways of being. The third theme describes student responses to being exposed to new ideas and to being disrupted by uncomfortable tasks, and the new imaginings that they hypothesised for later experimentation. The final theme emerged from their hypotheses, as students learnt from experimenting with these new ideas in their workplaces, enabling perspectives to shift.

## 7.6 A reflective note

My role in this project has been complex. As academic convenor of the programme, I needed to ensure that all academic requirements were met, and the institutional structures to which I am accountable, also empowered me to enforce these requirements. At the same time my position as researcher demanded that I ensure that all quality assurance processes were met, within the fairly rigid timelines. In this role, I relied on my relationships with the participants to ensure progress, more so than on institutional structural power. The third role I played was that of participant, being intimately involved in generating context for the clinical encounters and co-creating data in the focus group discussions.

While the separation of these roles was conceptually clear, the reality of integrating identities was messy and complex. The messiness lay in my own process of navigating between roles, often in the same space-time context. A prime example of this is the clinical encounter: as clinical supervisor I was assessing student performance from a positivist perspective; as programme convenor I was cognisant of the quality criteria of this assessment and the need to monitor student progression; as observer I was part of creating a context for the performance of the clinician and the response of the patient; and as researcher I was constantly searching for the emergence of new knowledge. The complexity was embedded in the relationships that evolved with participants. It must have been disconcerting for students to engage with me in a focus group discussion as equals, when an hour before I had been teaching them and advising about how they would be assessed.

Probably the deepest impression that has been imprinted in my mind has been the emergence of a newly acquired trust in the experiences and reflections of my students. I think this became possible as I observed their authentic and deep reflections, and the transformative impact of this on their

perspective. What started initially as a journey fraught with trepidation that the process would not generate of data of sufficient depth, transformed into one filled with humility and awe, as I witnessed the blossoming of new ways of being. This was far beyond my expectations, and I started seeing my role as researcher and educator shift from a collector-interpreter/disseminator of knowledge to a cultivator of sorts: scattering the seeds, creating the context favourable for germination, and then learning from what emerges.

What this has meant for my pedagogy is that I have consciously and explicitly foregrounded student experience and reflection and made reading texts and listening to lectures secondary to these. I believe that this is a revolutionary and powerful shift in health professions education, as any learning that emerges would be unavoidably contextually grounded and texts are interpreted though this lens, rather than contextual experiences being interpreted through a textual lens. On reflecting on this, I considered the words 'context' and 'text'(87) etymologically and discovered that 'text' derives from a meaning of things that are woven, while 'context'(88) implies a togetherness in the process of weaving. To my mind, this makes for richer learning, as different perspectives are woven into a new knowledge fabric.

This radically transformed perspective is influencing how I think about research, in that context is non-negotiable, education in the sense that contextual experiences are core to learning, and academic management as an organising framework for this type of education.

# CHAPTER 8: DISCUSSION - An African re-imagination of educational praxis for doctor-patient relationships

## 8.1 Introduction

This chapter discusses the empirical findings described in the preceding chapters, relating them to some of the key ideas found in the corpus of literature, where appropriate. An argument is developed that draws on a discussion about *suffering and vulnerability* as pathways to rediscovering humanity, on *intersubjective connectedness* as a key concept, and how these concepts can lead to the student *finding meaning* across time (historically) and space (geographically and socio-culturally). At the point of convergence of these three concepts, I propose an Ubuntu inspired epistemology of DPRs in an African context. Emanating from this foundational epistemological proposition, a decolonial pedagogy of DPR is presented, which is cognisant that human interconnectedness brings a natural tension around the issue of power. A reimagined educational praxis emerges, offering an African re-imagining of the DPR: *the triad of educator-student-patient exist intersubjectively in the clinical encounter which is grounded in a concrete experience of local context, bonded by a shared vulnerability to suffering, finding refuge in each other's humanity, becoming critically conscious of how power manifests, and co-creating pathways to learning and wellbeing.*

But first, a brief reflection on the use of three seemingly divergent theoretical perspectives synthesised into a complementary framework for this project. These seemingly disparate approaches: Ubuntu, rooted in African tradition; Mezirow's transformative learning rooted in western liberalism; and Foucauldian post-structural power analysis have been drawn together by two questions that have informed my thinking in the context of this study: what does it mean to be human; and what does it mean to be free? As the argument unfolds below, 'being human' unifies these concepts, and 'becoming free' proposes a method for their complementarity. By drawing on contemporary Ubuntu scholars, who propose ideas that distil the core principles of Ubuntu into our current reality without retaining the social structures, I was able to step away from the hierarchies inherent to African traditional societies. The perspective transformation of Ubuntu from an essentialist to a realist perspective was facilitated by borrowing from a Foucauldian analysis of power, which challenges the essentialist nature of hierarchical power, and helped me in seeking and finding agency in unlikely places. And while the human and relational dynamic was unfolding, the learning for students happened individually. This was framed by Mezirow's transformative learning theory.

The conceptualisation of the Ubuntu humanist dimensions of medical education is drawn from Archbishop Desmond Tutu's reflections on his role as the chairman of SA's Truth and Reconciliation

Commission, that sought to plant the seeds of social and political harmony in post-apartheid SA. Tutu's concept of humanity is inextricably bound up in Ubuntu, and is best presented in his own words:

> Ubuntu… speaks of the very essence of being human. When we want to give high praise to someone, we say: "*Yu, u nobuntu*.": "*Hey, he or she has ubuntu*." This means they are generous, hospitable, friendly, caring and compassionate. They share what they have. It also means my humanity is caught up, is inextricably bound up, in theirs. We belong in a bundle of life. We say, '*a person is a person through other people*.' It is not '*I think therefore I am'*. It says rather: "*I am human because I belong*." I participate. I share. A person with Ubuntu is open and available to others, affirming of others, does not feel threatened that others are able or good; for he or she has a proper self-assurance that he or she belongs in a greater whole and is diminished when others are humiliated or diminished, when others are tortured or oppressed, or treated as if they were less than what they are(86, p34)

In this project, humanism in the context of the DPR adopts the individual's characteristics described so eloquently above and makes them serve the higher purpose of establishing relationships between student-doctors and patients that binds them in common purpose and humanity.

## 8.2 The clinical encounter

> *A patient walks into a consulting room in a primary level clinic, somewhere in Africa. The hurried doctor mumbles a greeting, scans her folder rapidly, and asks a series of questions designed to aid her in making a diagnosis. An examination follows sometimes, followed by a brief explanation and a scribbled prescription, and off she goes to the pharmacy. The entire consultation lasted 10 minutes, and she will repeat this every six months. The doctor repeats it 30-40 times per day, five days a week, for forty-eight weeks of the year. When this doctor is also a student, she is also consciously aspiring to learning new skills and experimenting with them to develop competence.*[5]

Considering this scenario, typical of the patient's and postgraduate student experience in countless clinics across the continent, it is little wonder that medical educators working in these clinical spaces are dealing with rampant levels of emotional distress among medical students and staff who are

[5] ***Explanatory note:*** *In this chapter I use vignettes and extracts to link the raw data to the discussion. Though some of the vignettes themselves are fictional, they are entirely based on the raw data presented earlier.*

expected to work and learn in this context. While the health service imperatives are being met (supply of services in response to population needs), serious questions about learning and wellbeing arise. The response of medical educators has been noteworthy in their attempts to understand and impact the challenges presented.

In recognising that the consultation model, based as it is on the disease model, does not answer the humanistic demands, there has been a focus on developing empathy and enhancing communication skills(90). Empathy is interpreted as the doctor's willingness and ability to understand the patient's perspective of their illness, and when applied as 'cognitive empathy', becomes a measurable skill that can be taught, learned and assessed. The implicit consequence is an enhancement of the DPR, though the literature is opaque on what this 'enhanced relationship' is. Nonetheless, in a concerted push to entrench empathy in the practice of medical educators and students, several studies across the world quantitatively explored levels of empathy in medical students using a standardised tool (the Jefferson Scale of Empathy - JSE), (38,40,42) finding that in some contexts empathy was enhanced, and diminished in others. Disappointingly, the reasons for the variations were never investigated, with authors speculating that cultural beliefs and practices may have been responsible for this. In keeping with this positivist trend towards viewing empathy as a competency to be learned and performed by students, and taught and measured by teachers, attention was turned to training medical students to become empathic communicators (39). While these efforts indicated success in measuring the empathy constructs, they do not provide us with an epistemological frame for thinking about empathy as a human characteristic within health sciences education, and the related questions about knowledge acquisition and generation.

Similar to the paradigm that dominates medical education with its strong emphasis on competence-based learning and assessments, one of the key texts in FM dealing with communication skills leans heavily on a positivist approach to pedagogy(9). In this text, Silverman and colleagues do an outstanding job in providing a comprehensive approach that medical educators can adopt in teaching communication skills that are patient-centric, in the sense of enhancing collaborations with patients that result in improved efficiency in practice, improved health outcomes for patients and wellbeing for doctors. There is broad consensus on what constitutes the curriculum for teaching communication skills, as evidenced by the Kalamazoo statement of 2001 (91). Notably, this statement has no African authors or references (or any Global South representation, for that matter), a key criticism when thinking about communication, central as it is to understanding human society. We are left to our own imaginations to fathom the philosophy that undergirds it.

Two other humanist dimensions have captured the attention of medical education researchers in recent years: burnout and resilience. Burnout, recognised by the World Health Organisation (WHO) as a "syndrome conceptualised as a result of chronic workplace stress that has not been successfully managed"(92) is described in terms of three dimensions: energy depletion; depersonalisation; and reduced sense of efficacy at work. This has been recognised as a problem in our local context as well, where Rossouw and colleagues found in excess of 70% of primary care doctors surveyed in CT in 2013 demonstrated significant traits of burnout(83). Interestingly, Hojat and colleagues found an inverse relationship between empathy constructs and burnout constructs, that is, lower levels of burnout was found in medical students with higher levels of empathy (93). These are certainly useful tools in the kits of medical educators and the educational systems they work in, who must constantly be finding ways of enhanced wellbeing for themselves and their students.

In response to the epidemic levels of emotional distress and burnout, medical educators turned their attention to resilience, and in keeping with competency-based approaches to medical education, resilience training. The last decade has seen a plethora of research in this area, which is well summarised by Seo and colleagues in their systematic review of resilience interventions in medical education(94). However, once again context and episteme are sorely absent from their discussions which focusses almost entirely on individual responses to stressful situations, and consequently we are left with unanswered questions as to how knowledge dealing with the humanistic aspects of medical education is acquired and generated in a context where populations are not westernised, educated, industrialised, rich or developed (WEIRD).

I have spent some time discussing the current dominant trends in some humanistic dimensions of medical education. These trends are directly linked to the findings of this present project and were necessarily summarised as a backdrop to the discussion that follows, wherein it is proposed that a deeper understanding of personhood is needed to re-think the humanist crisis the medical world is facing.

## 8.3 Interconnectedness: A case for Ubuntu

> *The doctor calls a nurse to assist with translating from English to isiXhosa, the patient's home language. The patient, a middle-aged lady, had come for her routine consultation to manage her high blood pressure. At this visit, the blood pressure readings are worryingly high, and the doctor enquires via the nurse-translator about the usual causes for this: "Are you taking your medication?" "Yes."; "Are there any side effects?" "No." When she asks: "Do you have lots of worries at home?", the patient struggles to contain her emotions, as she relays a lengthy story*

*in isiXhosa, punctuated by trembling silences, silent tears flowing down her cheeks, and quivering lips struggle for dignity in front of these strangers. Her story touches the nurse-translator so deeply that she is unable to hold back her own tears, and after containing herself, narrates a story of domestic strife and abuse that the doctor listens to in silence. She gasps, reaches out and grasps the hand of her patient, and in that moment, these three women are bound together in a place that is more than physical.*

*I, the educator observing from an obscure corner of the room, am a silent witness to this drama.*

Becoming conscious of vulnerability and suffering offers us three ideas that could be central to the humanising project: sensitivity to suffering of the other as a means of interconnectedness; the role of the emotions in facilitating these connections; and how this leads to meaning-making in the clinician-patient encounter. Ubuntu, focussed as it is on building interpersonal and social connections, is proposed as an episteme to usher in this ambitious project.

### 8.3.1 Suffering as an intersubjective bridge

I have already shown how patient-hood is validated by attention to suffering. This suffering, as expressed by the patient and acknowledged by the doctor, becomes a bridge between the two. By engaging with the vulnerability that is generated by the suffering, the sick-role of the patient and the healer-role of the doctor are validated respectively. It must be stated quite clearly here that making a diagnosis and the subsequent treatment does not equate to validating suffering. The former activity is a technical task, needing a certain amount of knowledge, skills and competency, while the latter is a humanist trait, needing insight, empathy, compassion and resilience. As shown in chapter 5, when the clinician's work is reduced to a series of diagnoses and treatments, a spectre of the clinician-automation is raised, condemned to a work-life of daily repetition, never raising its eyes from the desk in front of it, as it ploughs through the problems of anonymous others. Alternatively, when this process is expanded to elicit, acknowledge and respond to the suffering of the patient induced by the litany of problems, the doctor realises her ability to alleviate the suffering (to some extent, at least), which fulfils and validates her humanity and worth in the world. In as much as acknowledging the patient's suffering benefits the patient, the recognition of her ability to ease suffering profoundly benefits the clinician.

The centrality of suffering and its accompanying vulnerability in the therapeutic space is recognised across disciplines. Cecil Helman, the renowned medical anthropologist and doctor, defines medical anthropology as the "study of human suffering and the steps that people take to relieve and explain that suffering" (15, p1). Rita Charon, professor of medicine at Columbia University but writing from the

perspective of the medical humanities, elevates the engaging with suffering as a foundational skill for doctors in training, proposing that "it brings both conversationalists (*doctor and patient*) straight toward what it means to be alive, what it costs to be alive, what is this life of ours"(95). In the context of medical humanities, she suggests that engaging with suffering might be *the* key imperative for incorporating the humanities into medical training. Taking this argument even further, Nicole Piemonte, the American medical humanities scholar, laments that "patients so often feel unseen and unheard in their encounters with healthcare professionals" and that "healthcare professionals are experiencing what we might call a crisis of meaning in their work"(96). She suggests that foregrounding vulnerability in medical training is so essential that a critical approach to medical epistemology is needed to understand why doctors struggle with this phenomenon, and that when the reductionist approach to biological disease is equally applied to the existential humanist challenges faced by medical educators and students, the "human element… is likely unintelligible within the dominant discourse of medical practice that tends to drown out and even dismiss such expressions." Though not in the context of medical education, Banda explores an Ubuntu-based response to human suffering induced by widespread poverty and conflict across the African continent, proposing that a key value in an Ubuntu relational worldview is the enhancement of human flourishing(97). As a direct response to tragedies, hardship or distress afflicting some people within the community, African communities have historically established traditional practices aimed at alleviating this suffering, based on a shared vulnerability. In this sense, Ubuntu operates in the space between people, energising this intersubjective space, thereby providing the motivation for action that manifests socially and economically. Applied to the ever-present suffering that permeates medical practice and education, Ubuntu may offer a way of navigating towards the epistemic solution that Piemonte calls for. If suffering is regarded as a human condition, then our responses to this condition can be observed in our emotions and behaviour. When we broaden our gaze in this sense, it is impossible to separate the suffering from the sufferer, and it is to this that we next turn our attention.

### 8.3.2 An emotional connection

Patients were particularly enthusiastic about the way doctors made them feel, expressing gratitude, joy, contentment, discomfort, anger and disgust, depending on their experiences. Their recollections about previous encounters, in the consultation room or corridors, were enveloped in these emotional responses to said encounter. They reacted to indifference, coldness, being rushed, being listened to, being respected, being welcomed with a single theme: a desire to be humanised, which I interpreted as validation of their personhood. While the enactment within the clinical encounter is shaped by

ethical values and moral behaviour, the human response to these experiences is not only cognitive, but importantly, emotional.

According to the SA clinical psychologist, researcher and educator, Wahbie Long, emotions, more than thoughts, are what exists in the intersubjective space between people(98). If one accepts this position, which I do, and reads it in conjunction with the above interpretation that acknowledging and engaging with the patient emotionally validates their personhood, then we have a powerful construct for medical educators in considering the student-patient encounter. However, this seems too simplistic, because I respond to my dog emotionally, with very little cognitive overlay, and the engagement excites him in his dog-hood and calms me down as a recipient of unconditional love. Are emotions really so powerful that they lay claim to existential validation? This assertion seems to strike at the heart of rationalism with its dominant cognitive methodology, which has dominated scientific thought for the last few centuries.

The political theorist and philosopher, Martha Nussbaum, seems to think that emotions do carry existential power(99). While acknowledging the role that political power and morality play in influencing public behaviour, she adopts a position that it is in the emotional domain that individuals and society react to their lived experiences, with emotions such as anger, disgust, envy, sympathy and love. These emotions are embedded in the collective psyche of a nation, and manifest in policies and laws that are enacted and enforced. Nussbaum explains that emotions facilitate enhanced interpersonal connection when the actors involved have “thoughts of similar possibilities”(96, p144). In everyday language this would echo the 1993 Whitney Houston classic song, “We have something in common”, where she (correctly, as it turns out) predicts the love that will follow her thoughts of similar possibilities(100). Tragically, this love proved to be dysfunctional as the world witnessed her untimely death, after years of abuse, in 2012 at the age of 48 years. This brings us back to Nussbaum, as she struggles to explain the value of love in political liberalism which values individual freedoms. Love, which unites people and can be used to coerce the public towards a particular goal, which may not be democratic or serve the cause of justice, could be co-opted by charismatic leaders to animate misleading, or even oppressive behaviour. She resolves this dilemma by proposing that love, in particular, motivates actions that are altruistic and aim for good, but is in need of moral guidance, and in the absence of this moral (or legal) guidance, one finds dysfunctional forms of tyranny flourishing, similar to Whitney Houston’s fractured love she shared with Bobby Brown. This argument is extended to other emotions that similarly have the power to motivate action. Emotions, in as far as they motivate action in the spaces between people, are central to the concept of relations, whether shaping perception of the self, the other, or the collective.

With emotions being such an integral part of being human, I now turn to Ubuntu, as an African expression of being, to explore whether it can enhance our understanding. John Mbiti's seminal text describing Ubuntu as an African philosophy(18) narrates the concept of personhood as inextricably related to others, mediated by relationships, which in turn, according to Letseka, are founded on emotionally-driven humaneness, kindness, compassion and concern, among other altruistic characteristics(61). Applying Nussbaum's understanding of love, that it is an emotion that seeks good for the other, to this conception of Ubuntu would suggest that love is the central emotion that Ubuntu values. The centrality of emotions to any idea of humanity has been recognised in Ubuntu and similar African philosophies, and likely existed since before recorded history. Banda describes how a person devoid of these characteristics is not recognised as a full person, being deficient in the ability to show genuine concern and compassion that facilitates co-existence(97). These ideals are challenged, however, by the reality across Africa of immense suffering in the postcolonial era, despite the ubiquitous presence of Ubuntu-like philosophies in communities across the continent. Unpacking the reasons for this sorry state is beyond the scope of this project, but one cannot speak of Africa without also mentioning her shame. At the level of the doctor-patient encounter, the findings presented earlier resonate with these Ubuntu ideas about personhood in relation to the emotional lives of medical educators, student-doctors and patients and is wholly operational within Tutu's humanistic framework. And it was not only in the validation of the patient's personhood that this Ubuntu ideal is achieved. In being a full person, the doctor-student was a full participant in this humanising process, rediscovering their own meaning and purpose in their work.

### 8.3.3 Finding meaning

When students engaged empathically with the suffering and vulnerability expressed by their patients, responded compassionately, and carried themselves in a way that resulted in feelings of trust starting to spark in the encounter, they found that they were reconnecting with their reasons for studying medicine in the first place, caring for suffering people. This rediscovered sense of purpose led them primarily to a sense of emotional gratification with their work, which in turn led to contentment and peace, and when reflecting on this state, discovered that their work had assumed deeper meaning. This remarkable perspective transformation occurred in the same workplace, with the same pressures that they had been operating under prior to the commencement of their studies. This finding of meaning and connection to a higher purpose mitigated directly against burnout and emotional distress, which has been problematised as an epidemic in medical education.

The SA educationists, Keet, Zinn and Porteus propose that meaning-making frames are arranged hierarchically within an individual's experience, and making sense of the world(101). These competing

epistemes come to the fore dynamically in the process of experiencing, learning and reflecting. It follows that a person may use different frames to explain and understand different experiences. The meaning-making frame facilitates the emergence of identity, a necessary realisation if the individual is to be a full member of society. Following this thread, our students made meaning (reinforced identity as healer) of their experiences through a reflective and dialogic process where the harmonisation of their and their patients' emotions, intentions and actions was the key focus. This suggests that the dominant episteme that facilitated this meaning making is one that places a high value on interpersonal harmonisation.

When Mbiti describes the whole human being in terms of an Ubuntu worldview, he describes a person whose relationships with humankind and the natural environment is aligned with principles of emotions, intentions and actions, where good emotions are aimed at achieving optimal potential for self and the community, and bad emotions disrupt this sense of optimisation of potential(18). Desmond Tutu similarly states that the achievement of social harmony is the highest expression of society that Ubuntu guides us towards(89). Metz and Gaie agree with this conception, framing Ubuntu as a moral theory that seeks to establish social harmony and healthy communal relationships, though they err in marginalising the spiritual belief in ancestors and connection to the land that is so central to a broad understand of Ubuntu(65). According to Mbiti, when a person understands and connects with her living relations and the geographic space she occupies, she finds meaning in a particular space(18). When she connects with her ancestors, she finds meaning for her life across time, knowing that she will similarly be connected with her progeny after her own death. This holistic (physical-emotional-ethical-social-spiritual) commitment to establishing harmony across time and space is what gives meaning to the life of the individual. It is in this meaning-making frame, I propose, that the medical educator and the student-doctor can explore new ways of being with each other and with the patients whose suffering they seek to teach about and alleviate. Ubuntu gives all of these protagonists a place in the world and in history, firmly rooting them in their lived experiences. In our instance, this suggests that Ubuntu provides an epistemic framework for developing meaning about teaching and healing in a decolonising society, located on a continent which is ripe for co-creating a harmonious future.

## 8.4 An Ubuntu-inspired humanist epistemology of the doctor-patient relationship

> *The doctor reflects on the consultation with me and admits to feeling inadequate. She doesn't feel as if she had done enough to help this lady manage her blood pressure. I try explaining that in this incredible moment of interpersonal connection, she has probably done more good than in all the preceding encounters that only foregrounded the blood pressure. She looks at*

*me, puzzled: "But I did nothing, I just sat there and listened!" "Exactly", I respond, "because that's what she needed." "My training definitely did not prepare me for this" she states, shaking her head. "It's not something I can measure."*

Thus far I have made the argument that Ubuntu offers the educator-student/doctor-patient triad opportunities for validating their role in society at a particular point in time, as people with a shared sense of vulnerability (albeit that the actual vulnerabilities differ) which connects them intersubjectively, and that the ultimate outcome for the student/doctor is a (re)discovered sense of purpose and meaning in their work. By achieving this outcome, the student mitigates directly against the problems which opened this chapter: erosion of empathy, emotional distress, burnout and lack of resilience. In so doing, Ubuntu presents a solution, and a challenge, to medical educators which entails stepping beyond the bounds of the dominant medical episteme, which seeks objectivity by problematising everything within the disease model, needing to be diagnosed, treated and the passive object (patient) returned to 'normal', devoid of context and values. While this model has been undeniably successful as the past few centuries of scientific progress can attest to, precisely because it excludes values, context and subjectivity, it fails spectacularly at addressing the humanistic problems that are in a constant state of eruption. For the DPR, I have argued that an approach to knowledge is needed that pays attention to subjectivity, identity, context and values. Can Ubuntu fill this gap?

Jan Illing, professor of Health Professions Education at the Royal College of Surgeons in Ireland, defines epistemology as "the theory of knowledge, its origins and nature, and the limits of knowledge"(99, p333). Knowledge, in turn has been described in the Stanford Encyclopedia of Philosophy(103)as having three distinct components:

1. 'Knowing individuals (who)' identifies the key relations that an object has to its environment, and in the case of human society, the people with whom we are acquainted. It therefore establishes some kind of context, via this relationality, that allows us to know where the object/person fits.
2. 'Knowing how' identifies that it is not sufficient to know facts, but one must be able to know how to identify those facts, and apply them in the world. In this sense, knowing how operationalises relationality and facts, allowing knowledge to become active in the world.
3. 'Knowing that' is a description of facts. Facts are deemed to become knowledge when they can be justified (either empirically or rationally), when they are true, and when they are believed.

While adhering to Mbiti's presentation of Ubuntu as an African philosophy of life(18), I recognise that characterising it as an epistemology would be reducing its value from an all-encompassing existential paradigm that provides a spiritual, emotional, social, and personal model to explain life. Rather, Ubuntu could be regarded as an ontology, a philosophy of being, with its own axiological aspirations that in turn energises and inspires an epistemology that is intersubjective, transactional, and grounded ontologically in historical realism, that takes into account the historical, socio-political, and geographical instances that shape current experiences of reality(62,64). This Ubuntu-inspired epistemology answers the key questions raised above.

Firstly, operating in the intersubjective space, relationality becomes a key element, not only to other people, but also to history and the natural environment. In its commitment to history, this epistemology would also pay keen attention to the future, as current events generate historical moments. In the context of DPRs, this attention to *holistic relationality* is central to building a common platform for engaging with each other's humanity as a key objective, leveraging off *mutual vulnerability* as the means to this end. Secondly, in learning to 'know how', the student engages experientially with the patient and educator, experimenting with new ideas, and co-creating the expanses and limitations of their knowledge. Operating in the clinical encounter demands a high level of this practical knowing, more so given the sensitivities that are on display as described earlier: the patient's vulnerability in her illness-induced suffering and the doctor's vulnerability in her wellbeing. Thirdly, the description of their own humanity, that of others, and the issues at play when the two meet, allows the doctor to learn (get to know) facts of the encounter, and subsequent relationship, that allow optimisation of the relationship and the respective humanities. The onus of providing the justification of these facts rests on all the actors in this drama. The educator who observes and interprets, and the doctor-patient dyad who engages and reflects. An Ubuntu-inspired epistemology for the DPR therefore answers the key philosophical questions that allows it to identify itself as such. While this project did not focus primarily on the student-educator relationship, the nature of the knowledge, the context of the work, and the intersubjective process of knowledge production, means that of necessity, this relationship must be included in our conceptualisation of a humanist epistemology.

This idea of an Ubuntu-inspired epistemology finds traction among some African educationists. In compiling their comprehensive work examining the opportunities for new educational paradigms in Africa, Takyi-Amoaka and Assie-Lumumba provide the rationale for their project as the continent needing an "ubuntu-inspired education for humanity" and "some practical solutions that exemplify" this(101, p11). Abdi acknowledges the existence of African, and specifically Ubuntu-inspired

epistemologies while decrying the colonial project of marginalising and covering up the “pre-colonial African achievements and life-management systems that represented time-and-space tested ways of living, learning, and advancing”(102, p22). His analysis of the historical impacts of colonial epistemologies describes how epistemic domination, individualisation and marginalisation, stood in stark contrast to the cosmopolitan, communal and hence, inclusive, philosophies of the colonised people across the continent. I approach this essentialist interpretation with caution, as it seems to project a romantic image of pre-colonial African society, and Abdi himself warns against being too naïve in this matter, as this continent has produced individuals who “can become capable of doing the exact opposite of Ubuntu”(102, p31). In addressing some of these excesses of African leaders that characterises many post-colonial, and now neo-colonial African states, Lumumba-Kasongo proposes that Ubuntu represents a key decolonising, value-laden paradigm for an African educational future(106). This value-laden paradigm, which places a high premium on enabling, hospitable human interactions, is exactly what informs the educational potential of Ubuntu, if we are to accept that education is a social activity between people that characterises hospitality and optimisation of potential(107). These African scholars write inspiringly about the potential contribution that Ubuntu can make to educational systems, curricula and pedagogy. However, in the context of medical education, where so much progress has been made under the umbrella of positivist science, is it even possible to contemplate a new epistemic approach?

The solution to this dilemma may lie in the envisioning of a humanist episteme, inspired by Ubuntu values and philosophy, that stands next to the positivist episteme, complementing each other in answering the health needs of the African population. This sounds plausible, but the experiences of others have indicated that the positivist thoughts have deeply infiltrated the structures of educational institutions, offering little support for “epistemic generosity”(108). Similarly in psychology, where the dominant natural science episteme is seen as ‘first principles’, to the detriment of the relational dimensions of the therapist-client relationship, there have been calls for a multi-epistemic space that is complementary, allowing for education to become more holistic(109). Given these obvious challenges to hegemony of the natural scientific episteme, the argument for including an Ubuntu-inspired humanist epistemology in medical education rests on two pillars: the first is the failure of the current episteme to address the humanistic crisis that medical education and practice faces across the world, and the potential that Ubuntu (or other humanist philosophies) holds to mitigate this crisis; and the second rests on the Ubuntu principle of inclusivity, which is regarded as a universal good, and when applied to medical education, demands that a decolonised educational system acknowledges its own oppressive history and makes space at the table for discovering new ways of being.

## 8.5 A transformative humanising pedagogy for the doctor-patient relationship

*Despite my attempts at re-assurance, the doctor's feeling of inadequacy persists. That afternoon, as she walks to her car to leave the clinic, the patient she had seen earlier calls her from the pharmacy waiting area. "Gqirha! Enkosi kakhulu, Gqirha. Enkosi kakhulu!" Puzzled, the doctor asks the security guard to interpret, and he smiles as he tells her "She is thanking you doctor. You must have helped her a lot today! The other patients, they also say you have a good heart." Inadequacy is replaced by pride, and as a warm glow of satisfaction radiates throughout her body, the doctor skilfully avoids the potholes in the street outside the clinic, humming the opening lines of the Bill Withers classic "When I wake up in the morning, love, the sunlight hurts my eyes, and something without warning, love, bears heavy on my mind…"*

In this section I propose a pedagogy that humanises the DPR that seeks to reclaim the fully human identity of the colonised, emerging from an Ubuntu-inspired humanist epistemology. In the context of this project, and in keeping with Paulo Freire's ideas that revolutionary zeal is motivated by a desire to be fully human, to attain and enjoy freedom and justice, I propose that medical education needs to enter a discourse that explores what it means to be fully human, and therefore free. This humanising movement, which Freire calls a "humanising pedagogy"(110) holds the real potential for combining the humanist and decolonial ideals, and so, in proposing a humanising pedagogy for the DPR, I am also proposing a decolonial pedagogy. When thinking about decolonising pedagogy, I use Stein and Andreotti's broad definition of decoloniality, that states that decolonisation is "an umbrella term for diverse efforts to resist the distinct but intertwined processes of colonization and racialization, to enact transformation and redress in reference to the historical and ongoing effects of these processes, and to create and keep alive modes of knowing, being, and relating that these processes seek to eradicate"(108, p2). The humanising and decolonial projects have remarkably similar themes, particularly in relation to reclaiming humanity from colonial historical practices. When Foucault described the "medical gaze", the doctor as a powerful being represents the coloniser, while the docile patient as passive recipient was the land being colonised as the doctor and disease waged war(17). As we seek to humanise the patient, the doctor, and the clinical encounter, our educational praxis will of necessity be decolonial insofar as the traditional doctor-patient encounter represents colonial practice. This means that this pedagogy must pay attention to identity, relationality, and the power that flows within the encounter.

In constructing this pedagogy, I draw on the key relevant findings of my project. The first of these findings is the search for identity, which is inseparable from context, meaning and purpose. The second broad theme is the need for interconnectedness between student-doctor and patient, and between

student and educator. The assertion here is that an Ubuntu-inspired pedagogy is necessarily dialogic, from which co-creation of knowledge is a natural outcome. The third theme relates to power as it manifests in and around the clinical encounter, and the somewhat surprising manners in which it surfaces in these engagements, allowing us to think in new ways about ways of analysis in this space. As pedagogy is squarely within the ambit of the educator, the key target audience for this section are medical educators, who are challenged to open their minds to new ways of being with their students. These proposed new ways of being will, of necessity, challenge the status quo in terms of knowledge production and power.

### 8.5.1 The search for identity in clinical encounters

One of the key findings in our study was that students developed critical consciousness of their role within their facilities, and within their encounters with patients. This consciousness included critical self-awareness, awareness of the emotional (unseen) experiences of patients, of the presence of a power dynamic (unseen) in the encounter, and of the context of their work. The heightened level of awareness proved to be a crucial educational step, allowing them to explore these phenomena dialogically within the educational space. Flowing from this consciousness and dialogue, they reflected on, and found affirmation in the humanistic expressions within their clinical encounters, reconnecting them with who they are as healers, their sense of meaning and purpose in their work, which led to a feeling of peace. This process represented a (re)discovery of their identity, covered up as it were, by the ever-present health demands of the communities they serve, and the service demands of the system in which they work. This learning, facilitated by an educator, was grounded in the contexts in which they worked, and following Jack Mezirow's transformative pedagogy, the point of reference for this learning was a context-specific "disorienting dilemma"(16). The depth of the initial engagement, and the critical reflection and action that followed, resulted in a radical perspective transformation of the doctor-patient encounter for these students, from a transactional, technical exchange to a meaningful humanist connection.

The importance of context in medical education cannot be overemphasised. It was Donald Schon who demonstrated the value of reflection as a learning tool for adults, based on their concrete experiences in the world(57). Similarly, Kolb's adult learning cycle describes four steps of adult learning based on experience, reflection, reconceptualization and experimentation with new ideas, which results in new experiences which then starts a new learning cycle(57). Thirdly, the educational theory that has animated this project, that of Mezirow's transformative learning theory, is rooted in a specific experience in a specific context, elevating a context-specific experience as a point of reference for the entire educational process(16). For Paulo Freire, learning and context cannot be separated, as the

context produces the lessons to be learnt, and the subjects co-produce the knowledge that invigorates these lessons(110). Adult learning is therefore intimately bound to the context of experiences, this being very well demonstrated in medical education and the clinical encounter in particular. Critical contextual awareness becomes a non-negotiable attribute that the student-doctor needs to cultivate, and the medical educator needs to nurture, if the doctor is to successfully become an agent of positive transformation in the context in which s/he works. For the DPR, it means that the educator and student have to enter the context of the patient, the student in direct engagement with the patient and the psychosocial challenges that constitute that reality, and the educator as observer, occasional participant, and facilitator of guided reflection. In so doing, the clinical encounter (experience) and the classroom (reflection and theory) have complementary roles to play. The value of the movement into the patient's world holds profound learning potential for the student's identity formation as an emerging clinician.

Closely related to the development of contextual awareness, students started engaging with their roles in the encounters, critically questioning their previously held values and behaviours, and hence their identities. In reconfiguring their own self-perceptions and modes of engagement, they witnessed new dimensions of relationships with patients unfolding, that held promise for future clinical encounters in terms of enhanced collaboration, and deeper appreciation for the work they were doing as clinicians. Cruess and colleagues, in engaging with the idea that professional identity formation is an imperative of medical education, concede that the positivist approach does not have the pedagogical capacity to address this complex issue, and propose that a "change in goals, objectives and educational strategies is required"(3). The competency-based approach that typifies medical education cannot capture the ways in which doctors are socialised into the medical world, demanding that educators step away from the dominant pedagogy and explore new approaches to teaching and assessment(112,113). This new praxis, as demonstrated in our study, should facilitate the finding of meaning and purpose in their work through enhanced humanistic expressions in the clinical encounter which strengthens their recently transformed perceptions of themselves in their professional identities. The importance of reconnection with purpose and meaning making is explained quite clearly when considered in the light of Karl Marx's alienation theory, as explained by Long(98). Born out of the industrial revolution, when mass production workers became alienated from the means of production, the profits of production, and the ability to build social networks at work, they lost touch with the deeper meaning of their work. This alienation from the meaning of work is justified by the need for enhanced efficiencies that a highly pressured system demands, as ways to optimise productivity becomes a key system driver. For the medical educator, this critical self-consciousness becomes a powerful educational tool. Reflective and

dialogic processes led students to critically analyse their roles, motivations, aspirations, challenges and limitations. Guided by mutually agreed upon values that represent the groups' humanistic aspirations, the internal reflection-dialogue process leads to new imaginings of how they see themselves with their patients. While an appreciation of the patient's context broadens their perspective beyond the scope of biomedicine, this internal process exposes the limitations of the historical identity imposed on them and offers them an opportunity to search for freedom to express their humanity. They are now able to explore new ways of engaging with their patients.

### 8.5.2 Doctor-patient connectedness

It is within the humanised doctor-patient encounter that we find so much potential for meaning, and that offers us possibilities of new ways of thinking about illness, health and wellness. We have already identified in a previous section how the subjective intentions, vulnerability, and acknowledgement and response to each other's emotions (empathy and compassion respectively) leads to higher levels of intimacy and trust in the encounter, with subsequent rewards for patient and clinician. In this section I present some ideas about how this enhanced connection can be achieved, within the Ubuntu-inspired educational praxis.

The educator, student and patients are active participants in this making of a connection, with each having respective roles. The educator is a critical reflector, able to observe, explore experiences, provide feedback and facilitates dialogue that produces knowledge. The student is immersed in the encounter, and engages in critical reflection, based on input from the educator and patient, and explores new imaginings in a peer group with students who are undergoing similar experiences. And finally, the patient provides valuable experiential knowledge on what validates the encounter for them and provides feedback on their perception of the level of connection in the encounter, identifying barriers and bridges. This means that the educator-student-patient triad are intimately involved in every moment of producing the new knowledge that will shape this student's professional identity, and the corpus of knowledge that informs educational praxis. For this to happen, my findings suggest that a few principles need to be established.

The first principle is that achieving deeper connections with patients requires a proactive attempt by the student, drawing from the critical consciousness that was outlined above. The translation from theory to practice requires that the student exercises agency in enacting a humanistic encounter in a health system that is not geared towards this. The intention to practice humanistically for the student, requires emotional energy as it necessarily means engaging with his/her own vulnerability in a system that may expose and rupture his/her wellbeing. McWhinney describes the "connectional moments"(7)

(7 p41) that a humanising clinical space will facilitate and engage with, where the doctor's humanity is the midwife to a deeper connection being birthed. The role of the educator is vital in creating a safe emotional and reflective environment wherein the student can experiment with these new practices.

The second principle is that building bridges in the intersubjective space requires action and movement. It is not an abstract concept that will magically manifest because a few new ideas are being explored. The data generated in this study indicates that the emotional movement towards the patient, and physical movement across socio-cultural barriers to visit patients in their homes, were vital in ensuring that students embodied their learning about the lived realities of patients. This embodied learning made the patient's reality part of the student's reality, forever changing perceptions and attitudes. For the medical educator, this means that of necessity, medical education about the DPR must take place outside of the comfort zones of students and in the context of their patients, where they can experience, at first hand, the (often invisible) psychosocial challenges that patients bring into the clinical encounter. Mezirow and Freire both emphasise the importance, in the learning process, of being exposed to a contextually rich problem that provides enough disturbance to the status quo that change is deemed necessary. The medical educator, as curriculum designer, should seek out such opportunities that traverse barriers, in theory and practice.

The third principle emphasises the social dimensions of learning and teaching about DPRs. As has been established, this relationship does not fit neatly into natural science or clinical textbooks and is therefore inaccessible to those coming only from a natural or clinical science-based perspective. As we have established, learning about relationships is experiential, reflective and dialogical. Lave and Wenger have described this process of developing the professional identity as part of a community of practice, imbued with values and norms, and comprising multiple layers of learning that the individual needs to traverse in transitioning from peripheral to full membership(57). The medical educator, fully aware that the health system environment may not be conducive to the practising of an emotionally centred, relationship-oriented clinical encounter, is challenged to use his seniority and influence to challenge existing norms and policies, employing research and advocacy in the quest for a more humane system. Additionally, role modelling to junior colleagues becomes a valuable educational strategy to employ in this regard, as students explore the limits and delimits of their transformed practice. The issue of role modelling the humanist dimensions of health care should not be undervalued. Ras and colleagues, in evaluating a postgraduate training programme in CT, found that students identified humanistic traits in role models as the values they were more likely to emulate than technical skills(114). In addition to peer groups', reflection and dialogue, educators are intimately involved in the social dimensions of learning, especially so in a performative profession such as

medicine. Educators, therefore, also need to engage with their own vulnerability, exploring new ways of being with students that foregrounds humanistic values. An Ubuntu-inspired humanist pedagogy binds the patient and doctor as they search for healing, and similarly binds the educator and student as they search for knowledge.

The work of the educator in facilitating learning about enhanced doctor-patient connections must traverse these three principles. This pedagogy is wholly dependent on the active participation of the student. It would ensure that the student discovers and exercises their own agency within the clinical encounter, harnesses their willingness and energy to engage in purposeful and relevant bridge-building activities, and immerses them in the social-dialogical component of learning as they enter a community of learning and practice. The patient is a willing, active and critical participant in the encounter, providing key information about the intersubjective experience that has proven to be so central to this humanising process. The educator, as role model, observer and facilitator of critical enquiry and reflection, is fully present cognitively, emotionally, and relationally. While Ubuntu unites and humanises, seeking harmony within this triad, when the time comes for action in pursuit of an objective, either of learning or healing, it becomes an issue of power.

### 8.5.3 Power in the clinical encounter

> *The patient sits quietly in the waiting room, contemplating her experiences that day. It was the first time that she had spoken about her secret to anybody, and she feels liberated. And all thanks to that nurse and doctor who asked her about her stress. "Why did I tell them all of that?" she wonders. "Maybe it's because I felt they really care about us, even though they have to see so many patients every day." Other times, the consultations were always so rushed, and she understands this, as the clinic is always full, and the doctors and nurses work under very tough conditions. But this time… something was different. "I think next time I come, I'll bring them some of my magwinya[6] that everybody loves so much."*

When considering power in the clinical encounter, I refer to the key findings detailed in previous chapters. The patient as a critical agent, fully engaged in an evaluative process which demonstrates their power, becomes an actor who demands dignity and respect. The doctor's power resides in the structure (health system) she represents, has extremely limited individual agency, and is analogous to Foucault's "docile body"(84) subject to disciplinary power that dictates action and removes autonomous decision-making. In the medical context, this is in the form of evidence-based medicine, that informs the medical curriculum and clinical practice. From the humanistic perspective that seeks

[6] Magwinya – a traditional fried dough bread

to transform the DPR, it appears that the patient is empowered to act freely, while the doctor is constrained by systemic demands and policy. In terms of learning and knowledge production which the experiential and dialogic spaces must claim in this pedagogy, thereby challenging the traditional unidirectional flow of the positivist medical paradigm, which in contemporary times is a one-way street that can be characterised as: laboratory → pharmaceutical industry → medical profession → clinical spaces. In addition to the roles of the actors and the context of the action being re-imagined, one must also pay attention to the way in which power manifests and flows. I propose a schema for the doctor-patient encounter that identifies *decision-making, implementation of decisions*, and *accountability* as three distinct nodes of power. This schema becomes vital for the educator who seeks to guide students towards more democratic encounters with their patients. In re-imagining a transformed power dynamic in the DPR, and proposing alternate spaces for knowledge production, I am challenging the traditionally held beliefs of these structures, with its roots in colonial practice. As such, the flavour is completely decolonial.

The most radical proposition, and an exceedingly surprising one, was the notion of the disempowered doctor, subject to the disciplinary power of the profession and the system, held in check by the ever-present quality assurance mechanisms that monitor quantity and quality of output, where improved efficiencies for a highly stressed health system is the ultimate reward. As demonstrated previously, this mechanised approach to healthcare and the educational system that produces doctors geared to fulfilling its needs, cannot answer the humanistic needs of the individual doctors. Over time, doctors develop ways of coping that put them at odds with the system in which they work, as demonstrated by Oliver Human's depiction of the HIV-clinician in a busy practice, where she deviated from the clinical protocol and relied on her own intuition in making diagnoses and administering therapy(115). Similarly, Gaede describes the re-interpretation of policies in clinical facilities as a manifestation of "street-level bureaucracy", as doctors re-interpret directives from higher offices in a manner that make them palatable and implementable in the clinical space(116). These actions of power, reflecting a response to the constraints of the health system, can be likened to James Scott's description of Malaysian peasants' responses to social, economic and political matters beyond their control, as they cryptically exercised agency in the form of qualified compliance that was "false", "minimal", "partial" or "withdrawn"(82). The subaltern, it seems, has a voice, but it operates in the shadows and in the tea-rooms, away from the boardrooms where structural power resides. Despite exercising agency in findings ways to connect humanistically with their patients, the students in Ras and colleagues' study were often overwhelmed by the demands of the system and found ways to escape from the system in pursuit of their objective, even if for only a few minutes every day by dedicating extra time to at least

one patient in a busy clinic where they were able to engage deeply with the patient's fears and expectations(114). The social power that Foucault described as inherent to the 'medical gaze' only finds validity when the doctor-patient encounter follows the traditional, transactional format. When we deviate from this colonial practice, we are in new and strange territory, which, if the student were to face it alone, would be a terrifying and overwhelming experience. In that moment of vulnerability, the student needs to understand that the educator is right beside her, and they are united in their vulnerability as they enter into this new space together. As the educator repeats this process year after year, each time into a new space with a new student, he might not know the lie of the new land being explored but brings his critical role as an experienced explorer to bear on this educational expedition.

### 8.5.4 An African re-imagination

The metaphor of a new land being explored is apt to describe the opening up of new ways of learning, and new spaces in which to learn. These spaces are material and external, in the sense that they are found in the clinical encounters, and so rooted in the socio-economic and cultural contexts in which they exist. And they are at the same time emotional, existential, subjective and intersubjective, hence hidden, immaterial and internal, in the sense that they exist within the experiences, aspirations and relationships that students will develop as a result of the educational exposure. The medical educator, as a public intellectual, to borrow from Edward Said, has the responsibility to "*raise embarrassing questions, to confront dogma (rather than to produce them), to be someone who cannot be easily co-opted by governments and corporations, and whose raison d'etre is to represent all those people and issues that are routinely forgotten or swept under the rug*"(115, p29). Said's call to justice therefore places educators alongside those who would act (students), and not at some distance, critiquing from afar.

These new spaces become zones of revolution within medical education, as their decentralised power structures are radically different to the traditional power hierarchy in medical education and practice. The patient's voice is no longer drowned by the beeping of the ICU monitor, or the whirring of the centrifuge in the laboratory, but is placed centre stage as he guides the intrepid travellers into what McWhinney calls, the "sacred ground of his life"(7). As a result, the educator-student-patient triad becomes a revolutionary unit, establishing new zones of knowing and being far from the centre, forcing the dissemination of power out to the periphery, and away from the established hierarchies. Instead of knowledge production being typified in the linear fashion described above as flowing from laboratory to clinical space, we now have a decolonised pedagogy that generates its own decentralised power by drawing on the agency of the individuals in the clinical encounter. The trustworthiness and

credibility of the knowledge produced in these spaces requires that some attention be paid to the mode of production.

When Freire envisaged dialogical practice as being essential to the humanising project, he imagined the inclusion of all voices in this dialogue, and from this process new knowledge would arise(110). The educator, as critical theorist, must carry the burden of translating the unshaped words of the student-patient dyad into language that will transform and inform medical curricula. The process of generating this knowledge lies in examining the qualitative experiences of the triad, and because this is new to medical education, we could borrow from the wealth of collective wisdom within the sciences using qualitative methods as their primary mode of inquiry. The quest for validating this knowledge lies in its methodology, which must be trustworthy and credible, and be able to muster sufficient "transferability, dependability and confirmability" to be accepted as knowledge worth having(71). It would require that the medical educator who accepts the challenge to imbue his practice with this decolonial humanist pedagogy must become well versed in the qualitative methods of knowledge generation. Being a revolutionary means stepping out of the positivist medical comfort zone and into the value-laden, subject-rich, power-driven realities of normal human beings, the same world that medical educators live in when they are not educating.


Figure 1: Bidirectional flow of power

The final point to be made about power is the proposed schema comprising the three interlinked nodes of decision-making, implementation and accountability as seen above in figure 1. Involvement in decision-making is the most obvious of the three and has been identified as a moment where the encounter can be democratised, as the doctor and patient practice "shared decision-making"(118). This is a visible action, and easily accessible to the observer-educator, who will provide a critical voice in feedback to the student. It includes the concept of informed consent, so central to the dignity of patients(35). The implications of shared decision-making and informed consent lies in the honest and comprehensive sharing of information by all actors: between the educator and student, and between

the student and patient. The second and third nodes are not so easily discerned by mere observation and must be explicated in the doctor-patient discourse. Implementation of decisions is an act of power, whether it results in implementation of decisions made during the encounter, or not. It is here that we are drawn again to Scott's depiction of "false compliance" – the illusion that compliance will be given, only for it to be withdrawn or fragmented in private(82). The language of compliance in implementation must change in this new pedagogy, as the patient is no longer seen as a passive recipient, and the doctor as powerful master. Implementation in this pedagogy would explore issues of relevance to the patient's life and to the medical science at hand, accessibility to the resources that enable successful implementation, and acceptability to the patient and doctor, whether this be personal preference, cultural acceptance, or professionally sanctioned. The third node of accountability is found in the medical encounter between the two protagonists, where each holds the other to account to certain humanist standards. The doctor is additionally accountable to authorities within the system and subject to professional regulations and ethics, with final arbiter of accountability being the law. This schema of power provides a framework for the educator to observe and analyse the discourse, always aiming for the attainment of freedom and justice for all, only to be found in their collective and individual humanity.

## 8.6 Conclusion

While much has been written, especially in the medical humanities, of the need for a more humanistic approach in medical training and practice, none have gone so far as to propose that a humanistic episteme inspired by indigenous philosophies could provide a clear path on which to tread. In this section, I have argued that an Ubuntu-inspired humanistic episteme fits neatly into the gap that exists within medical education of the DPR. In an African context, this is even more important, as the values within this philosophy aligns with the traditional lived experience of so many people and communities, despite these values being ravaged by centuries of colonialism, apartheid and now capitalism. Similarly, in a global context, this argument supports the emergence of indigenous epistemologies and ways of being within formal educational structures. However, the potential of engendering social harmony within medical educational praxis is challenged by the vast inequalities present in our African realities, pervasive poverty and the multiple complexities these impose on the clinical encounter. Of necessity, therefore, when seeking to embrace this episteme and explore deeper opportunities for learning and growth, the scholar needs to be keenly aware of the socio-political and cultural barriers that would need to be crossed. The pedagogy that complements this episteme is therefore one borne of struggle and steeped in contextual richness.

The second section of this chapter proposes that a pedagogy of the DPR from an Ubuntu perspective, humanising and decolonial at its core, grounded in the local context of the clinical encounter, is feasible and practical, given the resource limitations so prevalent in African settings. The major breakthrough that this proposal makes is that it has its empirical roots in data, which is wholly African, although the philosophical underpinnings are not purist, but borrowed from several sources and synthesised in this contemporary reality, a kind of 'philosophical globalism'. The form of this pedagogy is radically different to that of the current praxis in DPRs, cognisant of new ways of being and perceiving power in the clinical encounter and demands a high level of socio-historical criticality from the student-doctor and her teachers. If one follows this path toward decolonising the praxis of DPRs from its hierarchical power relations and emotional denialism, it holds the promise of deep knowledge expansion for educators, enhanced wellbeing for clinicians, greater satisfaction for patients, and the potential transformation of the clinical encounter into a healing encounter.

A significant challenge lies with medical educators and their ability to transition from a purely positivist paradigm to a world view that embraces plural epistemologies. This would need a conscious ideological shift within the systems that produce and support educators. When this happens, the skills of the medical educator must include a keen understanding of what constitutes legitimate knowledge within these epistemes, the means of production of this knowledge, and the ability to analyse the social discourse to which they are witness. Additionally, the relative seniority of clinical educators and supervisors means they carry the added burden of attempting to transform the norms and policies of their health and educational system into a more humanistic one, which would support students in this journey, rather than constrain and thwart their aspirations. An Ubuntu-inspired epistemology and pedagogy, as described, can serve the purpose of aligning these attempts to establish a medical educational and clinical praxis that promotes social harmony in an unequal society.

## LIMITATIONS

As with any academic study, there exists within this study some limitations of which one needs to be cognisant. The key issues that may have had an impact qualitatively on this study related primarily to the people who were participants, and their relationships. Related to this is the manner in which data was generated, and some key external factors that impacted this process, as well as the process of data analysis and interpretation.

The relationship between the research participants (students, patients, educators and me) was fraught with issues of power. In terms of the differential between the academic convenor/key researcher (me)

and at least one of the cohorts (students), an attempt was made to mitigate some of the risks inherent to the students, of being victimised for non-participation, or having their grades influenced by the research process. This attempt was described in the chapter on methodology, focussing on the key principles of voluntary informed participation, the constitution of an external participant-advisory panel, complete transparency of the grading process, and a clear *a priori* delineation between the academic and research activities. Of note is that we received no complaints from students about any issues of victimisation, the panel received no communication from student-participants about any infringements of their rights, no drop-outs from either the academic or research processes. The realisation that these mitigating attempts do not erase the power differential or risk of abuse, mandates its mentioning as a potential confounder in how student-participants may have engaged in the data generating encounters.

Data was often generated within the clinical spaces, where I, as the educator and participant-observer, stood in a position of judgement and authority in relation to patient-participants and student-participants. As such, how real were their responses within the clinical encounter? Can the data thus generated safely be deemed to have reached the threshold of trustworthiness described earlier? In the context of a study of this nature, where expert observers are required to identify nuances that the untrained eye may not notice, we have to accept that it is a limitation that is unavoidable. We could have mitigated against this by video-recording the consultation, but this too introduces a 'foreign body' into encounter. Once again, the potential confounder that being a participant-observer present is unavoidable, and addressed in this study by maintaining a high level of reflexivity throughout, from conception of the research proposal and continuing into the reporting and writing process. Having stated this uncomfortable reality, I juxtapose it against the significant learning that I experienced, as discussed in the short reflective chapter. The position of participant-observer was a transformational pivot, as I consciously struggled with, and engaged in deep and critical reflection on the complicity of my roles in entrenching power hierarchies.

The third set of limitations, falling broadly into the theme of 'external factors', relates in large part to the COVID-19 pandemic, and the direct and indirect impact on this project. Data collection had to be curtailed when the pandemic struck, and while I was able to collect all patient and student related data per protocol, the third educator focus group was abandoned, which could have implications for the data analysis. As I was intimately involved in the health system response to the pandemic, my engagement with the data was suspended for about twelve months, not ideal when one deals with qualitative data, which needs close, acute and iterative engagement. Did this influence some of the findings? Certainly, my own growth and development as a clinician, leader and educator during the

pandemic was exponential, and this may have come to bear on the interpretation of the dataset. The pandemic's indirect impact on this study could bring into question the validity of the data as we cautiously emerge into a post-pandemic world. Will we find that the world has changed so much that some of these findings are no longer relevant? While this question may seem overly dramatic, what is certain is that the pre- and post-pandemic eras may have some qualitative differences, yet to be fully explored.

## CONCLUSION

In this project, we have asserted that Ubuntu has a central role to play in developing an emergent decolonial educational praxis for the DPR in an African context. This assertion is seen in two aspects: the participatory methodology that democratises the co-creation of new knowledge that is grounded in local African realities, and secondly in the actual data that is produced, which proposes that an epistemic and pedagogical framework inspired by the humanist principles of Ubuntu is feasible and desirable.

An Ubuntu-inspired episteme and pedagogy is proposed, based on validated data, grounded in local realities, and synchronous with contemporary educational theories. This meeting between an ancient philosophy, modern reality, and current theoretical frameworks represents a novel approach to generating new knowledge in health sciences education and offers a path to a decolonised medical curriculum. In so doing, a humble approach to epistemic plurality is needed, as we move away from the hegemony of the biomedical model. Epistemic plurality dictates that a key principle would be inclusivity, which in our context means that we depart from a specialist-driven educational system, towards a matrix of equality, with multiple intersecting voices raised to a common purpose: that which is best for Africa.

Patients, as empowered, engaged agents, are key educational actors in this African imagination, affirmed in their person-hood and patient-hood by a close attention to their suffering. Centring the educational project on the appreciation and alleviation of suffering, and the necessary intersubjective emotional dynamic that this ushers in, opens the door for an African re-imagination for clinical and educational praxis. This re-imagination is fundamentally and unapologetically humanist, in establishing the interconnectedness between doctors and patients as a source of solace and inspiration. The patient narrative contains lessons for the doctor about humanity and hope, which creates a platform for healing and learning, and additionally offers the doctor some insights into life, enhancing their own humanity in the process. Patients, therefore, are no longer the passive recipients of the magnanimity

of the medical profession and health systems, but are actively involved in the co-creation of knowledge, and the co-design of systems.

Health systems, being the theatre of clinical practice and health sciences education, are the fertile ground for spreading the seeds of a new future. However, existing power dynamics that sacrifices the wellbeing and humanity of doctors (and other clinicians) in favour of efficiency and productivity, has much to gain from finding ways of optimising inclusivity, particularly in decision-making, implementation and accountability processes and frameworks. The clinical encounter analysed in this project is a microcosm of the larger health system and is a suitable unit of analysis when attempting to engage with the complexities that will be encountered.

The educators, students and patients who populate the health sciences educational context are on the one hand brought together by the patient's suffering, and on the other share a common experience of vulnerability. This vulnerability represents a powerful opportunity for experiencing a common humanity and becomes a tool for transformative education in an unequal society. By engaging with their own vulnerability as well as that of others, Ubuntu ensures that learning and knowledge generation spans the cognitive, affective and existential domains. This re-imagined praxis is the gift that Africa can present to herself and to the world.

# RECOMMENDATIONS

Several recommendations are made that will build on my findings. Broadly speaking, they could be grouped into three categories: educational; clinical practice; and future research.

The educational dimensions relate to my proposal of an Ubuntu-inspired episteme and pedagogy for praxis of the DPR. The key recommendation in this regard would be the adoption of a pedagogy that is built on the following framework:

> **Step 1:** Developing *critical consciousness* as a core feature of the emerging professional identity. In practice, this needs an explicit disorienting dilemma that is cognitive, emotional and existential, exposing and conscientising the student to their own vulnerability, and the patient's agency. Experience of the social realities, therefore, precedes deep theoretical engagement. In our study, the home visit proved to be this moment, generating opportunities for self and context rich learning.
>
> **Step 2:** Facilitating *dialogue between peers* with the disorienting dilemma as the focus of the conversation, with the educator relating the discussion and student experiences to paradigms and theoretical frameworks that challenge or reinforce students' explanatory models.

**Step 3:** *Re-imagining new ways of doing and being*, from the perspective of critical consciousness. This re-imagining emerges from the critical dialogue, with the educator ensuring that various new forms are considered, as opposed to a linear, singular vision emerging.

**Step 4:** Students *experiment with the newly imagined ways* of doing and being, effectively translating theory into practice, this time from their newly discovered perspective of critical consciousness.

**Step 5:** Dialogue is continued, but is now infused and deepened with richer experiential, critical and theoretical constructs, that seek to *resolve the dilemma* identified as the point of reference for this learning.

**Step 6:** Learning is consolidated by the *student articulating their learning journey and the new perspective(s) that emerge* from this process. This final step allows the educator to evaluate the depth of learning that has taken place, and the size (if any) of the shift in perspective that has taken place.

Were this pedagogy to be adopted, it immediately becomes important that clinical educators and trainers should be trained to observe and analyse from the perspective of the humanities: becoming critically self-aware; being able to observe and analyse the interaction between others; and between people and their contexts/environments. This skills list has yet to be developed, though some learnings have been made within the field of the medical humanities.

The implications and recommendations for clinical practice are significant, as they offer new ways of perceiving the interaction between clinicians and patients, and the huge rewards that this could bring in the form of enhanced relationships and mental wellbeing of healthcare workers. By shifting the focus from 'patient as passive recipient' to 'patient as actively engaged agent', and acknowledging the very limited freedom that clinicians have in the context of managed care environments, the design of health systems in primary care can be radically altered by aligning this with the way that *power flows in the clinical encounter: decision making; implementation; and accountability.* While this model requires more work to explicate the operational details, the broad framework offers a decolonial lens by which to reconstruct a re-imagined primary care in African contexts.

In terms of the actual clinician-patient encounter, this 'power model' can be actualised into the consultation by paying attention to:

1. The doctor's intentionality/way of being/way of doing accountability;

2. Clarify expectations – accountability;
3. Validate illness experience – accountability;
4. Engaged decision-making – information sharing; common ground; goal setting/shifting;
5. Navigating implementation process – feasibility, acceptability, accessibility;
6. Accountability – follow up plan, role clarification.

And finally, a plethora of research would need to be engaged to explore some of the key findings. Are the proposed episteme and pedagogy educationally sound? How feasible is this pedagogy in settings outside of the study setting? Do African institutions have the capacity to expand their epistemological and pedagogical offerings in medical education, or are there serious limitations in this aspiration? How would the 'power model' manifest operationally in African healthcare settings?

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| Checklist score<br>Each of the items below is an important skill in the consultation and should be rated separately. Rating should be at the performance expected from a family physician. | **Shown (2 points)** | **Partially shown / not sure (1 point)** | **Not shown (zero points)** |
|---|---|---|---|
| **Initiating the session** | | | |
| Makes appropriate greeting / introduction and demonstrates interest and respect<br>Greets patient, obtains name, introduces self, attends to physical comfort of patient, shows interest and respect, and establishes initial rapport. | | | |
| Identifies and confirms the patient's problem list or issues<br>Gives an opportunity for the patient to list all their issues or problems before exploring the initial problem "So headache, fever - anything else you'd like to talk about?" Summarises and confirms the list with the patient. | | | |
| **Gathering information** | | | |
| Encourages patient's contribution / story<br>By use of open as well as closed questions, attentive listening, facilitation skills and summarization and responding to cues. As opposed to cutting off the patient, use of only closed questions in an interrogatory style. | | | |
| Makes an attempt to understand the patient's perspective<br>Elicits spontaneously and acknowledges the patient's perspective or uses specific questions– beliefs, concerns, expectations, and feelings. | | | |
| Thinks family, and obtains relevant family, social and occupational information<br>Elicits relevant information about the patient's household, family, occupation, and environment. | | | |
| Obtains sufficient information to ensure no serious condition is likely to be missed<br>Elicits enough clinical information to establish a working diagnosis and ensure no serious condition is likely to be missed. | | | |
| **Explanation and planning** | | | |

| | | | |
|---|---|---|---|
| Appears to make a clinically appropriate working diagnosis<br><br>The apparent diagnosis is clinically appropriate according to the subjective and objective evidence. If necessary, the notes in the patient's folder can be reviewed later to establish what the doctor was thinking. | | | |
| There is a clear explanation of the diagnosis and management plan<br><br>The explanation is well organized, in small chunks, avoids jargon, where appropriate makes use of visual methods, leaflets, repetition, signposting. | | | |
| Gives patient an opportunity to ask for other information and / or seeks to confirm patient's understanding<br><br>The patient is asked if they would like other information and / or their understanding is checked by reverse summarizing or opportunity to clarify | | | |
| The explanation takes account of and relates to the patient's perspective<br><br>The explanation connects, responds to or takes into account the patient's beliefs, concerns and expectations | | | |
| Involves the patient where appropriate in decision making<br><br>The patient is offered insight into doctor's thought processes, suggestions, and options and invited to participate in decision making through use of choice, expression of preferences or ideas. The doctor does not just give orders, directives or instructions of what must be done. | | | |
| Chooses an appropriate management plan<br><br>The management plan is based on scientifically sound evidence and is appropriate for the diagnosis. If necessary, the notes in the patient's folder can be reviewed later to establish what the doctor was thinking. | | | |
| **Closure** | | | |
| Closes consultation successfully in the time available<br><br>Brings the consultation to a conclusion rather than running out of time. Deals with any remaining issues from the patient. | | | |
| Provides appropriate safety netting for the patient<br><br>Shows evidence of having considered how certain they are of the diagnosis, what might go wrong with the treatment, how they will know if things do not go well, side effects occur, or more serious sequelae develop. Shows this in an appropriate plan of safety netting with the patient. | | | |
| **Additional skills – for merit** | | | |

| | | | |
|---|---|---|---|
| These will not be applicable to all consultations, but will depend on the content of the specific consultation | | | |
| Establishes therapeutic rapport / relationship in a patient with a mental or psychosocial problem<br><br>Shows evidence of basic counselling skills used in a mature and integrated way that offers supportive therapy to the patient: such as empathy, attentive listening, summarizing, unconditional positive regard, facilitative responses. | | | |
| Breaks bad news appropriately<br><br>Shows evidence of structured approach to breaking bad news that includes skills such as: setting the scene by summarizing or discovering where things have reached to date and check patients understanding; warn patient that difficult information is coming; give information clearly, directly and honestly; be sensitive to the emotional reaction from the patient by giving space for it, encourage expression of feelings; allow patient to ask their own questions, express concerns and elicit the type and amount of information they want, make a supportive plan. | | | |
| Shows skills in brief motivational interviewing<br><br>Shows evidence of brief motivational interviewing skills such as: setting an agenda, explores readiness to change, chooses skills appropriate to the patient's readiness to change (elicit-provide-elicit, decision balance sheet, brainstorming), rolls with resistance. | | | |
| **Total Score out of 30 (maximum = 30)** | | | **…/30** |
| **Above Total Score divided by 3** | | | **…/10** |

3780

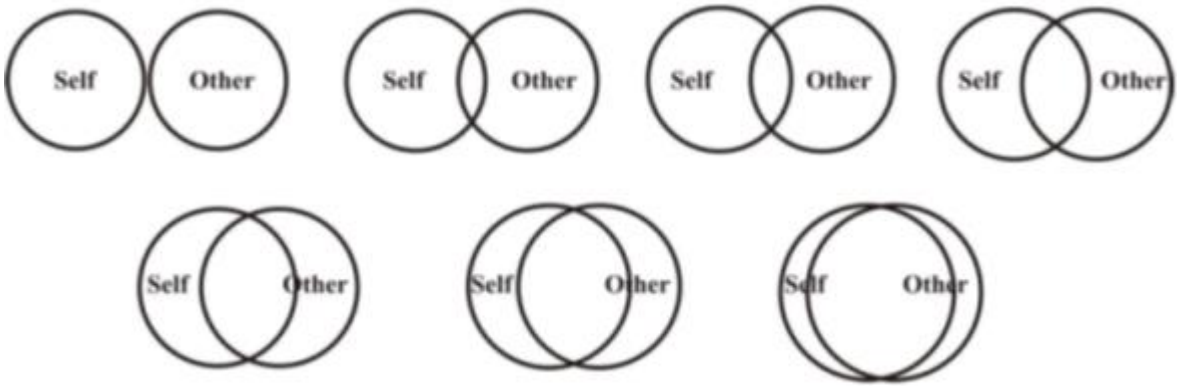
3781

3782

# APPENDIX 2: Inclusion of Self in Other Scale

Inclusion of Other in the Self Scale

Instructions: Please circle the picture that best describes your interaction with the doctor




**Adapted from:** Aron A., Aron EN, Smollan D. (1992). Inclusion of other in the self-scale and the structure of interpersonal closeness. Journal of Personality and Social Psychology, 63, 596-612.

# APPENDIX 3: Interview guide

**Semi-structured interview guide – patient-participant**

**For interviewer:**

This interview is conducted immediately after the patient has scored the encounter with the doctor on the IOS scale. The interviewer can provide clarity on how to complete the scale.

The interview should last between 10-15 minutes.

The patient

**Please read to the participant:**

This interview is part of a research project that is exploring how we teach doctors about their relationships with patients. Your participation is completely voluntary, and will not affect your treatment in any way. Your identity will not be recorded, and the doctor will not be told which patients provided feedback. The information that you provide will be used to teach this doctor about how patients view him/her.

Please answer the questions as thoroughly as possible. If you don't understand the question, please ask me to explain further.

Age:

Gender:

Preferred language:

Reason for visit: Acute / Chronic

1. If you were to choose one of these pictures to show whether the doctor really cared for you, what one would you choose? (Appendix 2 – Inclusion of Other in Self)
2. Why did you choose this score? **Or** How did you make this decision?
3. Did the doctor do anything that you liked / made you feel good?
4. What would you have liked your doctor to do differently?
5. Do you feel bad about anything that the doctor said/did?
6. In your opinion, what are the key features of a good doctor?

# APPENDIX 4: Guide for student reflection on patient encounter

Consider the following questions and write down your thoughts. Present these thoughts to your colleagues in class. The reflection on experience, formulation of ideas about your performance, and group discussion are essential to the learning process.

1. What happened in the encounter: context, reason, key actors, process, outcome
2. What went well?
3. What could have gone better?
4. Who dominated the encounter: controlled information, made decisions, directed conversation
5. How connected were you with the patient – why?
6. What options do you have to consider to improve your performance in the future?
7. How will you integrate change (if any) into your future practice

# APPENDIX 5: Discussion guide

Discussion guide – the facilitator (candidate) will ask the group to reflect on the following issues:

1. How has your practise focussed in this course on the clinician-patient relationship?
2. How have students reacted?
3. What are the strengths of this approach?
4. How can it be improved?
5. What are your students learning?
6. What are you learning?

# APPENDIX 6: Consent form


**Informed Consent Form for** *STUDENT / PATIENT / EDUCATOR*

**PRINCIPLE INVESTIGATOR: PROF STEVE REID**

**PhD CANDIDATE: DR TASLEEM RAS**

**DEPT OF HEALTH SCIENCES EDUCATION**

**FACULTY OF HEALTH SCIENCES**

**UNIVERSITY OF CAPE TOWN**

**PROJECT: "Re-imagining doctor-patient relationships in an African context"**

**This Informed Consent Form has two parts:**

- Information Sheet (to share information about the study with you)
- Certificate of Consent (for signatures if you choose to participate)

**You will be given a copy of the full Informed Consent Form**

**Part I: Information Sheet**

**Introduction**

I am Tasleem Ras, a PhD student in the Department of Health Sciences Education. I am currently working as the postgraduate convener in the Division of Family Medicine, School of Public Health and Family

Medicine, Faculty of Health Sciences, University of Cape Town. This research project is to fulfil the requirements of the degree: Doctorate of Philosophy – Health Sciences Education.

**Purpose of the research**

The discipline of Family Medicine has adopted a Biopsychosocial model of the consultation, which complements the concept of patient-centred care. These theoretical models were developed in a North American and European context and implemented in an African context. This study will explore the influence of Ubuntu (social connectedness) and power dynamics in the development of the doctor-patient relationships, and aims to propose a unique model of teaching and learning about the doctor-patient relationship that is responsive to an African context.

**Type of Research Intervention**

This will be a **mixed methods study, using qualitative and quantitative methods**. It involves collecting data from direct observations of consultations, individual interviews with patients and students, focus groups discussions with students and educators, and review of student journals. The PhD candidate will be responsible for all data collection.

**Participant Selection**

You have been invited to participate in this study because you are:

a. A student who is being engaged with learning about the doctor-patient relationship

b. A patient who is interacting with a doctor, and have opinions of your experience in this encounter

c. An educator who is teaching in this programme whose experience is a valuable source of new knowledge.

**Voluntary Participation**

Your participation in this project is entirely voluntary. The choice that you make will have no bearing on your treatment (patients), your assessment (students) or performance review (educators). You will be able to withdraw from this process at any time, with no negative consequences.

**Procedures**

The process of the project is as follows:

a. You will be invited to participate in the study, after the candidate has presented an overview of the project. You will be asked to sign a consent form if you agree to participate

b. For students, the data will be collected in the following manner:

I. Direct observation of encounters with patients at 3 monthly intervals over the course of the year.

II. Focus group discussions with other students – 3 for the year

III. Documentary analysis of the reflective journal

c. For patients, the data will be collected in the following manner:

I. Direct observation of encounters with doctors

II. Semi-structured interview with the researcher

III. Completion of a rating scale immediately after the doctor encounter

d. For educators, the data will be collected in a series of focus group discussions – 3 for the year.

e. The researchers will analyse the data and present it to all participants to verify the content.

f. The research findings will be presented at conferences and submitted for publication in peer-reviewed journals

**Duration**

The data collection will be done over a period of 10 months. During that time, you will be contacted a few times: to invite participation; to collect data (for students and educators, this will happen multiple times). For patients, this actual process of the interview will take about 15 minutes. For students and educators, the discussions will last about 90 minutes per session.

**Risks**

It is understood that by answering these questions honestly, you may run the risk of damaging **relationships**. To ensure that this risk is eliminated, all interviews will be stored anonymously in a secure area by the researchers. The data analysis will be done anonymously by the researchers. Interviews and focus group discussions will be transcribed without including any names or specific incidents that may identify participants. While we recognise that confidentiality within a focus group is sacrificed, we will ask all members of the group to sign non-disclosure agreements prior to commencement of the discussion.

**It is further recognised that students may feel coerced into participating in the research. At no point is this the intention. You have the right to participate or refuse to participate on a purely voluntary basis.**

**You will be able to withdraw from the study at any time, even after giving consent, with no penalty. A panel of three senior academics in the department have agreed to form a panel that will respond to any concerns you may have arising out of the research process. You will be able to contact any of them directly.**

**Benefits**

The direct benefit of this project is that it will generate new knowledge about the process of teaching and learning about the doctor-patient relationship in our context.

**Reimbursements**

You will not be paid for taking part in this study.

**Confidentiality**

We will maintain confidentiality by:

1. ensuring that anyone who refuses participation remains anonymous
2. Ensuring that each participant is given a unique identifier that does not in any way reveal their identity.
3. Interview notes and tape recordings will be stored in a secure area. None of the recordings will have any data that could identify who the participant is.
4. Once all the data is analysed, and it is agreed that the project has reached completion, the written notes and voice recordings will be destroyed.

**Sharing the Results**

The overall results of the study will be shared with all participants. It will also be shared with interested parties in the University community, and a formal write-up will be submitted to a peer-reviewed journal for publication. The final project write-up will be the thesis towards a PhD by Dr Ras.

**Right to Refuse or Withdraw**

You have the right to refuse participation in this study at any time. This includes if you have signed consent, but change your mind afterwards. Your refusal or withdrawal will not result in any negative consequences in any way.

**Who to Contact**

Dr Tasleem Ras

Senior Lecturer, Division of Family Medicine, UCT

tasleem.ras@uct.ac.za

021 650 5221

This proposal has been reviewed by the University of Cape Town, Faculty of health Sciences' Health Research Ethics Committee (HREC). The HREC can be contacted at 021 406 6338 for any further comments or questions regarding your rights and welfare as a participant in this study.

You can ask me any more questions about any part of the research study, if you wish to. Do you have any questions?

**Part II: Certificate of Consent**

**I have been invited to participate in research on doctor-patient relationships in Cape Town, SA.**

**I have read the foregoing information. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study**

**Print Name of Participant_____**

**Signature of Participant _____**

**Date _____**

**Day/month/year**

**Statement by the researcher/person taking consent**

I have provided the information sheet to the participant. I have ensured that the participant understands all implications of participating.

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

**A copy of this ICF has been provided to the participant**

**Print Name of Researcher/person taking the consent_____**

**Signature of Researcher /person taking the consent_____**

**Date (Day**/month/year) **_____**

# APPENDIX 7: Draft budget

| Study | Funding category | Amount | Specific costs | Motivation |
|---|---|---|---|---|
| Objective 1: Explore and understand student learning | Research Assistance | 3450 | Transcription: 3 X 2hr focus groups = 6 verbal hrs X 5 @ R115/hr | 3 focus group discussions will take place at intervals during the course of the study |
| | Travel and subsistence | 3520 | (Wesfleur visits x 4 = 110km X 4 = 440km)+ (Fish Hoek visits X 4 = 73 X 4 = 280 km) + (CHC visits x 6 = 42 X 6 = 252km) @ R3.61/km | Direct observations of student-patient consultations at intervals during the course of the year |
| | Research events | 2250 | Catering: focus group discussions - 3 X 15 people @ R50/head | University venues to be used, participants will pay for own transport, will link with teaching sessions to minimise |

| | | | | |
|---|---|---|---|---|
| | | | | travelling and other logistics |
| | Minor equipment | 3500 | Handheld audio recording device | Essential to data collection - consultations and focus groups |
| | Running costs | 600 | Stationary | Consent forms; observation guides; transcription stationary |
| | | **13320** | | |
| Objective 2: gather feedback on patient experiences | Research Assistance | 2000 | Translation costs @ R115/hr) | translating consent forms, semi-structured interviews |
| | | 3600 | Interviews of patients in their home language: 4hrs X 10 sessions @ R90/hr | Home language interview integral to data quality and addressing the power differential between researcher and participant |
| | | 11500 | Transcription of interviews: 20 verbal | 12 patients will be interviewed per session, with 12 sessions |

| | | | | |
|---|---|---|---|---|
| | | | hours X 5 @ R115/hr | during this data collection phase |
| | Travel and subsistence | 960 | Taxi fare: R40/d X 12 days X 2 assistants | Assistants must meet the researcher on campus before travelling together for fieldwork in the researcher's vehicle |
| | Research events | 0 | | |
| | Minor equipment | 0 | | |
| | Running costs | 600 | Stationary | Consent forms; interview guides; transcription stationary; quantitative data collection tool |
| | | **18660** | | |
| Objective 3: Explore educator's perspectives | Research Assistance | 3450 | Transcription: 3 X 2hr focus groups = 6 verbal hrs X 5 @ R115/hr | 3 focus group discussions will take place at intervals during the course of the study |

| | | | | |
|---|---|---|---|---|
| | Travel and subsistence | 0 | | |
| | Research events | 2250 | Catering: focus group discussions - 3 X 15 people @ R50/head | University venues to be used, participants will pay for own transport, will link with teaching sessions to minimise travelling and other logistics |
| | Minor equipment | 0 | | |
| | Running costs | 600 | Stationary | Consent forms; observation guides; transcription stationary |
| | | **6300** | | |
| Publication/Dissemination | Article 1 (Objective 1) - local | 14000 | | |
| | Article 2 (Objective 1) - local | 14000 | | |
| | Article 3 (Objective 2) - local | 14000 | | |
| | Article 4 (Objective 3) - local | 14000 | | |

| | | | | |
|---|---|---|---|---|
| | Conference travel (overseas) | 55000 | | |
| | Conference travel (local) | 20000 | | |
| | | **131000** | | |
| | | | | |
| Total | | **169280** | | |

3994

3995

3996

3997