

**Medical students' attitudes towards
and perceptions of the
primary health care approach**

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Medical students' attitudes towards and perceptions of the primary health care approach

The Primary Health Care (PHC) approach has been adopted by the South African Department of Health and forms a major component of the MBChB curriculum at the University of Cape Town (UCT). The aim of this research was to provide an understanding of medical students' attitudes towards and perceptions of the PHC approach, and this was done using mainly qualitative methods, namely focus groups, interviews, and one questionnaire. This research also investigated students' views of the way in which the PHC approach was taught, their understanding of the PHC approach, what could influence students' views of the PHC approach, the appropriateness of the PHC approach in South Africa, their opinions of the fact that UCT has a PHC-driven MBChB curriculum, their views of the role of doctors in the PHC approach, and a number of other related issues. The main findings were that students enter their medical degree with an expectation of a biomedical emphasis and a lecture-based curriculum. Their understandings and perceptions of the PHC approach are for the most part accurate, and they generally have a positive attitude towards the theory of the approach, but find it problematic that this theory does not match the reality of the implementation of the PHC approach in South Africa, and most feel that the approach is idealistic. Students also expressed a range of views about the various aspects of the PHC approach, highlighting a number of strengths and weaknesses, as well as obstacles to and requirements of the successful implementation of the approach. These attitudes and views were examined in the context of South Africa's current health situation as well as the context of their learning environment. The implications of these findings are both academic and political, and have highlighted the need for teaching the PHC approach in such a way that medical students not only have an understanding of the approach and the need for it in South Africa, but also embrace the philosophy and the values of this approach.

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Introduction and Literature Review

Introduction

Health is an issue that no individual or community can ignore. Irrespective of our socioeconomic status, culture, ethnicity or gender, we are all required to, or ultimately forced to be aware of health, be it our own, or the health of those around us. This is certainly the case in South Africa, with HIV/AIDS and tuberculosis topping so many agendas. Linked to the issue of health is the help that we seek to either maintain a state of wellness, or to alleviate or eradicate some illness or disease. How often does one stop to consider the nature of this help? Is the health care that we have access to simply taken for granted if it is adequate, or simply accepted and endured if it is not? Who defines what is adequate, and who is responsible for ensuring acceptable standards? These are difficult yet important questions to which answers must be provided, particularly since the deadline has come and gone for the World Health Organisation's goal of Health for All by the year 2000.¹

Health professionals play a pivotal role in the delivery of health care, as many could look to these individuals as the ones accountable for the state of the health system they have access to. But what of that level above the health professionals? In the public sector, this would be the government, both local and provincial, and would encompass aspects of implementation as well as policy making. In the private sector, this would be those managing and directing the health care companies. The nature of these two sectors and collaboration between the two must surely be unique and country-specific.

Ideally, there should be collaboration between the health sector (public and private) and the institutions training the health professionals that are to work in this sector. It would seem obvious that the training that health professionals receive is congruent with the system in which they are to carry out what they have learnt. This could help to ensure a high level of preparedness for work in the health sector, and could also assist in matching the skills, knowledge and attitudes of new and existing staff in health facilities. Following on from that, it makes sense that the expectations of health professional students regarding the work they are to ultimately do is also compatible

with the reality of the circumstances in the health sector. This could go a long way to prepare students mentally and psychologically for their course of study, and could perhaps ameliorate some difficulties of adjusting to a new academic environment.

The South African situation and the primary health care approach

As part of The White Paper for the Transformation of the Health System in South Africa,² the South African Department of Health committed to the primary health care (PHC) approach as its strategy for working towards the goal of “developing a unified health system capable of delivering quality health care to all our citizens efficiently and in a caring environment”,² arguing that the PHC approach is the “most effective and cost effective means of improving the population’s health”.² This commitment to PHC came three years after the arrival of South Africa’s new democratic government, following in the wake of apartheid. Apartheid legitimated a long established system of segregation and inequality, allocating health care on the basis of power rather than need.^{3,4} This system provided adequate and indeed top-class health care to a privileged minority of the population, but had a profoundly negative impact on the physical and psychosocial health of the segregated majority, leaving a mark on health care in South Africa that has yet to be erased.³⁻⁵

This commitment undoubtedly gave hope to those whose health needs were previously marginalised, but also called for a rethink of the training and employment of health professionals. Regarding the employment, a year of vocational training, often termed ‘community service’ was instituted in 1998 for medical doctors; this has since become a requirement for other health professionals. With regards to the training of health professionals, the White Paper stipulates that as part of the goal of developing human resources available to the health sector, education and training programmes should be developed that are “aimed at recruiting and developing personnel who are competent to respond appropriately to the health needs of the people they serve”² and that “particular emphasis should be placed on training personnel for the provision of effective primary health care”.²

The White Paper also maintains that an emphasis should be placed on training generalists rather than specialists, and states the following regarding PHC-oriented curricula:

Health sciences curricula should be restructured to reflect community needs more accurately, and teaching should place greater emphasis on community and outcome-based programmes. The fundamentals of a community needs-based health sciences curriculum are primary health care, social sciences, health promotion, ethics, basic management, community participation, conflict resolution and communication, basic counselling, epidemiology, research methodology and information use, and first aid (emergency care).²

From this White Paper, the South African government's intentions for health care are quite clear, and what is also clear is that there are ramifications of the commitment to PHC and the associated responsibilities for training institutions. Since the creation of this White Paper, the commitment to PHC has been reaffirmed at the National Primary Health Care conference in August 2003. The outcome of this conference was the Kopanong Declaration on Primary Health Care, and this declaration outlined the key focus areas for the strengthening of PHC in the five years to follow.⁶

Clarification of the term 'primary health care'

At this point, it is necessary to clarify what is meant by 'primary health care', and it is important that it be seen as an approach that goes beyond first-contact services.⁷ Referring to it as the PHC approach acknowledges that it is both a strategy as well as a philosophy. It is a strategy in the sense that it represents the manner in which health services need to be organised and delivered, stressing the provision of health care and the deployment of the range of health institutions and health workers for health care delivery. The PHC approach is a philosophy as it requires traditional health care systems to institute considerable changes in both their structure and the content; it emphasises the need for health and other sectors to work together at multiple levels to facilitate general social and economic development, of which PHC is a vital part; and it argues for a community-based and decentralised approach to health and health care, which is rooted in a drive for development and empowerment, and will ultimately make it possible for the kind of care to be supplied so that peoples' lives might be socially and economically productive.⁸

The best explanation of the PHC approach is taken from the Declaration of Alma-Ata, which was developed at the International Conference on Primary Health Care in September of 1978:

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health process.¹

Implicit in this approach is the need to view health from more than just a biological perspective, but to rather view health from a 'biopsychosocial' perspective, which acknowledges the biological, psychological and social dimensions of health and illness and aims to understand the whole patient rather than just the disease process.⁹

If one considers the fact that the Alma-Ata Declaration called for world wide support and implementation of PHC, it is feasible to expect that various countries throughout the world may have differing understandings and interpretations of PHC, and these differences may be particularly noticeable between developed and developing countries. It is also reasonable to expect that within any specific country, different individuals and groups of individuals may differ in their understanding and interpretation of PHC. The possibility of a wide range of understandings and interpretations of PHC serves to highlight the importance of returning to and emphasising the original explanation of PHC, as well as clarifying how PHC is conceptualised and presented to students at the University of Cape Town (UCT).

Within the literature, it does seem apparent that one of the common misconceptions of PHC is that it is referring to primary care, or that the terms 'primary health care' and 'primary care' are used interchangeably.¹⁰⁻¹³ Although primary care is undoubtedly one

of the main aspects of PHC, and in certain settings may be particularly significant, referring to PHC as ‘primary care’ does not acknowledge that PHC is an approach and a philosophy as has been discussed previously. Specific aspects of PHC focussing on primary care may be more pertinent in some settings, for example, in developing countries, providing health care for the poor and those in rural areas,¹⁴ but this should not alter or limit the essential definition and meaning of PHC.

The PHC approach and UCT’s MBChB curriculum

In order to better coordinate the teaching of PHC in the Faculty of Health Sciences, UCT adopted a PHC policy in 1995, leading to the formation of a PHC board and the appointment of a chair of PHC at UCT. The PHC Directorate was then established in mid-2003, and continues to oversee the teaching of the PHC in the Faculty. UCT also adopted a new MBChB (Bachelor of Medicine and Bachelor of Surgery) curriculum in 2002, which is largely problem-based and PHC driven. In their second semester of study in the MBChB curriculum, medical students at UCT are introduced to the following PHC diagram in the course ‘Becoming a Health Professional’ (For details on the MBChB curriculum refer to Appendix A). This diagram (Figure 1) is based on the Alma-Ata Declaration, but has been added to, summarised, and presented as an approach:

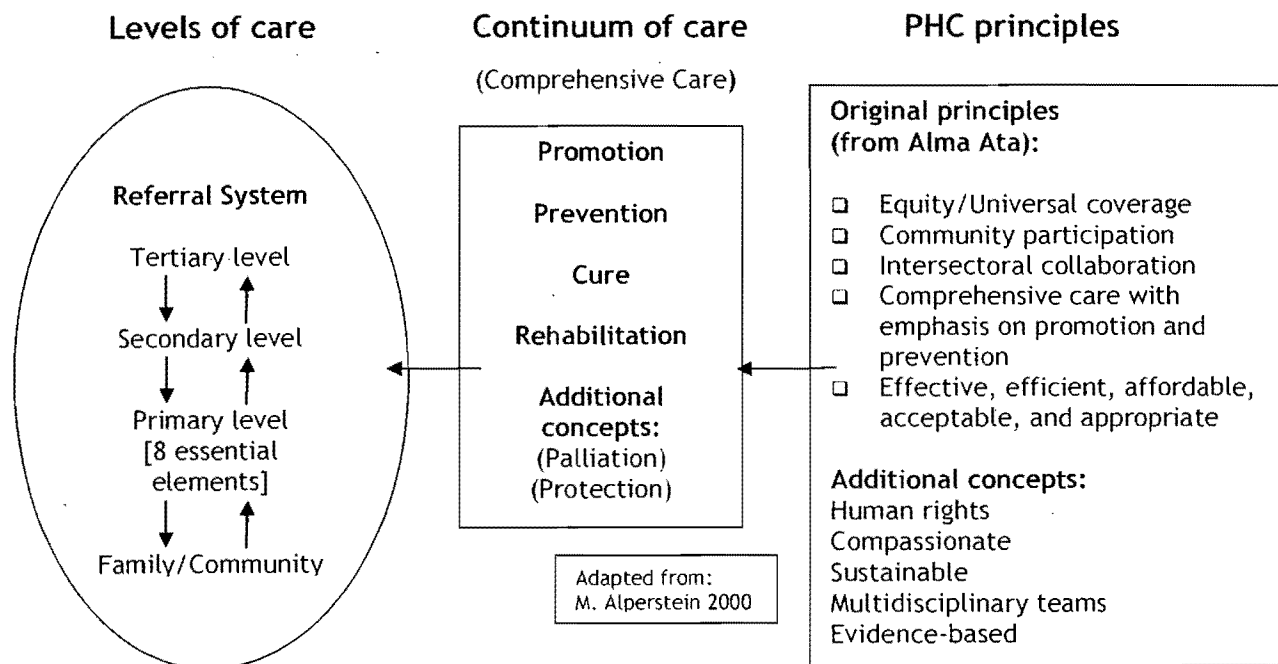


Figure 1: The comprehensive PHC approach

Having been involved in various academic capacities* with the first year of the MBChB curriculum at UCT from 2000 - 2004, I have been able to observe and gain insight into the medical students that have registered for this course - their expectations regarding the course, their perceptions about the profession of medicine, their views on health and health care, and their aspirations for their future as doctors. As medical students are exposed to the PHC approach in their first year, I have also been able to take note of their attitudes towards and perceptions of this approach, and it has been my impression that students are generally resistant to learning about this approach, and do not expect PHC to form a part of their training to become a doctor. It has also been my observation that many medical students seem to start off their degree with a very scientific and biological view of medicine, and seldom value the need to learn about people and how they relate to each other in society.

These have been somewhat disconcerting observations and impressions in light of both UCT's aims to include PHC in the curriculum, as well as the needs of South Africa and its people. Yet these observations and impressions were the impetus behind this research and prompted me to look into the medical students' views of the PHC approach. It struck me as vital that our future doctors should be 'buying into' the approach that is not only endorsed by the WHO, the South African government, and UCT, but is also aimed to address many of the social inequities that plague the people of South Africa. While course- and self-evaluation are commonplace in the new MBChB curriculum, no quantitative or qualitative investigation had been done of UCT medical students' views of PHC, and this research was undertaken in order to bring to light the students' perspectives, as they will be the ones to take PHC into the future. It is hoped that once these perspectives are revealed, they can be better understood, thereby facilitating positive change in the training of health professionals to work within a PHC approach.

Research questions & Theoretical framework

As the title of this thesis suggests, there are two main research questions that frame this study: 'What are UCT medical students' attitudes towards the PHC approach?' and 'What are UCT medical students' perceptions of the PHC approach'? A range of medical students in the new curriculum, from first to fourth-year, were included in order to

* These included group facilitation, lecturing, curriculum design, the setting and marking of assessments, and general administration and organisation.

allow for any changes in their attitudes and perceptions to emerge. The nature of this research is largely descriptive, and issues are intended to be explored rather than hypotheses tested. Although the rationale behind this research may imply a hypothesis that medical students have negative views of PHC, the intention was to use this supposition as a starting point for a process of investigation. These research questions are not framed within in a particular theoretical position, but this should not be judged as a weakness of this study, as Patton¹⁵ emphasises the often practical nature of qualitative research and argues that not all research needs to be theory based. Seale also points out that “good quality research doesn’t depend on the adoption of a particular philosophical or theoretical position” (p.417).¹⁶

The endpoint of this process of investigation, as alluded to earlier, is hoped to be one of improvement through understanding. This improvement could include improvement of the medical students’ attitudes towards PHC, improvement of the way in which PHC is presented and taught to medical students, and improvement in the collaboration between academic institutions, health services and government. This aspect of improvement places this research under the banner of ‘action research’, as does the level of involvement of myself as the principal researcher, considering my previous involvement with the MBChB curriculum, as well as the inclusion of UCT staff involved in teaching and implementing PHC as key informants. These two aspects of improvement and involvement are seen to be crucial to ‘action research’, but perhaps more pivotal is the intention of ‘action research’ to bring about positive change in a particular context,¹⁷ and it is this intention that corresponds so strongly with the purpose of this research. ‘Action research’ is being seen more and more in health related settings, and although it is not necessarily qualitative, it often employs qualitative methods.¹⁸ The suitability of case study methodology, which is employed in this research, to ‘action research’ will be discussed further on, along with the appropriateness of a qualitative paradigm and methodology.

Research aims

√ The aim of this research was to qualitatively investigate and examine UCT medical students’ attitudes towards and perceptions of the PHC approach. In order to fully understand these attitudes and perceptions, other issues related to these attitudes and perceptions were explored:

- Students' perceptions of their understanding of the PHC approach.
- Students' opinions of the fact that UCT has a PHC driven MBChB curriculum.
- Students' views of various aspects of the PHC approach.
- Students' views of the role of doctors in the PHC approach.
- Students' views of the way in which the PHC approach was introduced and taught in the MBChB curriculum.
- Students' perceptions of the need for and appropriateness of the PHC approach in South Africa.

It was also necessary to look into a number of other related issues:

- Students' perceptions of medicine and doctors and what makes a good doctor.
- Students' expectations about studying medicine and being a doctor.
- Students' reasons for studying medicine.
- Students' future aspirations, that is, place of work, specialising.
- Students' views of the new MBChB curriculum.

In order to provide a fuller context to the views of the students, a number of key informant interviews were conducted with members of UCT staff that are involved in the inclusion and teaching of the PHC approach in the MBChB curriculum. Key informant interviews were also conducted with three staff members of other South African universities in order to place the UCT context within the broader South African context.

Contextual and developmental issues to consider

As this research was conducted at one university, it is necessary to identify and discuss a number of issues that influenced this research. These issues and their relevance to the results will be raised later as part of the discussion. It is necessary to give some description of the context of the study, so that 1) readers of this report and other researchers can establish in which other situations these results and conclusions may be applied,¹⁹ and 2) to comprehend the wider social and historical significance of the research.²⁰

This research took place in South Africa, a country with a rich and unique history of political change. However, the majority of the students included in this study were

between the ages of eight and ten years old when the new democratic government came into power in 1994. The implication of this is that most of these students have been exposed to racially integrated schooling and have a more historical rather than experiential understanding of apartheid. As a result of this, many of them may not be aware of the state of South Africa's health services pre-1994, when the focus was on the provision of services to the white minority, and may therefore not fully understand the extent of what the PHC approach can offer to a country such as this.

The group of students may also be divided between those who have had access to public health services, and those who have had access to private health services, the two being vastly different in most areas of South Africa. It is quite probable that on arriving at university, many students have only had exposure to one type of health service, and may have never made use of or even seen the other type. How this could influence the students' views may depend on the sector that they have been exposed to. On one end of the spectrum, an affluent student that has never set foot in a public health facility may be completely oblivious to the needs and issues of the public sector and hence fail to see the necessity for the PHC approach. On the other end of the spectrum, a disadvantaged student who has only had limited access to inadequate and inefficient public health facilities may be all too aware of the need for an approach such as PHC. Ultimately, students from all along this spectrum are going to arrive at medical school with differing perceptions of what it is to be a doctor and practice medicine.

Because of the history of apartheid in South Africa, issues of race and ethnicity cannot be ignored as an influencing factor, even if race is no longer as divisive as it was before. In the past, race could determine one's opportunities, access to education and health care, and living conditions. These experiences of discrimination could no doubt play a role in developing one's views, values and priorities in life. Socioeconomic status (SES)* could also play a role in influencing these, and in addition, could influence students' need for job security, their economic needs, as well as their need for status in their family or community. These needs could in turn influence students' plans for the future to meet those needs.

* Socioeconomic status is a rating of one's standing in society in terms of social and economic markers including occupation, education, living conditions, income and other financial resources.

More specifically, the context in which students are studying medicine - at UCT in Cape Town - could influence the students' views. The environment of a medical school has its own influences, and the notion of the 'hidden curriculum' will be addressed in more detail further on. The environment of UCT is also unique, as UCT is a reputedly good university that maintains a high academic standard. Notions of what constitutes or upholds this standard could be in conflict with the new MBChB curriculum which is PHC-driven and has a psychosocial component that is often seen to be more of a 'soft science'. UCT is also located within a relatively suburban environment, but within close proximity to the city of Cape Town. This means that students are exposed to urban and suburban influences, and this exposure could be quite profound for students who are unfamiliar with this type of environment.

Students' views also need to be evaluated in light of their current developmental stage, namely the transition between adolescence and young adulthood, and which Gerdes terms 'youth'.²¹ Other personal factors that need to be taken into account are upbringing, moral values, religion and spirituality. These factors would almost definitely have an influence on students' values and priorities, and could play a part in determining their world view.

Literature review - Methods used

A number of methods were used to locate relevant literature for this review. South African university library databases were searched to find books and theses using the key terms 'primary health care' and 'medical students'. The main method to locate journal articles was the use of PubMed on Medline. The key terms used for the search were 'students' and 'primary health care'. 'Hand searching' was another method employed, and this was done with the journals likely to yield the most relevant material, for example, Medical Education, Academic Medicine. This method was adapted and used for the journal 'Medical Teacher' which was available only electronically. Reference lists of articles were also consulted for further relevant references. Preference was given to more recently published articles, although some articles published in the 1980s and early 1990s were also included in the review as they help to identify trends and provide some of the history behind certain issues.

The PHC approach and medical education

In response to the WHO's recommendations, PHC has been integrated into a number of medical and other academic curricula,^{10,22-29} and the philosophy of PHC has continued to call for changes in the nature and content of medical education^{11,30}. Some would argue, however, that it requires a shift in approach to health care, and not merely changes in curricula.¹³ Throughout the last two decades there has been the belief that medical education should aim to offer training that is relevant as well as responsive to the needs of the individuals, communities and populations that they serve,^{22,24,26,31-36} emphasising a generalist orientation that is grounded in the practice of PHC within community settings.³⁷ PHC is seen to be integral to good medical practice as it is evident at all levels of health care, thereby demanding that it be taught in a constructive manner.³²

Within the PHC approach, there is an expectation of doctors to surpass their traditional curative role and its associated knowledge, skills and attitudes.^{38,34} They need to involve themselves in the other aspects of care, namely prevention, promotion and rehabilitation,³⁴ and should be equipped for a leadership role in the community in which they are based.^{34,26} Doctors also need to have an understanding of the influence that social issues, poverty and rural living have on health,¹⁴ and, because of the numerous cultural changes that they are likely to encounter, they need to be adaptable within the environment they are placed.³² Related to these qualities that doctors working within a PHC approach need to possess, the WHO specified a number of skills that medical students need to be trained in, and these centre around community education and empowerment, working in multidisciplinary and multisectoral teams*, and providing health care for the underserved, vulnerable and disadvantaged.³⁷

It is vital that these reforms argued for in medical education are supported by appropriate changes in and integration with the health system in which the doctors are to work.^{26,30,34} Commitment is also essential from government and educational institutions, and strong links need to exist between national authorities, non-health sectors, universities and communities.³⁷

* Within the PHC approach, 'multidisciplinary' or 'multiprofessional' refer to the range of disciplines within the health sciences, such as medicine, nursing and physiotherapy. 'Multisectoral' or 'intersectoral' refers to sectors other than health, such as engineering and education.

Medical students and the PHC approach

Very little research seems to have been done on medical students' views and understanding of PHC, and the research that has been done is not recent - it is mostly published before 1990.^{14,25,39} The reporting of attitudes is complicated, as most of these articles ostensibly assess attitudes, but the results reported on seem more to do with evaluations of the students' exposure to PHC in their curriculum, or they do not report clearly positive or negative feelings about PHC.^{14,39} Students' negative attitudes towards PHC were reported as part of a study that did not explicitly look at students' attitudes.²⁵ Unfortunately these attitudes were not discussed in detail except to mention that they were probably reflective of the general population's opinions or were caused by the university's environment and socialising influence - known as the 'hidden curriculum'.²⁵

In a study done at UCT in the mid-1980s,³⁹ final-year medical students who had been exposed to a PHC block, completed an attitude questionnaire to assess their attitudes towards: "1) the need for teaching of PHC; 2) whether or not the aims of the block had been realized in their case; 3) the tutors as clinicians and as teachers; 4) the structure of the exposure; and 5) the PHC emphasis they would have liked"³⁹ (p.258). The most helpful and relevant finding (for this review) was that 96% of the students indicated that they were in favour of exposure to PHC. Although this could be interpreted as a positive attitude towards the PHC approach, it is not stated as such, and it appears as if this particular study was more of a course evaluation exercise than an inquiry into the nature of students' views of the PHC approach.

A similar study was done with final-year medical students in India in 1989,¹⁴ looking at attitudes towards PHC and focussing also on students' attitudes towards poverty and related social issues in India. Again though, attitudes were not explicitly explored, and this is evident in the research questions intended to be answered:

- 1) What does the concept of PHC mean to student doctors?
- 2) What do the students understand by the concept of the health team?
- 3) What understanding do the students have of poverty?
- 4) What understanding do the students have of the influence of the health problems of rural India?
- 5) What attitude do the students have towards the specialty 'social and preventative medicine' which has been specially created to give a social orientation to medical education?
- 6) Do

differences in sex and socio-economic background of the student doctors affect their responses to the above-mentioned issues? ¹⁴ (p.464)

A questionnaire comprised of a number of sections, gathered information on the students' socio-economic background; it asked them to rank, according to preference, specialties that they would probably encounter at undergraduate level; and posed open-ended questions on "poverty, the PHC approach and its relevance, the concept of the health team with a doctor as the team leader, and the implications of 80% of the population living in rural areas" ¹⁴ (p.465). Content analysis was then conducted on the responses to these open-ended questions. Very few of the results point clearly to the nature of the students' attitudes towards PHC, and the results appear to be slightly incongruent: 54% of the students indicated that PHC is relevant to India, yet social and preventative medicine, which as a specialty would draw heavily on the PHC approach, was ranked only fifteenth overall out of the nineteen specialties offered. ¹⁴

Otti³⁴ also found that community health, which is very similar in content and focus to social and preventative medicine, was an unpopular discipline with final year medical students in Nigeria. The unpopularity of social and preventative medicine, combined with the fact that the majority of students were reported not to have a good understanding of the PHC approach, its relevance, and the social issues that impact on health, could suggest that students' attitudes towards the PHC approach are not clearly positive. Perhaps the most interesting finding was that there were no significant differences between the students' responses from different socio-economic groups, although there were some significant differences between responses of male and female students.

The only recent study to give some indication of medical students' attitudes to PHC was conducted in 2001-2 in Saudi Arabia,³⁸ and investigated sixth-year medical students' perceptions of the teaching methods used in a PHC course. The students were reported to have an overall positive view of the course, and the majority (93%) of students felt that the course is important as part of their training as well as their future careers as doctors. While this study did not set out or claim to assess attitudes, it would seem reasonable to assume that the results reported are reflective of positive attitudes.

Other research into medical students' attitudes, views and beliefs

While the research on medical students' attitudes towards PHC is minimal, it is encouraging to note that there is a growing body of more recent research (1994 to the present) into medical students' attitudes, views and beliefs on a variety of issues and topics. These include: academic curricula and courses, teaching methods and medical education⁴⁰⁻⁴⁷; primary care^{48,49}; skills^{50,51}; future careers as doctors⁵²; diversity⁵³; experience in early medical education⁵⁴; teamwork⁵⁵; and attitude change during medical education.⁵⁶

Nursing and the PHC approach

It is worthwhile noting that, while reviewing the relevant literature, a number of studies were encountered that looked into nursing and the PHC approach.^{12,57-62} These studies explored issues such as the role of nurses in the PHC approach, and it seems to be acknowledged that this role is an important one,^{12,58} with some describing nurses as those at the "front-line of PHC"⁵⁹ (p.8). Nursing students' attitudes towards PHC were also reported on, and a study conducted at the University of Malta on teaching PHC within an interdisciplinary approach found that these students were generally positive about PHC, feeling that they had a role to play in this approach, and that PHC is applicable to them as nurses.¹²

A Canadian study conducted within the field of nursing set out to develop and test a psychometrically sound questionnaire that is able to measure knowledge, attitudes and practice of PHC, and the testing of this Primary Health Care Questionnaire (PHCQ) was carried out with both nursing faculty members as well as a range of students. Attitude and knowledge scores were reported as percentages, and the mean score for students' attitudes was 73.3 and knowledge was 76.05, although there were significant differences between the various groups of students, with more senior students scoring higher on knowledge and attitudes. Categories of attitudes and knowledge were not specified, as it seemed that highlighting differences between groups had a higher priority, but regarding attitudes (more pertinent in this review), a lower percentage was described as a 'less positive attitude', while a higher percentage was considered to be a 'more

positive attitude'. One can deduce from this that the nursing students' attitudes towards PHC tended more to the side of 'more positive'.⁶²

This PHCQ was adapted for use in the United Kingdom (UK) to investigate nursing students' knowledge of and attitudes towards PHC. Although students' scores varied according to their educational level and the programme for which they were registered, no differences were found between the knowledge and attitude scores of male and female students, and they were found to have an understanding of the key concepts of PHC and a generally positive attitude towards these concepts.⁵⁷ Although only a few studies on nursing students' attitudes towards and knowledge or understanding of the PHC approach have been reviewed here, the results of the studies reported on seem to point to the fact that nursing students have generally positive attitudes towards PHC, as well as a good understanding and knowledge of the approach.

The scope of this research does not allow for a full scale investigation into nursing and PHC, and specifically nurses' views of the PHC approach, although it does seem likely that a great deal more research would be uncovered were this the case. If one bears in mind that nurses generally take on many responsibilities of primary care, and that many mistakenly consider PHC to be limited to primary care, it would be realistic to assume that nurses are associated more strongly with the PHC approach than doctors are. However, I believe it would be incorrect and unwise to simply transfer and apply findings from research with nurses and PHC to doctors. These two professions are undoubtedly very different in terms of their roles and responsibilities in a health care setting, they occupy different positions on the hegemonic hierarchy of health professions and of health professionals, and society's perceptions of each profession are very distinct.

Gaps in the literature

Although this review of the literature is not exhaustive, it is definitely possible to identify a number of gaps. Most noticeably is the lack of recent research into the PHC approach, and included in this would be students' views and understanding of the approach, doctors' views and understanding of the PHC approach, the role of doctors in the PHC approach, and general understandings and perceptions of the PHC in health services and among health professionals. These gaps exist not only in the South African

literature, but in the international literature as well. One could discuss at length how the lack of acknowledgement of these views, understandings and perceptions, and the absence of a firm consensus on the meaning of PHC could potentially be detrimental to both medical education and the health services.

Qualitative research is also noticeably scarce in the literature, and while some research into students' views, attitudes and beliefs employed qualitative approaches and methodologies, for example, interviews and small group discussions,^{41,54,55} some combining qualitative with quantitative methods,^{40,44,53,55} the majority of these types of studies encountered used predominantly quantitative methods of gathering data, for example, surveys and questionnaires.^{14,39,42,43,45-52,56} While these types of studies are important, as they acknowledge the viewpoints and experiences of the students, they fall short in the sense that they do not provide the rich data that is yielded from a qualitative approach.

Conclusion

This chapter has introduced the main issues covered by this research and has clarified the term 'primary health care', placing the PHC approach within both the South African context as well as the context of the new MBChB curriculum at UCT. It has also clarified the research questions, theoretical framework and aims of this research along with contextual and developmental issues that need consideration. In terms of the literature review, the methods used for this review have been outlined, and the existing literature on the following topics has been reviewed: the PHC approach and medical education, medical students and the PHC approach, research into medical students' attitudes, views and beliefs, and nursing and the PHC approach. Existing gaps in the literature were also highlighted. Methodological issues shall be covered in the following chapter.

Introduction

As has been mentioned previously, a qualitative approach has been taken in this research, and this has influenced my general outlook throughout the research process, and has also influenced the methodology, in that mainly qualitative methods were used. This chapter will be addressing these methodological issues, including an explanation of the qualitative approach taken and why it was taken, and will also describe the methods employed and the research instruments used. Sampling and procedural issues will also be discussed as well as ethical considerations and potential sources of bias and error.

General framework

This research study borrows some aspects of grounded theory methodology, which is a commonly used approach in qualitative research, and which aims to develop theory that is 'grounded' in the data and theory that has emerged from the data.⁶³⁻⁶⁵ Also within this qualitative framework, a 'case study' strategy¹⁷ has been employed to guide the methodology. The key features of case study are as follows: Firstly, it focuses on a particular case,¹⁷ which in this study is medical students in the new MBChB curriculum at UCT. Secondly, it is empirical, in that it relies on the gathering of evidence using multiple methods,¹⁷ which in this study would be the gathering of data from questionnaires, interviews and focus groups. Thirdly, it looks at a phenomenon,¹⁷ which in this study would be medical students' views of the PHC approach, in the context of UCT, and more specifically within the new MBChB curriculum. Within in this case study strategy, it is important to note that the term 'case' is not limited to one individual, but could also be referring to a situation, group, event, relationship or organisation, among other things.¹⁷

This case study strategy is by no means in conflict with the qualitative nature of this research, but rather it supports the qualitative aims of in-depth and meaningful analysis through focussed exploration of a phenomenon, taking into account the range of

contextual factors that could impact the results. The perspective of action research discussed earlier also fits comfortably into the case study strategy, as both place emphasis on looking at a specific situation in its context. The purpose of drawing on all these perspectives is not to complicate matters, but rather to provide a sound theoretical framework in which to place this research, in order to better understand the research process and ultimately make more sense of the results.

The qualitative approach

The qualitative approach and qualitative methods are being used more and more in health sciences research, a field in which 'hard sciences' and a quantitative paradigm have dominated. Qualitative research is frequently described in contrast to quantitative research, as the methods of qualitative research often seem an antithesis to quantitative or statistical methods.⁶⁶ Qualitative research is seen to be complex,⁶⁷ and there are multiple understandings of qualitative research, as well as multiple methods that fall within the qualitative approach.^{20,66,68,69} Qualitative research is naturalistic in its approach, in that it aims to investigate phenomena in their natural settings.^{66-68,70} It is concerned with meanings, and endeavours to understand phenomena and social experiences, often complex in nature, with reference to the meanings people ascribe to them.^{20,66,67,71} The qualitative approach is interested in the perspective of the individual,⁶⁷⁻⁶⁹ but also acknowledges the significance of context,^{15,67,68,71-73} emphasises the socially constructed nature of reality,⁶⁷ and values rich descriptions and explanations of the social world and social processes.^{68,72}

Strengths of qualitative research include the fact that it is exploratory and descriptive, and is able to contribute to and expand the understanding of social processes.^{71,72} This makes it a particularly suitable approach for investigating issues that are not well understood. In addition, rather than merely accepting everyday notions and explanations, qualitative research poses essential and penetrating questions about the nature of social phenomena,⁶⁶ and is also flexible,^{68,71,74} thereby facilitating the exploration and description of phenomena.

Appropriateness of a qualitative approach

As this study aims to uncover, explore and describe attitudes and perceptions around the PHC approach, as well as to make sense of the social processes that contribute to these attitudes and perceptions, I felt that a qualitative approach would be more appropriate. It was also important within this study to look beyond common sense assumptions about students and their views about PHC, and to probe into some of the issues surrounding these views, particularly as these views had not previously been investigated and were therefore not well understood, and the flexibility of qualitative research⁶⁸ made it easier to accommodate these issues within the research framework. Through this study I also hoped to highlight some individual views as well as to obtain a broader understanding of the contexts in which these views are developed and upheld.

Focus groups and in-depth interviews as qualitative methods

Focus groups are a popular and well known method of collecting qualitative data, and a focus group can be defined as a group of people (participants) who are guided by a moderator to engage in a relatively informal discussion that is centred around a specific issue or topic.⁷⁵ The moderator's role is to pose questions to the group, generate discussion and encourage group members to participate and interact with one another,⁷⁵ as well as to listen carefully and learn from them.⁷² The focus group format also gives the moderator flexibility to pursue unexpected issues that emerge in the discussion.⁷¹

Focus groups were favoured as the dominant method of data collection in this study, as the group process, not present in one-on-one interviews, can aid in the exploration and clarification of group members' views. Focus groups benefit from the communication and interaction between group members to produce rich and elaborate data.^{15,69,75-77} If group interaction is dynamic, then group members themselves can explore and investigate a range of issues, and can also construct their own interpretations of these issues that emerge.⁷² Group members are also available in a focus group setting to validate statements and views expressed by other participants that may be incorrect or extreme,⁶⁹ and it is often relatively easy to assess whether a particular view raised in the group is shared between group members or not.¹⁵

It is the flexible nature of focus groups, as well as the unique dynamics of each group that make it difficult to predict how each group will proceed,⁶⁹ often putting the control of the group more in the hands of its members. It is this possible reduction in control that moderators are able to exercise over the group process that could potentially make it easier for the culture of the group to hinder individual expression, or for one individual to dominate the group.^{15,69,77,78} However, the 'flip side' of this is that group members are given more space to explore issues most relevant to them, possibly reducing some of the power dynamics that exist in one-on-one interviews.⁷⁵

Focus groups are also praised for their naturalistic quality, in that they can encourage discussions that resemble the everyday manner in which opinions are formed, conveyed and shared.^{69,75,76} Despite the fact that focus groups are criticised for compromising the confidentiality of research participants,⁷⁷ and potentially inhibiting discussion around sensitive issues,⁷⁵ many argue that the context of the group can in fact facilitate the discussion of these types of issues, as more confident group members can 'break the ice' for quieter members.⁷⁵⁻⁷⁷ Focus groups also capitalise on human beings' nature as generally social beings, making focus group interactions enjoyable and therefore easier to conduct.¹⁵

In-depth qualitative interviews were also one of the main forms of data collection, and share much of the same naturalistic, interpretative philosophy as focus groups.⁷⁰ These types of interviews are intended to draw on and be expansions of everyday conversations,^{70,79} as the interviewee and interviewer take turns talking, and the interviewer is required to listen carefully to the interviewee and needs to frame questions around the interviewee's responses.⁷⁰ Within this approach to interviewing, the interviewee is viewed more as a partner, as opposed to a subject under examination, and the interviewee takes on an active role in directing the interview discussion and bringing the interviewer to a point of understanding his or her unique perspective.⁷⁰

The in-depth interviews conducted in this study were semi-structured, and the interviews were structured around relatively general, open-ended guide questions that defined what was to be explored, and intended to uncover the interviewee's views, perspectives and meanings that they attribute to certain objects and events. These

initial open-ended questions then provide a platform from which more specific issues can be followed up on, depending on the interviewee's responses.^{15,70,71,80}

Although one-on-one interviews are not able to draw on the dynamics and interaction of the group (as discussed previously), they are able to examine important personal issues as well as the personal views and experiences of participants in a concentrated way that focus groups are unable to. They can also help the interviewer focus on what is important to individual participants, and not merely learn about an issue or event - an important characteristic and requirement of qualitative research.⁷⁰

Key informant interviews, which have their origins in ethnographic research, were also conducted in this study, and took on a similar format to the other in-depth interviews conducted with students. Key informants are defined as those individuals who are knowledgeable in a particular area, or who hold special status or skills. These types of informants willingly share their knowledge and skills, as well as their unique perspectives, observations and insights to which the researcher would otherwise not have access, and these help to enrich the understanding of the researcher.^{15,81} Key informant interviews were conducted to provide both a local as well as a national context to the students' responses.

The role of the researcher in qualitative research

Within the qualitative paradigm, the researcher is seen as the research instrument,^{15,69,71,80,82,83} and becomes part of the research process.^{67,71} Because of this, it is highly unlikely that the researcher will be able to take on a completely neutral or objective stance in this process.⁶⁹ This influence of the researcher (their background, characteristics and position), on the research process is termed 'reflexivity', and is accepted in qualitative research, and qualitative researchers are indeed encouraged to acknowledge its presence.^{15,19,67,69,70,84,85}

The qualitative approach holds that the relationship between the researcher and research process should be considered and revealed throughout the process, and that in acknowledging this relationship, bias is not eliminated, but is accounted for.^{15,19} Malterud¹⁹ maintains that researchers need to begin the research process by identifying any preconceptions, beliefs, motivations and qualifications regarding their investigation,

as well as any related perspectives or theoretical standpoints that they may possess. Malterud also contends that these preconceptions, beliefs and motivations, can add value to research, and should only be seen as bias if the researcher does not acknowledge them.¹⁹

Within qualitative research, the researcher has a number of responsibilities. He or she is involved in interviewing, observation, self-reflection and introspection,⁶⁷ and needs to think critically about common sense assumptions and ideas that are taken for granted.⁶⁶ Researchers also need to consider whether they would be considered an insider or an outsider in the research process, as this would influence their choice of methods,⁶⁹ and they need to bear in mind how participants perceive them and the influence of their race, class and sex on the interview and group process.⁸⁰ Less practical and more underlying responsibilities of qualitative researchers, according to Janesick⁸³ would be to have a passion for people, for communication and for understanding people, and to guard against decontextualising individuals and depersonalising events, as this would contradict the values and aims of the qualitative approach discussed earlier.

Since the researcher is seen to be the research instrument, it is important to highlight certain skills that are required of such a researcher, and more specifically of an interviewer and focus group moderator. For both these roles, it is argued that the researcher's approach and attitude have a significant influence on the interview or group process, and researchers need to demonstrate empathy, acceptance, respect and non-judgementalism for participants, as well as a willingness to learn from and understand participants.^{15,70-72,78,79,86} Listening and communication skills are also seen to be essential for both interviewing and focus groups.^{70,72,78,86,87}

Other skills that are highlighted are flexibility within the interview or group setting; an ability to be objective and persuasive⁷⁸; openness with participants,⁷⁰ as well as to new ideas; an understanding and familiarity with group process (for focus groups); friendliness and a sense of humour⁸⁶; good organisational skills; and an ability to think on one's feet.⁸⁷ Regarding focus groups, it is stressed that moderators be able to manage the group dynamics, and should be able to direct the group discussion in a way that accomplishes the aims of the study without being too controlling.^{72,78}

Rubin and Rubin⁷⁰ emphasise the importance of the interviewer having an understanding of his or her personality and biases, and suggest that the interviewer learn something about the interviewee, as this not only can improve the interviewer's confidence, but could identify any commonalities in background, which could then serve to increase the interviewee's trust in the interviewer.

Regarding focus groups, Krueger⁸⁶ highlights the importance of participants feeling at ease with the moderator, and perceiving the moderator as an appropriate person with whom they can discuss their views. Linked to this, moderators need to be prepared to hear unpleasant views, and should realise that their role may not always be neutral. Considering all these skills mentioned, Krueger stresses that each moderator has unique talents and abilities, and that these, along with the moderator's personality, should be used to enhance the experience of the group. This is as relevant for interviewers, and it is important that both focus group moderators and interviewers should not be weighed down by the logistics of their role, but should "just get on with interacting" (p.20).⁷⁹

Issues of rigour

The main criticisms of qualitative research are to do with its lack of scientific rigour, specifically around issues of validity, reliability, reproducibility and generalisability. Qualitative research is also criticised for its anecdotal nature and the fact that it hinges on and comprises mainly personal impressions, which leave a great deal of room for bias.^{82,88} Although these issues of scientific rigour are widely discussed,^{15,17,19,69,71,82-85,88} many query whether these positivistic criteria are appropriate or applicable to qualitative research,^{19,71,83,84,88} and maintain that qualitative research does not attempt to replicate,⁷¹ generalise, or be statistically representative.⁸⁰ Others argue that concerns about reliability should be limited to quantitative research, questioning whether, in light of the dynamic nature of social reality, it makes sense to be concerned about whether or not research instruments measure correctly, that is, whether or not they are reliable.⁸⁸

Some do maintain that reliability is compromised in qualitative research because different researchers, depending on their involvement in the research process and their position and perspective, may present different explanations of an issue under investigation. The issue of reliability is an important one, because reliability is seen as a

requirement for validity,¹⁷ as validity seeks to ensure that findings are credible,⁸³ that is, they are “really about what they appear to be about” (p.66).¹⁷ However, the range of explanations presented by different researchers should be seen as alternative, yet equally valid, ways of looking at the same subject, and should not be perceived as a failure of reliability but as an opportunity to broaden the understanding of the complex issue being studied.¹⁹

In response to the above criticisms, it has also been put forward that in both qualitative and quantitative research, the researcher’s judgement and skill come into the research process, and that both types of research are selective, in the sense that data are gathered by certain methods, each possessing its own strengths and weaknesses.⁸² In addition, qualitative researchers do need to guard against becoming overly concerned and involved with method, and these issues of scientific rigour, thereby committing ‘methodolatry’, which, according to Janesick,⁸³ is a “preoccupation with selecting and defending methods to the exclusion of the actual substance of the story being told” (p.48), leading the researcher away from making sense of the research participants’ experiences. Reflexivity should also not be overshadowed by these issues but should be seen as having equal significance.¹⁹

This said, there are ways in which qualitative researchers can safely address issues of rigour, and ultimately produce information that can be reported and applied outside of the research setting.¹⁹ This rests on the understanding that qualitative research methods form part of a systematic and reflective process that develops knowledge that can be shared and challenged.¹⁹ Malterud¹⁹ claims that to achieve some level of transferability, researchers need to undertake to do the following: not take findings or explanations for granted, but to critically analyse them; not assume that validity is obvious or universal, but to assess it; be aware of the influence of context and bias; and present and review the analysis, not assuming that manuals on analysis have inherent trustworthiness. Mays and Pope⁸² maintain that reliability is attainable in qualitative research if a thorough and detailed account of data collection, methods and analysis are kept, in order to make it possible for another trained researcher to analyse the same data and come to similar conclusions.

Triangulation, generally referring to the use of multiple methods,^{67,69,84} is seen by some as a means of upholding validity,⁸² whereas Denzin and Lincoln⁶⁷ see it as an alternative

to validation. Either way, the use of triangulation signifies an effort to come to a deeper understanding of the phenomenon under investigation,⁶⁷ and would seemingly aim to improve the credibility of findings, thereby enhancing validity. Apart from methodological triangulation, data triangulation can be employed, which uses data from different sources, and possibly from different settings at different points in time.^{69,84} Investigator triangulation involves a team of researchers, instead of using one researcher, and theory triangulation can be adopted where researchers compare the data to a number of hypotheses.⁸⁴

Attitudes and perceptions

As this is a qualitative study, there are no explicit variables, such as there might be if this was a quantitative investigation. Although a number of issues were explored in this research, as outlined in the 'Aims' of the introductory chapter, it is important to operationalise the terms 'attitudes' and 'perceptions', as these do essentially frame this investigation, and could arguably be seen as qualitative variables. As my background is in psychology (I possess a Masters degree in Research Psychology), the explanations and definitions given here will be from a psychological standpoint.

According to Fishbein and Ajzen, an attitude is a "general feeling (ranging from positive to negative) or evaluation (good / bad) a person has towards self, other people, objects or events" (p.748),⁸⁹ and attitudes are said to have three components: cognitive (thoughts or beliefs), affective (evaluations or emotions) and volitional (motives or intentions). It should also be mentioned that there is a relationship between attitudes and behaviour, but this relationship is a complicated one, and attitudes do not necessarily predict behaviour.⁸⁹ For the purposes of this research, I have ascribed to this explanation of attitudes, and the various components of attitudes should be reflected in the research instruments as well as the results and subsequent discussion.

In the field of psychology, the term perception is used mostly with reference to cognition. In a cognitive context perception could be defined as the "process through which we give meaning to the information we get from our senses" (p.150),⁸⁹ and it refers to the way in which we organise information that we receive in order to make sense of it.⁸⁹ From a more lay perspective, perception has come to refer to the way in which we view and understand something, and has become more strongly associated

with opinions and beliefs, thereby making it logical to associate perceptions with attitudes. It is a combination of the lay and theoretical understandings of perceptions that I have drawn on in my research, and when investigating medical students' perceptions of the PHC approach, I have been interested in how they view or see the approach, how they interpret what they are presented with about the approach, and how they make sense of and understand the approach.

Research instruments

Qualitative methods (that is, focus groups and interviews) were chosen, since views, attitudes, opinions and perceptions, all complex phenomena, are not necessarily well reflected in quantitative measures, such as questionnaires. Such quantitative measures as these can be reductionist, and do not always capture the nuances of what students are saying. Qualitative methods allow for these issues to be explored in more depth, therefore allowing for a richer understanding. As was discussed previously, the researcher is seen to be the research instrument within the qualitative approach, and this is most relevant for the interviews and focus groups.

Interview and focus group guides were used as opposed to more structured questions or a questionnaire (see Appendix B). These guides are structured around a number of questions or issues that need to be covered in the interview or focus group session, and while they provide a certain amount of freedom for the interviewer or focus group moderator to explore these issues and develop a conversation with participants, they also ensure that certain lines of inquiry are followed with all participants by providing the topics for the interviewer or focus group moderator to focus on.¹⁵

The other research instrument used was a questionnaire administered at the start of 2004 to first-year medical students (see Appendix C). This questionnaire gathered basic demographic data, and also enquired about the following: reasons for studying medicine, approaches to health, understanding of the term 'community', familiarity with the PHC approach, expectations and fears about studying medicine, expectations and fears about being a doctor, perceptions of doctors, and future aspirations. The questionnaire comprised a combination of questions for which there were options for students to tick (some demographic details, reasons for studying medicine, approaches to health, familiarity with the PHC approach, perceptions of doctors and future

aspirations), and questions where students could indicate their response on a Likert scale (expectations about studying medicine and being a doctor). There were only a few open questions (understanding of 'community' and some demographic details).

The PHCQ was discussed earlier,⁶² and could have been used as a research instrument as it was designed to look specifically at attitudes towards and knowledge of PHC. However, as has already been mentioned, it was felt that a qualitative approach needed to be adopted for exploring the students' attitudes towards PHC. The attitude component of the PHCQ seemed rather intellectual, and did not give room to explore attitudes in much depth. It also did not seem to adequately acknowledge the complex nature of attitudes, and that they incorporate emotions, evaluation, motives, intentions, thoughts and beliefs. With regards to students' knowledge of PHC, I was more interested in their understanding and perceptions of the approach, and less interested in their factual knowledge about it, and the PHCQ appeared to test this type of knowledge rather than conceptual understanding.

The PHCQ has proven to be a very appropriate measure for identifying differences in knowledge and attitudes between groups of students and even staff,^{57,62} and while this would definitely have been a valuable exercise, the purpose of this research was to focus on depth more than on differences. It does need to be remembered that this questionnaire was designed and tested with nursing students and staff, and has yet to be tested with medical students and staff. The trouble with transferring and applying research findings from nursing to medicine has already been raised. Lastly, the PHCQ was developed and tested in Canada, and then tested in the UK, so it has yet to be put to the test in a developing country such as South Africa, and although the PHC approach is universal, there are certainly aspects of it that are more relevant and would need to be applied appropriately in developing countries.

Sampling

Purposive sampling was used in this research. This is a type of non-probability sampling that selects specific individuals or groups because they match criteria that are necessary for the investigation of the phenomenon being studied. This approach to sampling allows the researcher to explore particular issues relevant to the research, as well as to include particular key informants who can offer important and distinctive knowledge to the

researcher.^{15,17,82,88,90} Purposive sampling is often recommended and used in qualitative research^{15,17,68,74,82,90,91} instead of random sampling, as representativeness and generalisability are not key objectives of qualitative research as they are in quantitative research.^{82,91} The goals of qualitative research are information richness⁷⁴ and the understanding of social processes,⁸² and purposive sampling supports the attainment of these goals. At this point, mention should be made of the sample size of this particular study, which will be small in relation to samples from many large-scale quantitative studies. The justification for a relatively smaller sample is also to do with information richness, and Patton¹⁵ argues that this is more significant when looking at issues of validity, meaning and insight obtained from qualitative research than the size of the sample.

Before discussing the actual sampling strategy, it is necessary to justify my choice of UCT as a study location, and my choice of medical students at UCT as a study population. UCT was an ideal site⁷¹ and the medical students an ideal population to conduct this research for the following reasons: because of my existing profile as a past staff member, I had easy access to the students as well as the staff who could assist me in logistical issues, for example, contacting the students, and I am very familiar with the first year of the MBChB curriculum, in which most of the theoretical input on the PHC approach is given. Since UCT is the institution at which I am registered, I am familiar with the layout of the campus and have access to venues and resources. Having worked in this environment for a number of years, I am also aware of the diversity of the students as well as the culture of the medical school, and have had an invaluable opportunity to observe the setting of the medical school and the students for a substantial amount of time. Most importantly, my involvement with the students and in the MBChB curriculum has hopefully aided in the development of a relationship of trust between myself and the research participants, thereby enhancing the quality and credibility of the data generated.

In terms of the focus group composition, the first set of focus groups were organised according to racial groups, that is, White, Black, Coloured and Indian*, and groups contained male and female students. For this set of focus groups, Coloured and Indian students were put in the same group. When preparations were being made for the

* For the purposes of this research, 'White' refers to Caucasian or European descent, 'Black' refers to indigenous African descent; 'Coloured' refers to those of mixed race, and in this context would specifically include those classified as 'Cape Coloured'; and 'Indian' refers to those who are of Indian descent but are South African in nationality.

second round of focus groups, it was felt that race had not shown itself to be a strong enough predictor of students' views that it should necessitate racially homogenous focus groups. From the original set of focus groups, as well as my interaction and observation with the students, I also did not believe that race would guarantee homogeneity of views within the groups.

Homogeneity is recommended in focus groups as the background and characteristics that group members share can help to boost compatibility between participants^{69,90} and can make the most of group members' shared experiences.⁷⁷ Focus groups generally intend to explore group norms, so some commonality does need to exist between participants,⁹² and this can mean that the group members "share some ways of talking even before the moderator tries to get them to talk: assumptions about entitlement to speak, ways of disagreeing, ways of conceding, and a sense of humour" (p.69).⁹² In naturally occurring groups, the group members already know each other; they may have common interests,⁶⁹ and can also relate to one another's remarks about shared situations. In addition, they can pick up discrepancies between the professed views of group members and their actual behaviour.⁷⁷

Although the groups ultimately selected for second set of focus groups were not homogenous according to racial dimensions, they were homogenous to some degree, in the sense that all group members were all registered for the MBChB degree, were in the same year of study (in their particular group), and were therefore exposed to very similar academic influences and the context of the UCT medical school. These groups were also naturally occurring groups, but to varying degrees. Fourth-year students were selected from already existing 'block rotation' groups, while second and third-year students were likely to know the members of the focus group, as many of them have been placed in other academic groups and have regular contact with one another.

When interview and focus group participants were selected, an effort was made to ensure, as far as possible that all racial groups and both genders were represented. For the second set of interviews, at least two students were purposively selected from each gender in each racial group. In order to achieve this for the third set of interviews and second set of focus groups, the student class lists (for second, third and fourth-year) were stratified according to race and gender, and students were purposively selected from these lists. Due to the small sample size and the size of the focus groups, this

representation would not have been exact, this being compounded by the fact that a number of students did not arrive for the interview or focus group sessions, thus skewing the proportions. (See Appendix D for further details of sample composition.)

Questionnaire

All first-year students in 2004 were notified via their timetable that a questionnaire on PHC was to be completed in the main lecture theatre in the New Learning Centre (NLC) on Medical Campus at UCT. Due to the fact that whole class lecture attendance is not officially monitored, that is, role call is not taken, participation in this part of the research was implicitly voluntary. In spite of this, attendance was excellent (97%).

Set 1 interviews and focus groups and Set 2 interviews

First-year students were notified by a written memo that they had been selected to participate in this research, and that if they were able to participate, they were to contact myself. These written notes were handed to students by their problem-based learning (PBL) group facilitator when they met with their PBL group. The participants for this first set of interviews were all members of the same PBL group, and this was done partly for the sake of convenience, but also because an effort is made to obtain a good racial and gender mix in each group when the PBL groups are constructed.

Set 3 interviews and Set 4 focus groups

Interviews in this round of data collection took place with second-year students, and focus groups were conducted with second, third and fourth-year students (all in 2005). Interview and focus group participants were again purposively sampled to represent the composition of the class, but focus groups were no longer grouped according to race. Participants for these interviews and focus groups (except for three of the fourth-year focus groups) were all contacted telephonically, via a text message on their mobile phone (SMS), and/or via electronic mail (email). Once participants had confirmed their involvement, an email or SMS reminder was sent closer to the time of the session.

Contacting participants for this round of data collection proved to be harder than expected, particularly for the second-year students, as these interviews and focus

groups were set to take place very near academic registration and the start of the academic year. The students' contact details had therefore not been updated for 2005. Many of the students (not only second-year students) do not seem to check their email regularly, or do not reply to emails or SMSes. Contacting students telephonically was used to contact very few second-year interview participants, as I felt that this method puts unnecessary pressure on students to be involved in the study as it is harder to decline to participate over the telephone.

Two of the fourth-year focus groups were comprised of students who had recently completed their Public Health block, in which a number of issues and concepts related to the PHC approach are revisited. The remaining three fourth-year focus groups were approached on their lecture day in the Department of Obstetrics at Groote Schuur Hospital. The entire group of 34 students, from which the three groups were selected, was approached and informed of the nature of the research. The names of participants were then read out and these individuals were asked to stay behind. They were then given further details about the research and asked for their cooperation. Their mobile phone numbers were taken so that they could be sent a SMS reminder closer to the time.

The focus groups were selected from the obstetrics block for a number of reasons. Firstly, the course convenor for the fourth-year obstetrics block was aware of and familiar with my research, and offered to allow the students to be involved. Secondly, fourth year marks the beginning of the clinical phase of the MBChB curriculum, and students are generally difficult to bring together as they are spread between a number of health facilities in the greater Cape Town area. Because of the nature of obstetrics, students are required to stay for a portion of their time at a health facility, and I was thus able to conduct the focus groups at the facility where they were based. Lastly, the fourth-year obstetrics block functions as a very practical induction into the clinical phase, and serves as quite a marked contrast to the preceding pre-clinical years.

Key informant interviews

All key informants were purposively sampled based on their involvement in the teaching of the PHC approach and in medical education either at UCT or another South African university. They were contacted via email and an interview was requested and granted.

Procedure

Questionnaire

The first questionnaire was administered by myself. Upon entering the lecture venue, students received a questionnaire as well as a consent form. The purpose of the research was explained to the students, and the ethical considerations were reiterated verbally. Students were asked to read and complete the consent form, and to complete the questionnaire; they were assured that there was no way in which to connect the consent forms and questionnaires once they were handed in.

Set 1 interviews and focus groups and Set 2 interviews

The interviews and focus groups were semi-structured, and guide questions were used as opposed to more structured questions (see Appendix B). At the start of the interviews and focus groups, the participants were explained the purpose of the study and were given a general outline of the interview or focus group session, as well as a consent form to read through and sign. Ethical issues addressed in the consent form were reiterated verbally, and students were given an idea of how long the interview or focus group session would take. These interviews and focus groups either took place in one of the tutorial venues in the New Learning Centre (NLC), or in a seminar room in the School of Public Health and Family Medicine. These sessions were recorded via audio, and the interviews ranged from 20 to 30 minutes in length, while the focus groups ranged from 30 - 45 minutes. Refreshments were provided for the focus group participants.

Set 3 interviews and Set 4 focus groups

Interviews were conducted with the second-year students in venues in the Anatomy Building and NLC, and lasted approximately 45 minutes in length. The interviews were intended to serve as an opportunity to pilot the guide questions that were to be used in the focus groups, and to help provide a sense of how these focus groups might progress. Focus groups were between 45 and 60 minutes in length, and both interviews and focus groups were recorded via audio. Focus groups with the second and third-year students took place in one of the tutorial venues in the NLC, while the focus groups with the fourth-year students took place at a location convenient to the students, as they were

on clinical block rotations. Three of the fourth-year focus groups were doing their Obstetrics block, and so these sessions took place at three of the training sites: Mowbray Maternity Hospital, Somerset Hospital, and Groote Schuur Hospital. The other two fourth-year focus groups were doing their General Medicine Block, and these focus group sessions took place in a venue in the Department of Medicine at Groote Schuur Hospital.

The format for these interviews and focus groups was similar to the format of the first and second round of interviews in that guide questions were favoured. However, the nature of the participants and the group dynamics in the focus groups seemed to largely determine how the sessions progressed and what issues were to be addressed in more detail. At the start of all interview and focus group sessions, students were encouraged to share openly and honestly about their views, and were assured that the interviews were not intended to test their knowledge of the PHC approach. Ethical issues outlined in the consent form given to students were reiterated verbally, and students were explained the purpose of the study. They were given a general outline of how the interview or focus group would proceed as well as an idea of how long the session would take. Refreshments were served to focus group participants.

Key informant interviews

The majority of these interviewees were interviewed in their place of work or other venues at UCT. The interviews were recorded via audio, and lasted between 45 and 60 minutes in length. The interviews were all semi-structured, and guide questions were used to lead the discussion. Due to the fact that all interviewees hold different positions, and some are at different universities, the interview needed to be guided largely by the issues that were relevant to the interviewee or that were raised during the course of the interview.

Ethical considerations

Ethical approval for this research was obtained from the Research Ethics Committee in the Faculty of Health Sciences at UCT. The main ethical consideration of this research was the students' anonymity, and the related possibility of students being concerned about the fact that sharing their opinions would negatively impact their academic performance. These issues were addressed in the consent forms (See Appendix E) that

were given to all participants, and were reiterated verbally at the start of the interviews and focus groups, and when the questionnaire was administered. Students were reminded, both verbally and in the consent forms, that their participation was voluntary and appreciated, and fortunately no students withdrew once the questionnaire was administered or the interviews and focus groups had commenced.

As was explained in the introductory chapter, I, the principal researcher (who administered the questionnaire, and was the interviewer and focus group facilitator), was a member of staff until the end of 2004. My contact with the second and third-years would have been quite extensive, as I was involved in whole class lecturing, setting and marking of assessments, and small group facilitation. There was also a possibility that I may have facilitated some of the fourth-year students. When sampling, I did make an effort not to select students that I had facilitated in a small group, but in some cases, this was unavoidable.

My involvement in the curriculum could have intimidated students and set up a power dynamic that would have been counterproductive to my research aims, particularly in the interviews and focus groups. However, through my involvement with the students in the curriculum and in my research, I have always tried to maintain a relaxed yet professional relationship with the students, and endeavoured to be approachable to the students, showing non-judgementalism and a willingness to listen. The fact that students shared openly and honestly during interviews and focus groups, and often discussed contentious issues in the focus groups, seemed to indicate that they were not intimidated. Another factor that could have worked against the potential power dynamic was the fact that I was no longer a member of staff during 2005, in which the bulk of data was gathered (through interviews and focus groups). During the course of 2005, I continued to enjoy a good rapport with students through contact on campus.

Another ethical issue that was raised, owing to the use of interviews and focus groups, was the issue of remunerating participants. This was a difficult issue to resolve, as there are arguments both for and against. On the one hand, money can indicate an appreciation of participants' time, and interviews and focus groups can take anything from 45 to 90 minutes - a substantial amount of time when one is busy, as medical students generally are. Interviews and focus groups also require a certain level of participation, and call for participants to share their views and in the case of focus

groups, discuss these with other group members. Remuneration can also show appreciation for this participation, which can be taxing for some.

The main argument against paying participants is the possibility that participants feel that their views are bought, and their participation might therefore not be genuine. Would participants share the same views or participate in the same way if they were not paid? Another pertinent question in this regard is: how much to pay? If participants perceived the amount to be too little, would they be offended and reduce their participation? Whatever the amount, offering remuneration for participants can become very costly, particularly if there is a high number of interviews and focus groups. On the basis of these reasons, a decision was made not to remunerate participants, and this did not seem to negatively impact the research process, nor was it raised in any of the interviews or focus groups.

As an alternative way of showing my appreciation to participants, refreshments were served in the focus groups and the majority of interviews, and these seemed to have an overall positive effect, particularly in the focus groups. Many participants were pleasantly surprised when they saw that refreshments were being served, and voiced their gratitude on many occasions. The presence of refreshments seemed to create a relaxed and comfortable atmosphere, and this could be related to the fact that the notion of sharing food and drink holds a positive connotation for most people.

The ethical considerations for the key informant interviews were different to those previously mentioned. Since all interviewees were approached because of their involvement in the MBChB curriculum or in medical education in South Africa, I felt that it was important that their position was stated in order to provide some context for their responses. All interviewees were given the choice to remain anonymous, but were all willing for their identities to be included in the final report.

Potential sources of bias and error

The potential sources of error would seem to centre mostly around the collection of data, and specifically the use of interviews and focus groups. I have already mentioned the possibility of a power dynamic existing between myself and the students, and although a concerted effort was made to counteract this effect, it could have led to the

students feeling pressured to present the views that they felt I wanted to hear. In this regard, the one-on-one interviews could have been more inclined to trigger such a response, as the focus group members may have drawn more confidence from the presence of other students. However, within the focus groups, members may have felt more pressure to agree with one another, and the threat of this was also discussed earlier. Students who disagreed with the views of the group or were undecided on their opinions may have been seen to acquiesce to the views of the group, thereby skewing the results. It is hoped that good observation and an ability to keep a careful track on the group discussion would have helped to prevent this to some extent.

Conclusion

This chapter has explained the qualitative approach taken in this research, looking at the strengths and the appropriateness of such an approach, the qualitative methods used, the role of the researcher, and issues of rigour. Key terms and research instruments used were described along with the type and strategy of sampling for each data set, and the procedure for the questionnaire, interviews and focus groups was explained. Lastly, ethical considerations and potential sources of bias and error were addressed. In the following chapter, the type of analysis and the analysis process will be covered.

Analysis - Introduction

Introduction

In this chapter, an explanation will be given of qualitative data analysis, which was used in this research, along with a more detailed description of the analysis process of this research and an outline of the emergent themes. The chapters following this will give more detailed descriptions of these themes, embedded with excerpts from the interview and focus group transcripts.

Data analysis

Qualitative data analysis is the “process of bringing order, structure and meaning to a mass of collected data” (p.111).⁷¹ Dey²⁰ likens the process of qualitative data analysis to the making of an omelette - the collected data are the eggs, which are then broken and beaten together to produce something different (the omelette) to what was started with (the eggs). Essential to the process of qualitative data analysis are the description and classification of a phenomenon through the meaningful dissection of data, all the time being aware of maintaining connections between various concepts.^{20,68} Because of the volume of data that is usually generated in qualitative research, this process can be vague and time consuming, and owing to the fact that it is not a linear process, it can also be messy, unstructured and complicated.^{15,71,93,94}

Within qualitative research, analysis is not a discrete phase, but is continuous, and merges and overlaps with other phases.^{93,95} Analysis generally starts within the data collection phase,^{15,17,64,65,70,71} and this is not surprising, as it would be very difficult for the researcher not to have any thoughts about the data that is emerging⁶⁵ or to have ideas about how to make sense of the data that is being generated.¹⁵ It is possible that the researcher might refine or discard certain research questions once some data has been collected, and other issues that have surfaced might be pursued.^{65,71} Some would claim that analysis begins before data collection, in the sense that the researcher is analysing the data, by reducing it, and by deciding on which cases will be used, what

research questions will be asked, how data will be collected and what conceptual framework will be used.⁶⁸

In terms of the actual process of qualitative data analysis, guidelines and conventions do exist that can assist researchers in this process,^{15,17,88} and it is stressed that analysis be verifiable and be carried out systematically.⁹⁵ Patton does point out, though, that utilising these guidelines depends on the judgement, creativity and analytical intellect of the analyst, and that because of the uniqueness of each study, the approach taken to analysis will be unique in each situation. Qualitative data analysis is essentially a process of data reduction in which the researcher selects, focuses, simplifies and categorises data, thereby dividing it into more manageable pieces so that the researcher can give meaning to the data.^{68,71} This process may be inductive, if patterns, themes and categories are derived from the data itself, or deductive, if categories are introduced either at the start of or part of the way through the analysis and data are analysed according to this framework.^{15,65}

The process of analysis generally starts with the coding or indexing of the data, for example, interview or focus group transcripts. This is an important phase in the process as it serves to organise the data and helps to identify themes and categories, and at this stage, coding and categorisation should be inclusive rather than exclusive. These codes are essentially labels that enable the researcher to attribute units of meaning to the information that is presented in the data. Once themes and categories have been developed, the data is then classified according to these (some categories may be refined), and a conceptual framework starts developing from which conclusions may be drawn.^{15,17,20,65,68-71,93-95}

There are computer packages that are designed to perform qualitative data analysis, but a decision was made not to make use of one of these packages for a number of reasons. Firstly, I, as the researcher, have knowledge of and experience with performing qualitative data analysis 'manually', and I felt more confident in and trusting of my own skills of analysis than in my skills (which would be newly acquired) with a computer package. Secondly, computer packages are only an *aid* to analysis,¹⁵ and do have their limitations. Some argue that these packages can distance the researcher from their data,⁹⁶ and they are not generally able to take the analysis beyond the point of description; the analytical skills of the researcher may still be required to develop

hypotheses and draw conclusions.⁶⁵ Lastly, the process of coding and categorisation are time consuming and rather laborious as the researcher is required to read and re-read the data. However, this repeated and lengthy contact with the data allows the researcher to develop an intimate knowledge of and familiarity with the data,⁶⁵ which can serve to enrich the researcher's understanding of the data and can hopefully help lead to more meaningful conclusions.

The nature of the analysis process

As discussed in the previous chapter, the phase of analysis tends to overlap with other phases of the research process. In this case, analysis could be said to start from before the data collection phase when the initial questionnaire was designed. Owing to the fact that medical students are only introduced formally to the PHC approach in the second semester of their first year, it is only then possible to effectively assess their views of this approach after they have completed this semester. However, the questionnaire and the first set of focus groups and interviews and the second set of interviews took place in the students' first year. Therefore, it was necessary to begin the process of analysis by deciding which issues could be related to students' attitudes towards and perceptions of the PHC approach. These issues were then investigated and explored in the questionnaire, focus groups and interviews, and are now available for comparison with the other data.

In the analysis of my findings, I adopted a content analytic approach, and the process was both deductive and inductive. It was deductive in the sense that these issues mentioned above helped form the categories and hence the framework against which the data were analysed. In addition, the fact that students' attitudes towards and perceptions of the PHC approach were specifically being investigated meant that the interview and focus group discussions were largely guided by my intentions to uncover these attitudes and perceptions. The process was inductive in the sense that many of the themes were derived predominantly from the data. Some of these themes were included as more peripheral issues in the interview and focus group guides, but emerged as significant for some participants and therefore helped form and contribute to some of the main categories of analysis.

This process of analysis was indeed time-consuming, and while it was often laborious, it allowed me, as the researcher to develop a familiarity with the data that has fostered within me a deeper understanding of and insight into the data. I relied on my experience in the field of qualitative data analysis, and made every effort to be systematic throughout the process, aiming for an appropriate amount of structure and order in the data.

The structure of the analysis process

For the purposes of clarity, it would be helpful at this stage to recap on the different data sets, and these are outlined in the table below. Owing to the fact that each set of focus groups and interviews would differ to some degree in terms of the issues covered, each set was analysed separately, although there were overlaps. In order to develop the different coding systems for each set, each set of transcripts was read and the contents of these transcripts were noted. This information was then organised into meaningful categories, and from this a conceptual framework was developed for each set of focus groups and/or interviews, each framework possessing a set of codes with which to classify the relevant data. Each set of data was then classified according to the relevant coding system, and this entailed applying the coding system twice to each set of data in order to pick up any oversights or errors in classification.

Set 1	Interviews and focus groups	1 st year students	February 2004
Set 2	Interviews	1 st year students	July 2004
Set 3	Interviews	2 nd year students	January 2005
Set 4a	Focus groups	2 nd year students	January / February 2005
4b	Focus groups	3 rd year students	February 2005
4c	Focus groups	4 th year students	February / March 2005

Using the appropriate codes and the conceptual framework for each set of data, mind maps were drawn up in order to group the relevant data, which would be the students' responses, into various categories. All the frameworks were then evaluated against one another to see where overlaps and links were evident, and a new conceptual framework was developed that encompassed the categories from all sets of data collection. This framework then formed the basis for seven major themes, which shall be outlined in the following section. All the relevant data for each category from each set was then

grouped according to these themes so that where possible, similarities could be identified and comparisons could be made between the responses of students from each data set. The reason for reporting on the data according to themes was because this highlighted the similarities between students' responses, and there were in fact more similarities than expected. Where there were differences in responses, it was felt that more insightful and closer comparisons could be made between the sets of responses, and that the richness and depth of the data would be drawn out.

Outline of themes

Below are the themes around which the subsequent chapters will be structured:

1 - What is medicine and what is a doctor?

- Perceptions of medicine and doctors, expectations of being a doctor, including what makes a good doctor and the role of personality.
- Expectations of studying medicine, with regards to content.

2 - Why medicine?

- Reasons for studying medicine, changes in reasons, and congruency with PHC.
- Future aspirations and how they relate to reasons for studying medicine.

3 - What is PHC?

- Awareness of the PHC approach prior to studying medicine.
- Perceptions of the PHC approach.
- Understanding of the PHC approach, what has helped and hindered understanding.

4 - PHC: for and against

- Attitudes towards the PHC approach: personal and class attitudes; why it is important to learn about the PHC approach.
- Feelings about the PHC approach being promoted at UCT.
- Influences of and changes in attitudes towards the PHC approach.
- Comparisons with other universities in terms of the inclusion of and emphasis on PHC.

5 - PHC: views of the approach

- Views of the PHC approach: strengths and weaknesses of the PHC approach, idealism of the PHC approach, theory versus reality, comprehensive versus selective PHC, comprehensive care, PHC principles, and the role of doctors in the PHC approach.

6 - Medicine and PHC in the South African context

- Students' views of health and health care: need for change in the health system, applicability of the PHC approach, and working conditions for health professionals.

- PHC in South Africa: the implementation of the PHC approach, the meeting of an old and new paradigm, and obstacles to and requirements of the implementation and success of the PHC approach.
- Government: dissatisfaction with the government, government's role and responsibility, what the government is doing.
- Public versus private sector: differences between the sectors, the appropriateness of the PHC approach for each sector, working in the public sector, and reasons for choosing to work in the public or private sector.

7 - The PHC approach and the learning environment

- Expectations of studying medicine in terms of teaching methods, and whether or not these expectations were met.
- New MBChB curriculum: feelings about new curriculum, benefits of the new curriculum, views on content and teaching methods.
- How the PHC approach is taught in the new curriculum, timing of input on the PHC approach, assessment of the PHC approach, other approaches besides the PHC approach, and suggestions for the curriculum.
- Clinical exposure.

Conclusion

The outline above confirms that there are a number of related issues that have been explored alongside students' attitudes towards and perceptions of the PHC approach. Although these issues may seem peripheral to the main aims of this research, it is vital that their importance be noted and that these issues be fully examined before focussing on the students' views of the PHC approach. All the related issues can be said to set the stage for the introduction of students to the PHC approach - they provide the backdrop against which the students see the PHC approach, one of the main components of UCT's MBChB curriculum. These related issues are in a sense the 'baggage' that students arrive with for their journey through their academic and professional career as a doctor. As these issues will be explored in the coming chapters, it should be clear how some of this 'baggage' is useful, allowing space for the PHC approach, while some of it is heavy and cumbersome, but is hopefully able to be discarded and exchanged for the more useful kind. Figure 2 helps to show the relationship between all the themes that emerged in the analysis, starting with before students arrive at UCT up until the time they graduate.

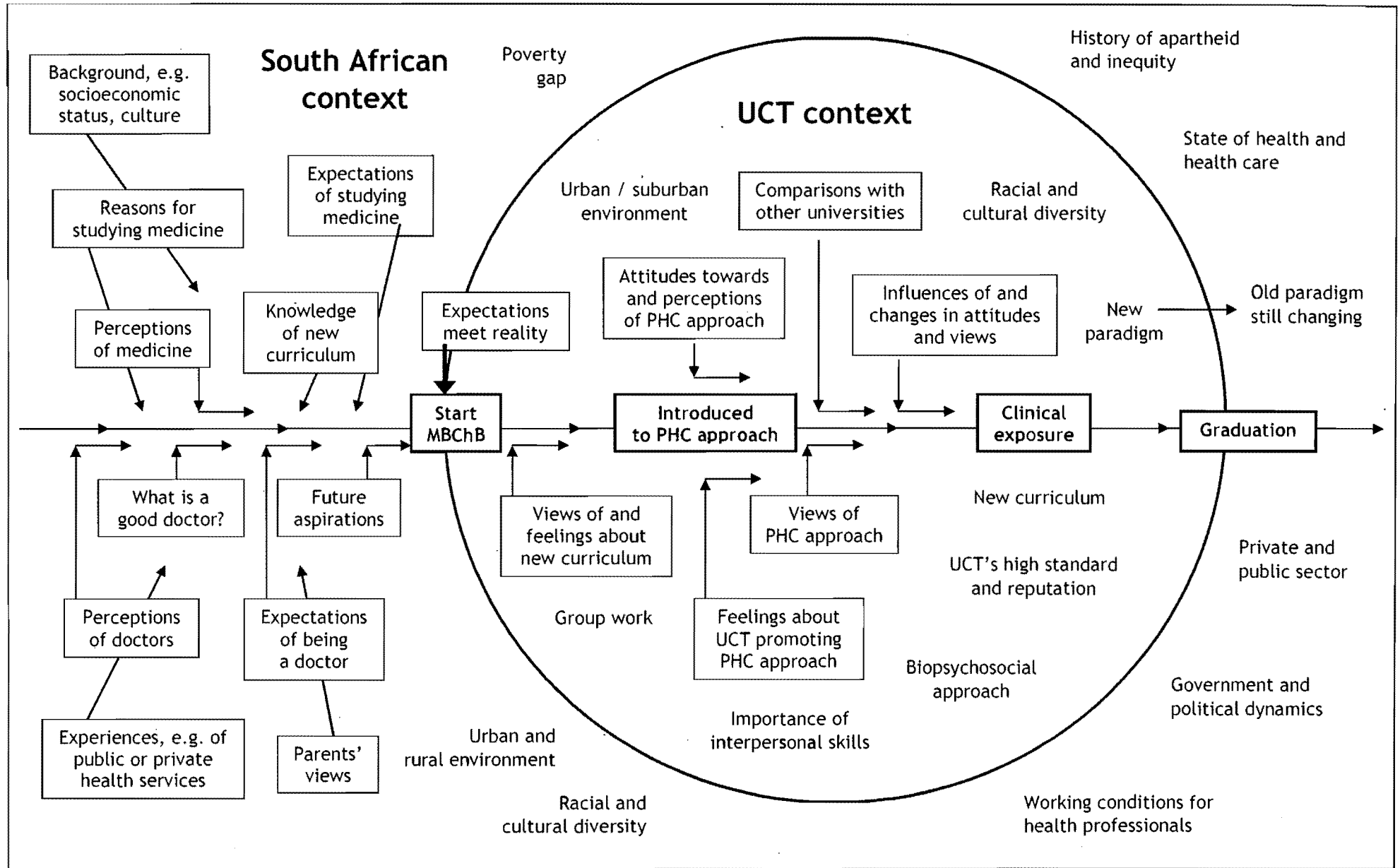


Figure 2: Into and through the journey of medicine

Theme 1 - What is medicine and what is a doctor?

&

Theme 2 - Why medicine?

“Being a doctor is not like being in ER, where you know...‘emergency, emergency’.

There’s a person underneath all that disease, there’s someone, a spirit who’s crying...there’s a person.

You have to look.” (set 4b)

“...the reasons why people are going into it are far more altruistic and far more wanting to help or wanting to make a difference...the majority are more people who are looking for other things than just the glorified career...” (set 4b)

Theme 1 - What is medicine and what is a doctor?

Introduction

As was discussed in the previous chapter, it is important to gain some insight into the perceptions that medical students have of the career they have chosen to enter into. What this section will address is how students perceive the medical profession, what they think of doctors as professionals, and what they expect of being a doctor. Figure 3 shows how these three issues are all distinct yet interrelated and interlocking.

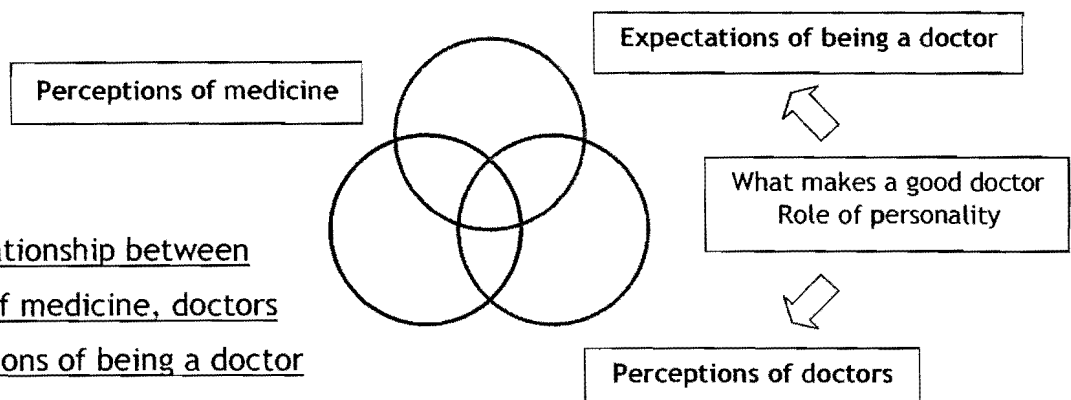


Figure 3: Relationship between perceptions of medicine, doctors and expectations of being a doctor

Students' perceptions of the medical profession give an idea of the socially constructed views that are held about this profession, and it is likely that these views draw on existing stereotypes, prototypical characters in the media, and possibly societal role models that students have been exposed to. Students' perceptions of doctors could be impacted by their perceptions of the medical profession, but are more likely to be based on their own experiences with individuals they have had contact with. It is quite feasible that because their perceptions of doctors will be for the most part based on the individual, they could differ from their perceptions of medicine, as these are derived from the general. Students' expectations of being a doctor are then a personal application of these perceptions, as they will adapt and adjust these perceptions in order to obtain congruency between their experiences, who they are, and what they think and expect a doctor to be.

As the diagram indicates, students' views of what makes a good doctor as well as the role that personality can play in shaping the type of doctor one will become are also issues that fall under this broader topic, and these will also be addressed. Lastly, students' expectations about the content of their medical degree will be explored, and these also relate to students' perceptions of the medical profession as one would assume that views of what a profession will entail are strongly linked to expectations of the training one receives for that profession.

Theme outline

- Perceptions of medicine and doctors, expectations of being a doctor.
 - o What makes a good doctor?
 - o The role of doctors' personality.
- Expectations of studying medicine, with regard to content.

Perceptions of medicine and doctors, expectations of being a doctor

These were explored quite extensively in the first set of interviews and focus groups with first-year students at the beginning of their first year, and so would provide quite a good idea of these perceptions and expectations before the students have been that strongly influenced by their exposure to the curriculum. These perceptions and expectations were also dealt with to a lesser extent in the other sets of interviews and focus groups.

On the whole, students seem to have a generally positive view of medicine as a career, and this is to be expected as medicine is the career they have chosen to pursue. Words such as “fulfilled”, “interesting”, “satisfaction” and “rewarding” definitely highlight this positive view:

“I see myself enjoying it...getting a lot of satisfaction out of it.” (set 1)

“...medicine is a rewarding career.” (set 4c)

Some students do admit to having a negative view of medicine or a negative impression of doctors, although these views do not seem to have put them off entering the medical profession, thereby showing an inconsistency between perceptions of medicine and perceptions of doctors. A student with a negative view of doctors has based this impression on his own interactions and experiences with doctors, and this impression has clearly not altered his perception of the medical profession enough for him to choose another career path. Another student with a “bad view of the profession overall” shows that negative perceptions of medicine and possibly doctors as well may exist alongside a belief in one’s own ability to resist conforming to those perceptions. In spite of this “bad view”, this student must surely see some potential or capacity for something good within the profession, otherwise she would have opted to study something else.

“...I had a bad view of the profession overall, but I still wanted to do it...” (set 3)

Many of the students’ comments seemed to imply a rather biomedical view of medicine, one that entails studying the human body in order to be able to cure it if it becomes diseased, and that does not include things such as psychosocial issues, working with communities, and expressing one’s feelings. From some of their responses, it is evident that they are grappling with the term ‘medical’ and what it includes.

“...we came in here thinking we are just going to cure stuff...” (set 4c)

“...all the psychosocial stuff...it is medical, I know we’re always being told it is medical, but it doesn’t feel medical yet.” (set 1)

However, other comments suggest that their view of medicine and doctors went beyond the biomedical and that psychological, social, and even spiritual dimensions needed to be considered, making medicine an increasingly complex term for some.

“...I’ve always thought it’s a scientific profession and so on, but now it’s more kind of in a sense almost spiritual.” (set 4a)

Some students also highlighted a number of interpersonal skills, such as empathy, listening, openness, communication, compassion and general social interaction, that they felt were part or should be part of being a doctor, hence further broadening their view of medicine from the purely biomedical.

“Someone who cares for people and who empathises with them.” (set 1)

“...your social skills need to be better than if you’re an accountant...if you can’t talk to a person, how are you going to be a good doctor?” (set 1)

One student expressed the assumption that what was being taught in the curriculum regarding interpersonal and intrapersonal skills was something that automatically went with being a doctor, confirming that these types of skills already formed part of her perception of doctors.

“...everything we’re getting taught in Becoming a Professional I already see in a doctor, so I just sort of assumed that would be the way we would turn out.” (set 1)

Some students admitted that their views of medicine had changed since they had started studying medicine, and that this change was generally from a more biomedical, curative view to a more holistic view that incorporates the psychosocial aspects. One student also commented on how the “glamorous” view of medicine is not upheld in reality.

“...I thought that you are going into medicine and it’s a profession where all this medication’s being discovered and you are just there to learn how to dispense it and how to give it. But now...we are finding it is not only about the right medication, it is also about learning about the people...” (set 3)

“...you get to see, after being in hospitals and in the programme and everything, it’s not quite as glamorous as it’s made out to be.” (set 4b)

Many students emphasised the role of doctors in helping people and caring for people, and this aspect of the doctor’s role suggests that medicine is a profession in which one has the opportunity to help and care for people. On what level this ‘help’ and ‘care’ will take place is not clear, but these are words with connotations that go beyond merely fixing people’s bodies and making patients better.

“...number one is helping people, definitely.” (set 2)

“...caring about patients.” (set 1)

Some students highlighted the ability doctors have to impact people’s lives and make a positive difference in their lives, and this could take on different meanings for students and doctors at various stages of their careers. For first-year students, this ability could be felt as an ideal to be able to “save the world”, whereas for qualified doctors, and older doctors in particular, this could be a means of control and power that doctors can have over their patients.

“...it’s something that allows you to take charge and not control, but play a leading role in someone’s life.” (set 4c)

“...people still perceive doctors to be paternalistic and to tell them what to do...” (set 4c)

Although many of the perceptions and expectations mentioned above could be seen as falling within the PHC approach, no students mentioned anything about the PHC approach as part of a career in medicine. When asked specifically if this approach featured in their expectations, students admitted that it did not, and one fourth-year student recalled her initial impression that being trained in the PHC approach would not qualify one as a “proper doctor”.

“Like even in my first year...they were going to train us in the primary health care approach and I was like ‘what, we were not going to learn how to be proper doctors?’” (set 4c)

The view presented thus far of medicine and doctors seems rather rosy, but some students did acknowledge the fact that medicine is a challenging career, one that is demanding of your time and emotions, and one that requires dedication. One student even described medicine as “a life”, rather than “an office job”, and this comment could be depicting medicine as some kind of ‘calling’, or as the type of job that is difficult to leave behind at the end of the day. In addition to these challenges and demands, many of the students do see the more difficult aspects of medicine and acknowledge that it is a career that involves long hours, hard work, a disrupted family life, frustration, stress, tragedy and difficult choices that will need to be made.

“...you really have to work hard for your money. You have to get your hands dirty. It’s not a glamour like job, you really have to work, and it’s emotionally stressful also because you see people suffer all the time and it has an effect on you...” (set 4c)

In spite of these difficulties, there still seems to be a high regard for doctors, and many students did mention the status, esteem and prestige that are associated with the medical profession. Students did not go into detail about why this is so, but possible reasons found in some of their responses were doctors' ability to cure and their assumed possession of the "answer to your problems", as well their high level of expertise, which is not clarified, but could be referring again to their ability to cure and heal.

"...you always see a doctor sort of as a superior figure because they have the cure and the answer to your problems." (set 1)

"...the height of human expertise." (set 1)

Along with the status and respect, some students also mentioned the financial benefits that go with being a doctor, and students' comments along these lines do seem to fit at certain points on a spectrum. At the top, 'glamorous' end, doctors are perceived to be wealthy, high income earners. At the lower, more possibly practical end, doctors are expected to be financially stable, and able to make adequate provision for their family and other needs. From the students' comments, it would seem that doctors can potentially fit at either ends of this spectrum or somewhere in between, as having financial security and stability could have a range of meanings for different students. However, it would seem that the perceptions of status and wealth may be undergoing some change. This shift in perception appears to be instigated by the impression that doctors are no longer paid so highly, thus making medicine a less financially lucrative field, but it also seems as if more altruistic motivations are taking precedence over aspirations of wealth.

"You'll be able to provide for your family, education and all that" (set 4a)

ER (a television programme based on a hospital emergency room in the USA) was mentioned on a few occasions as something that could be shaping students' views of the medical profession, and possibly feeding into the glamorous ideal mentioned earlier.

"It's like the impression you get of things, like if you watch ER...I think it's the impression you have and what you're expecting." (set 1)

The characteristics that make a good doctor were also discussed with some participants, and those characteristics mentioned seemed to depict quite a holistic doctor. Students did mention the importance of being knowledgeable, clinically competent, confident in

one's abilities, aware of one's limitations, and having a willingness to learn, but these were generally mentioned alongside a range of other intra- and interpersonal skills that were deemed important. On the more 'human' side, a good doctor was described as reflective, self-aware, humble, caring, compassionate, empathic, non-judgemental, understanding, able to listen and communicate, sociable, aware of professional boundaries, and able to recognise the psychosocial factors that impact on their patients.

"...be informed and researched...it's very important also to be what we're learning in BHP, being compassionate, empathetic, be understanding, be aware that your patient doesn't just come to you with a disease, that there's a whole history behind it and other factors influencing it in society." (set 2)

A few students did mention the difficulty of pinpointing the most important characteristics, and also noted that these characteristics could depend on the type of doctor (in terms of specialty). These comments do lead one to consider what is actually meant by a 'good doctor'. Is it a doctor that is able to save lives? In which case, one would probably want to see a doctor who can diagnose the life-threatening illness and prescribe or administer the right treatment. Or is a 'good doctor' someone who deals with the everyday issues that are probably not life-threatening? If this was the case, then surely one would value those characteristics that make those everyday types of interactions more pleasant?

"I would still rather have a doctor with no personal skills who is actually able to diagnose to a 'T' what's wrong with everyone. They are going to save a lot more lives than someone who's able to talk." (set 4c)

"...I would rather have a doctor that was good across the board but...I felt comfortable with, and I didn't mind going to see, I wasn't scared of, I could ask questions to, and they were interested...but you can't have one thing." (set 4c)

Most groups of students recognised the role that personality can play in shaping the type of doctor one will be, and interpersonal skills in particular were not seen by some fourth-year students as something that one is able to teach, but that students either had these personal qualities or did not.

"...ultimately your doctor-patient relationship and your communication skills is a personality thing. You can get taught so much but a person's bedside manner, that's a personality thing." (set 4c)

Some students pointed out character traits that they felt would not be fitting for a doctor, or that would need to be worked on, and these included arrogance, a feeling of

superiority, a short temper, introversion, financial motivation, indecisiveness, a lack of dedication, being influenced easily, and a difficulty with interpersonal interaction. Character traits were also mentioned that could be seen as more suitable for a doctor, and many of these echo the qualities of a good doctor: a desire to help and care for people, patience, diligence and concentration.

“...people who think themselves superior...what they know is right and you can't argue with them because they're just stubborn and obnoxious people.” (set 2)

“...you need to have a caring heart...because a lot of the things you're going to be dealing with are things that, unless you really, really like helping people, you're not going to really want to do.” (set 2)

In addition to these mentioned above, many of the characteristics that were said to make a good doctor can be strongly associated with personality, thus affirming the role of personality. However, the first-year students with whom this was discussed more extensively argued that there is not one particular personality type that is suited to being a doctor and that it would not be possible for one person to possess all of the characteristics that make up a good doctor.

“I wouldn't go as far as to say that there are some personalities that maybe you weren't meant to be a doctor, or you were meant to be a doctor...Because I know that there are a lot of different people at medical school from different backgrounds, they have different personalities...” (set 2)

Some of these first-year students seemed to be of the belief that everyone has the potential to develop or learn these characteristics, and this would appear to contradict the assertion mentioned earlier that interpersonal interaction is largely determined by personality and cannot be trained. This difference of opinion is most probably due to the fact that these first-year students are only one semester into their medical training, and have yet to take what they have learnt about interpersonal interaction out of the classroom. Fourth-year students on the other hand have been exposed to clinical settings, and are likely to have observed fellow class mates interacting with patients, and this is most probably what they are basing their comments on. It would be easier to agree with these students that have been exposed more to the reality of doctor-patient interaction, however this could then nullify portions of the medical curriculum that aim to teach and develop these interpersonal skills.

“...you can always learn. Even if you're not the kind of person who is kind all the time, you can always learn to be a good doctor.” (set 2)

Expectations about studying medicine: Content

There were a lot of similarities between the groups of students regarding their expectations about studying medicine with regards to content. Most found the content of the curriculum contrary to their expectations, and on the whole, students were expecting a more biomedical, scientific and curative focus, and were expecting to learn more about the 'hard sciences', such as biology, anatomy, physiology, physics and chemistry. The term 'medical' appears in these comments, and it seems quite clear that students use this term to refer to these subjects just mentioned.

"...I came here to learn biology and anatomy...I had this perception that it's going to be like anatomy, anatomy all the way." (set 2)

"...a lot of us went into it thinking we are just going to learn how to cure diseases..." (set 4c)

Talking about their feelings and interviewing (part of the Becoming a Professional course) and the psychosocial component of the curriculum did not feature in many of their expectations of studying medicine, yet some students did feel positive about them, and have been able to accept them and see their value.

"I didn't expect it to be as well rounded as it is...I was just very surprised, pleasantly, when I saw that they were looking at the more social side of medicine, not just the biological side." (set 1)

"...this BP is very strange, but I'm starting to understand the relevance of it...the whole integrated approach, I think that's actually very good." (set 1)

However, some negative feelings were expressed regarding these other subjects, such as apprehension and frustration, while some recall feeling upset and even hate.

"...I was very upset about it, especially the BP things, psychosocial issues..." (set 2)

"I hated it, I was like so bored." (set 4c)

In addition to these less 'medical' features of the curriculum, learning about the PHC approach was also unexpected for many students, particularly for those who were expecting a biomedical or scientific focus.

"But when I came here I found out that there's a whole lot of other things going on...the primary health care aspect, that was quite difficult at first to accept because it's not what I expected." (set 3)

"I think if you come into medicine and you enter it purely as a science...then primary health care is very foreign..." (set 4c)

Conclusion

This section has explored the students' perceptions of medicine and doctors and expectations of being a doctor, taking into account what students view as a good doctor as well as the role of the doctor's personality and their expectations about the content of their medical degree. Their perceptions of medicine and doctors were generally positive, and through some of their descriptions of doctors, the medical profession is depicted as one that is very significant and influential, to the point of almost being noble. Even though some of the more challenging and difficult aspects of a career in medicine were mentioned, these seem to be rather inconsequential when compared to this portrayal of the medical profession as well as the status and wealth that have been associated with this profession, even if the association is no longer that strong.

Some students appeared to regard the medical profession as more biomedical and curative in focus, although there did seem to be a strong move towards a more holistic view, and this was also reflected in their opinions of what makes a good doctor. However, this shift had not occurred in students' expectations of the content of their medical degree as they expected their degree to concentrate on the biomedical and the scientific, and therefore did not expect particular components of their degree, such as the psychosocial. There was one similarity in their expectations of medicine as a career and expectations of studying medicine, and this was that the PHC approach did not feature in either of these sets of expectations.

Theme 2 - Why medicine?

Introduction

Students' motivations and reasons for pursuing medicine are a vital issue for investigation, as combined with their expectations of their training and their career, these can play an integral role in influencing how students receive the knowledge they are given, and whether what they learn and are exposed to in the medical curriculum fits into the world view that students enter medical school with. This section will look into these reasons and motivations, whether or not these reasons have changed, what has instigated this change, and whether or not these reasons and motivations are

compatible with the PHC approach. Students' future aspirations for once they have graduated will also be discussed, and these also help to give some insight into the students' motivations for studying medicine, but are perhaps more open to influence and change throughout the curriculum.

Theme outline

- Reasons for studying medicine, changes in these reasons, and congruency with the PHC approach.
- Future aspirations and how they relate to reasons for studying medicine.

Reasons for studying medicine

Students' reasons for and motivations behind studying medicine seemed to have stayed relatively constant over the years, with many students appearing to have been motivated by more than one reason. In their discussion of their reasons they have often mentioned why they think other students chose to study medicine, and these will be reported together. Many students expressed altruistic and more 'people focused' motives such as helping and caring for people, making a difference, and interacting with people. Some were motivated by needs they observed in their community, or by the need for doctors in South Africa, and one student seemed to feel a sense of owing and responsibility to South Africa because of the privilege he had as a white South African.

"Mine was just purely the whole caring idea and helping people and seeing people sick and dying and wanting to do something about it..." (set 4c)

"...I think there is a lot of need for it in this country, and because it's something I want to do and it needs to be done, I think it's quite a good reason to do it." (set 3)

From some of the students comments it is evident that the reason of helping people is seen as a rather common one, possibly then undermining it as a genuine reason for some students or making it the reason that everyone provides instead of their 'real' reason, such as status or money. A few students felt that 'help' has become a misunderstood term, and that it has a deeper meaning than it is often not given credit for.

"...I've also been teased about my theory about helping people, and say 'but we all say that, but it doesn't necessarily mean it's true for you.'" (set 2)

"I think it is quite sincere. I think people start corrupting it...help means you make yourself out there, help, it's not just 'oh, let's help across the road', help is...you want to be an active person at that moment, that's a big thing to do..." (set 4c)

Apart from the more altruistic motives, a large number of students cited an interest in sciences, biology and the human body as a reason for studying medicine. Linking back to the previous section, this reinforces students' perceptions of medicine as having a strong biomedical component, as well as their expectations regarding the content of their curriculum.

"I was always fascinated by the human body." (set 4a)

The fact that medicine is a good academic choice was a reason for some, although it is apparently no longer a typical reason, but the implication of this is that medicine is an academically challenging degree. This could also be implying that doctors are intelligent, but this is not a perception that the students mentioned overtly.

"...it's no longer...the typical reason for doing medicine which was if you got really good marks, which were the top degrees to do, and it was engineering and medicine, and that proved that you were going into a high income bracket and you were really intelligent." (set 4b)

Some students mentioned family as playing a role in their decision to choose medicine, and this ranged from receiving pressure from parents or grandparents, a desire or pressure to be the first doctor in the family, or exposure to doctors within one's family that inspired or sparked a desire in them to become a doctor.

"...the fact that there is no doctor in our family also, that also inspired me to become a doctor." (set 4a)

"...my dad's a doctor, and so is my dad's father, and from what I've seen of their work and everything they've accomplished really inspired me to go and learn about it..." (set 1)

Other students were motivated by their interaction with or positive experiences of doctors and other health professionals, or by exposure to a clinical setting that triggered the desire in them to do medicine and awoke them to the need that something needs to be done. A few students spoke about how someone close to them had experienced illness, injury or death, and that this had motivated them to study medicine, either because of poor quality of health care they observed, the feeling of wanting to be able to do something for them, having increased exposure to a health setting, or because an individual they encountered in this experience had inspired them.

"...my grandfather was in hospital, and so I want to really help him. I feel like kind of helpless because I don't know anything about this...so I really want to study medicine." (set 1)

"...when my mother got ill...I hated doctors then, I hated hospitals. But there was this one doctor that would make you want to do medicine...he's the one who actually made my mother to come home. So he motivated me in a way..." (set 2)

For two students their desire to do medicine seems to be specifically linked to a particular specialty, and both of these students stated a desire to follow a career in specialties that are mostly laboratory based or research oriented.

"I wanted to do pathology, forensic pathology...I didn't do biology at school, so my only way of getting into pathology was to do medicine..." (set 1)

Some students claimed to have had a desire to study medicine since they were very young, and that medicine has been the only career that they have considered doing. These reasons must then draw on these students' perceptions of medicine and of doctors at a young age, and could very likely be based on their personal experiences of doctors or the experiences of those close to them. One student's comment that her desire to do medicine was 'instinctive' almost implies that a career in medicine is predetermined, that it is part of you, and that one does not decide to do medicine, but rather you discover that it is what you always wanted to do.

"...medicine was the thing I could see myself doing more than anything else..." (set 4c)

"...I've always wanted to do it instinctively from when I was younger..." (set 1)

Status and financial gain have already been discussed in relation to perceptions of medicine, and these were argued to be the motivation for many others to choose medicine. The majority of those to which these motivations were attributed to would fit somewhere at the top end of the financial spectrum that was mentioned in the previous section. Some students did mention status and/or money as being a reason they chose medicine, and this was often in relation to job or financial security, located somewhere near the lower end of this financial spectrum.

"...even subconsciously they don't even realise it maybe that that's actually the reason, because it's very prestigious, everyone respects..." (set 4b)

"I think the security of always having a job, I think that was most important. Secondly, I would say it's probably the security for finance..." (set 2)

It would seem that the view of doctors as wealthy and prestigious seems to be fading, and this seems mostly due to the fact that doctors are seen to be earning less, at least in South Africa, and that medicine as a career has become more difficult. Students did not go into why the status of doctors has declined, but one student suggested that they are seen as “lunatics” in South Africa, possibly because of the difficult conditions that many doctors are reputed to work in. Another likely reason is that status may be associated with wealth, and that should the wealth of a certain profession start decreasing, then the status of this profession may diminish as well.

“...now I think most people who do apply would now be people who want to actually become doctors and want to help because it's got much tougher and it's not as well paid...” (set 1)

“It used to be like that before...I think it has changed and I don't think doctors are seen as status symbols as much as they were before...” (set 4b)

Students did mention a few other reasons for choosing to studying medicine, and a number of these rest on the perception of medicine as a challenging career as well as the expectation that they will be able to take on a leadership role as a doctor. One student also felt that a career in medicine would enable her to “make discoveries.” A few students also admitted that their original reasons for going into medicine have changed since they have been at UCT, and this change generally seemed to be in a more positive direction to include more altruistic motivations.

Students who had been introduced to the PHC approach (that is, 2nd, 3rd and 4th years) were asked whether or not their reasons for studying medicine fitted into this approach. Some students stated that they did not, especially if one went into medicine with a scientific or research focus, while others students maintained that there was compatibility between their reasons and the PHC approach, even if it took a while to realise this. The reasons that seemed to be more compatible with the PHC approach were helping people and making a difference, and it would seem that for some students, the PHC approach may provide a means by which such motivations can be acted on. For some, the PHC approach reinforced their initial motivation to help people and communities and to make a difference, and a few students remarked on how being exposed to the PHC approach has challenged their reasons, on an individual and more general level, encouraging them to broaden their perspective.

"It wasn't initially, but I think that's since changed...You want to make a difference but you don't really know where and then you actually realise where you can..." (set 4b)

"...my main reason was to help people and it has actually motivated me more to become a doctor, this primary health care approach, because you're improving the community...in this way you help people on a...greater scale. So that is even more rewarding at the end of the day." (set 3)

The fact that students discussed both their own reasons for studying medicine as well as what has motivated others to study medicine, indicates that at some level, students could be comparing their own reasons with those of others. It is worth mentioning that at some level, students may be assigning the more altruistic motivations to themselves and claiming that these do not apply to others, and assigning the supposedly more selfish ones to others. A few students even went so far as to use the label of 'right' reasons, and applied this label to "caring" and "wanting to help".

"...I didn't plan on being like one of those rich doctors who study to earn money." (set 3)

"...most people don't think about it as helping people." (set 4b)

Although this label is not applied to many other reasons, one could reasonably imagine that the altruistic reasons mentioned at the beginning of this section could be regarded as 'right', whereas motivations of status and money would not be regarded as 'right'. However, by saying this, one returns to the financial spectrum discussed before, where very little, if any distinction is being made between aspirations of wealth associated with luxury, and aspirations of financial stability that enables one to live free of financial stress in an economically volatile age and environment.

Future aspirations

The issue of future aspirations was discussed with all student groups, although in more detail with some than others (set 1 and 3). Besides the extent to which these were mentioned, there were no major discrepancies between the aspirations of the different groups, their main commonality being the range of these aspirations. Students across all groups also seemed to have similar perceptions of working in the public sector, but this will be discussed in a later chapter.

A number of students mentioned where they would like to work in the future, and this ranged from returning to one's home community, to staying in Cape Town, South Africa

or somewhere in Africa. Motivations for staying in South Africa and Africa seem mostly to do with a desire to help and bring about positive change. One student was motivated to stay in South Africa because of her love for the country, while another student was adamant about staying in Cape Town, also because of his love for the city and the fact that it is his home.

“...definitely end up in this country...I want to help this country...” (set 4c)

“...a lot of my career I'd like to spend in Africa, not necessarily South Africa, working in communities that are so disadvantaged.” (set 1)

One student expressed his concern about doctors fleeing South Africa on graduation, yet despite his concern, students did not express a strong desire to leave South Africa, at least not permanently, and most of those who did want to go overseas were motivated by a desire to travel or to gain experience and planned to return to South Africa, with only a few citing reasons of financial benefit and comfort.

“...lots of people do want to practise overseas...just to travel and things like that, I don't think they want to settle there long term. It's not to skip things in this country, its just to do something else, get out for a while, especially if they haven't travelled before medicine, I think that's quite a big thing.” (set 4c)

The issue of working in rural areas is a pertinent one, and was raised quite frequently, the students' feelings varying greatly on this issue. While some expressed a desire and willingness to work in these types of areas, others felt this was not something they would want to do and not something they should be forced to do, even if they are aware of the need in these areas. Students' motivations for wanting to work in rural areas ranged from wanting to provide services for those where there are not any, to the outdoor lifestyle that can be enjoyed. The reasons students did not want to work in rural areas include the isolated lifestyle, and a preference for and familiarity with an urban environment. One student did mention the fact that if attractive incentives were given to work in these areas, more people would be willing.

“...probably to go practise in the outstretches of South Africa, like in the rural areas, where I know that maybe there aren't any available doctors, possibly to go help out where I can...” (set 2)

“...it's just that I've lived in an urban area all my life, I'm used to having the stuff, like facilities around me. I don't see myself out there, nothing to do, the hospital is your life all the time...it's very different to what I've been exposed to...” (set 4c)

Possible reasons for students' reluctance are the poor working conditions at facilities in rural areas and the fact that they feel doctors in these areas are overworked and underpaid. These students seem to be under the impression that working in rural areas means far less resources and equipment and far more responsibility than they would choose to work with.

"...some of the people that have done their community service in a rural area, they end up running the whole place, seeing every single person and they don't have the resources or the medicine or anything to really treat half of the people they see..." (set 4a)

The dominant impression some students have of those who want to go and work in rural areas is that these students are originally from a rural area and want to return to and help their own community. One student added that these people that would go to rural areas are very compassionate, implying that this compassion would need to motivate one through the difficult working conditions. Other students however, challenged this assumption and argued for why students from rural areas might not want to return. Reasons they put forward were that returning to a rural area after training to be a doctor could be seen as a 'step back' in one's progress in life, and staying in an urban area may be more convenient and appealing once one has become accustomed to the urban way of living.

"...the people that are most likely to go and work in such areas are those that either grew up there, or people that have just a lot of compassion for human kind, not to say that someone who chooses to work in a city doesn't have compassion..." (set 4b)

"I think once you come to Cape Town you get used to the Western life. You get new friends, you speak in a different way, you dress a different way, and it feels good, it's up the market, you're watching TV...you think, 'I want this car'. And then you go back home and you see all those things and you think...'oh, they're slow!'...you think, 'I'm not going to go back there', that's why." (set 4b)

Apart from where they would like to work, some students also mentioned the type of facility that they would like to work in, in the future. There seemed to be relatively even spread of those wanting to work in hospitals and those wanting to work in clinics, although some students, when speaking about their class in general seemed to feel that people would choose to work in a hospital over a clinic, possibly because of more difficult working conditions and fewer resources associated with smaller facilities. One student did feel that a smaller clinic would be more conducive to developing relationships, whereas another student pointed out that a hospital is a better learning

environment. Most of these comments suggest that these students are not especially rigid in their preferences, and some have said that they do not really mind where they work. For one student, the type or size of the facility seemed less important than the presence of other health professionals, and this could relate to what was raised earlier about the increased responsibility that doctors in rural areas are perceived to have.

“...I can’t speak for the whole class...many people don’t want to work in clinics...very few people in our class when they graduate want to run out and work in a clinic.” (set 4c)

Students also discussed whether or not they would like to specialise, and this was discussed more specifically with set 1. Despite the fact that the issue was not raised with the other groups, it still did not seem to be something that was at the forefront of their minds. No students were adamant that they would not specialise, and many expressed a desire to specialise, the prevailing view among these students being that this is a decision that needs to be made after one has been exposed to the range of options, and that one might not want to continue studying anymore after six years.

“I want to specialise, but I think as we go through the course...there’s so many things that you could do and by the time we’ll be finished there’ll be more...” (set 1)

“I always imagined myself specialising like after internship...these interns told me that after six years of studying and two years internship...you don’t want to study anymore.” (set 1)

Many students stated the specialty that they or others were interested in, some giving an explanation of why this particular specialty appealed to them. Gynaecology, paediatrics and neurosurgery were the specialties most frequently mentioned, followed by surgery, dermatology, orthopaedics, chemical pathology, forensic pathology, plastic and reconstructive surgery, immunology, cardiology, psychiatry, anaesthetics, sports medicine and radiology (from most to least frequency mentioned). Explanations of why these specialities are popular were varied, and include where the students’ interests lie, the challenge they present, their financial reward, the lack of stress or working hours involved, how fascinating they are, the need for certain specialists, what is currently being taught in the curriculum and who is teaching it, and the level of associated risk, mentioned with specific reference to HIV.

“There’s neurosurgery...there’s a lot of money in it...” (set 1)

“I think people are getting into more non-gory type of specialisations...I think the AIDS things...like dermatology, not too far at risk...” (set 1)

Some first-year students gave their opinion and the general perceptions of some of the specialties, and it would appear that those specialties that are able to help people more, deal with serious problems, and perhaps even save lives are seen to be “more noble”. Other students pointed out that money and comfort are the factors that influence most people’s decisions about specialising, and it is possible that those specialties most strongly associated with high incomes and an easier lifestyle could be perceived to be less ‘noble’ than those which are demanding and require more sacrifice.

“...some seem less helpful than others...they all have their place, but some seem almost more noble, like they help more. Like people have more serious problems that they come to you with...” (set 1)

Whether to work in the public or private sector was also a subject under debate, and throughout all groups, there were a range of responses, with a number of students expressing a desire or considering the possibility of working in both sectors. However, most students do not specify what level they would like to work at, that is, primary, secondary or tertiary.

“I have a big desire to work in the public sector, I always have ...” (set 4c)

“...I’m going to go to a private practice or a hospital, private hospital.” (set 4b)

With regards to their future aspirations, students spoke of a number of positive and negative influences on these aspirations, although there was some debate around students’ vulnerability or immunity to influence by the time they reach university. One student argued that students are vulnerable to influence, but another student felt that by around second year, most students have made up their mind what they want to do and that their beliefs and ideas are not likely to change.

“I personally think that we’re all pretty vulnerable to influence...I don’t think we’re all as strong as we’d like to be and we would totally not be influenced by what we’ve seen.” (set 4a)

“...in general, people have their belief system by now, we’re like...nineteen, twenty years old...people know where they want to go and what they want to do...I don’t think introducing them to PHC and taking them to the townships is going to make much of a difference to them...” (set 4a)

Influences on future aspirations that were mentioned were background, being introduced to the PHC approach, having to take care of family, financial need, personality, the governments’ treatment of doctors, exposure to public sector facilities during the curriculum, working conditions in public sector facilities, a love for South

Africa, and their involvement in certain academic activities, such as a community health promotion project.

“...you’ve seen like primary health care that’s really shown you some shots of where you could be, where you could be positioned so that you could actually help a lot of people...” (set 4a)

“...different personalities, different people, what conditions they want to work in...for a guy, if they want to support families and their wife’s not working...I think circumstances are going to dictate to all of us where we’re going to work.” (set 4c)

Other general comments were made by students on their future aspirations as well as the aspirations of others in their class, and these once again illuminate the diversity of views within the student groups. These aspirations range from working in a refugee camp, campaigning and community work, to research or politics, to specialising and going overseas and working in a developed country. One student, and there may be others, came across as nonchalant about the future, and is willing to see what the next few years hold.

Related to their future aspirations, some students also spoke about their desire to make a difference and bring about positive change in the health system in South Africa, and while some felt that bringing about change was idealistic and that it would only be able to take place on an individual level, others were particularly motivated to do what they could in the hope of motivating others to do the same.

“...you as a person are not going to make that much of a difference. Maybe you’ll make a difference to those people’s lives how you treat them, but on the grand scale, unless you’re going into a powered position where you’re making decisions...” (set 4a)

“...I don’t feel that I can change South Africa, or as medical students we can change South Africa. But I do believe in investing myself in a particular community and then make a small difference there...” (set 4a)

Conclusion

This section has looked at the range of students’ motivations to study medicine, how these may have changed and whether or not they are congruent with the PHC approach. What has been reported on students’ motivations seems to paint a rather positive picture of the students entering medical school and the future doctors that are to be produced. A large number of students express a range of feelings around biology and the human body, from interest to fascination, and although these reasons are prolific,

the more altruistic reasons do seem to overshadow these. In addition, the seemingly self-serving reason of financial gain seems to no longer feature strongly, and students do mention that in absence of this benefit, motivations should and do lie elsewhere.

It is encouraging to note that, considering the pre-eminence of the PHC approach in the UCT MBChB curriculum, many students find that their reasons for entering the field of medicine are largely congruent with the ethos of the PHC approach and that for a small number of students, the PHC approach reinforced their original motivation. Although only a few students speak of changes in their views, some because of the PHC approach, this nevertheless reveals that change is possible, and that students' original motivations when they arrive at medical school are open to be challenged and broadened by the time they enter their professional career as a doctor.

This section has also addressed students' future aspirations regarding where they would like to work, the type of facility and the sector they would like to work in, and whether they would like to specialise. Influences on these future aspirations were also discussed. Students mentioned a wide range of aspirations, and there appeared to be no predominantly popular or unpopular choices, other than the majority of first-year students (in set 1) expressed a desire to specialise. As was mentioned previously, future aspirations were not a major feature of focus group discussions with other groups, and the reason suggested for this earlier was that it was not explicitly raised in the discussions.

In addition to this, it is possible that the further students get into their studies, the less overtly concerned they become about issues such as where they will work and what they will specialise in, as they may focus more on what they are currently experiencing, and these current experiences may be more prominent in their minds. Due to their exposure to a PHC driven curriculum, which in line with the PHC approach would be aiming for the production of generalists as opposed to specialists, students may not have been encouraged or seen the necessity to choose a speciality. Students did say that choosing a specialty is difficult when one has not been presented with all the options, so as students are exposed to more specialties of medicine as they progress through the curriculum, they may realise that this is a decision and an issue that can be addressed and decided on at a later stage.

Theme 3 - What is PHC?

&

Theme 4 - PHC: for and against

“Sit back, think about what they’re actually trying to achieve, this whole thing, and don’t miss out the big picture...you read a theory over and over, you don’t understand what it means, but get the context rather and the rest will flow, and when you see it practically you will think ‘oh, so that’s what they meant by community participation’...” (set 4c)

“...I think everybody is positive towards the approach because the approach is like a perfect theory. I can’t see why anybody would have a negative attitude towards the approach because it is so perfect. Like how else could it be better? I mean accessible...culturally acceptable... nobody would disagree with those principles.” (set 4c)

Theme 3 - What is PHC?

Introduction

Before looking into the students’ attitudes towards the PHC approach, it is necessary to find out what the students think it is before finding out what they think of it. This section will address what they perceive the PHC approach to be in terms of how they refer to it and describe it, as well as their understanding of the PHC approach and the factors that have influenced this understanding in either a positive or negative way. Before looking at these issues, the issue of students’ awareness of the PHC approach prior to coming to UCT will first be addressed.

Theme outline

- Awareness of the PHC approach prior to studying medicine.
- Perceptions of the PHC approach.
- Understanding of the PHC approach, what has helped and hindered understanding.

Awareness of the PHC approach

Among most student groups there seemed to be a general lack of awareness of the PHC approach prior to coming to UCT. A number of students claimed to have only heard about this approach when they came to medical school, while none stated that they were particularly familiar with the PHC approach before coming to UCT with only a few students alluding to limited knowledge.

“...until I came here I didn’t have an idea about primary health care...” (set 4a)

This lack of awareness would seem to tie in with limited awareness of the PHC approach on the part of society in general, and some students remarked on the fact that the PHC approach is not “out there” - it is not portrayed in the media, and does not seem to be part of society’s general knowledge. Those mentioned as being unaware include the population in general, parents, and the president, and one student asked if the president is not talking about it, then how will the man on the street find out about it?

“...it wasn’t put out there. You don’t see it in the movies, you don’t see it anywhere...I wasn’t surrounded by people who emphasised the need for primary health care...” (set 4b)

“I haven’t heard the president talking about primary health care so if it hasn’t gone to his level, then I ask myself, has it got through to the ‘lighty’ in Hanover Park?”* (set 4a)

Considering that a large number, if not the majority of students enter medical school with little to no awareness of the PHC approach, it would be reasonable to assume that at the start of their first year, these students are essentially ‘blank slates’ in terms of their PHC knowledge. This could then imply that their perceptions and understanding of the PHC approach are strongly influenced by what they are exposed to during their time as medical students, which is mainly the curriculum.

Perceptions of the PHC approach

From the manner in which students refer to PHC, it would seem that the two dominant perceptions of PHC are PHC as an idea and PHC as an approach. Students also referred

* ‘Lighty’ is a South African colloquial term for a male child, adolescent or young adult. Hanover Park is a low socioeconomic area in the metropolitan area of Cape Town.

to PHC as a concept, a theory, a system, a strategy, a scheme, an ideology, a philosophy, and a lifestyle that doctors should be living.

"I think it's a brilliant idea...a good idea." (set 3)

"...it's a very important approach..." (set 4a)

A couple of students described PHC as something different and unconventional, and these characterisations are possibly drawing on their association of the PHC approach with the new curriculum, which is different in its approach, and they may also be contrasting it with the more traditional biomedical approach. Others referred to PHC as foundational, far-reaching, and something that encompasses the full scope of health care, right from the basic through to the top level of care.

"It's definitely a different approach." (set 4a)

"...what primary health care is trying to do is to try to sort of spread the medical field further..." (set 4b)

Some students also characterised PHC as a lot of common sense, less concrete, less scientific, and less academically rigorous, probably in comparison to other subjects such as anatomy and physiology. However, one student maintained that in spite of this, it is still something that should be included in the curriculum, and another student argued for the scientific foundation of primary health care and countered the notion that it is "new age". The term 'new age' has a whole host of connotations, but in this context seems to imply something based on little scientific evidence, and something more humanistic and possibly nebulous.

"...it's not that scientific...you can't gauge it...I don't suppose you can really test your knowledge on primary health care..." (set 3)

"...when you actually read the facts you realise that there is evidence backing this up. It's not sort of like this new democratic, new age like idealistic thing. It comes from a scientific basis..." (set 4a)

Other students perceived PHC to be an approach more suited to developing countries or possibly poor settings, although a few students have realised this is an incorrect characterisation of the approach, and one student remarked on how PHC can in fact help to reduce the disparity between the rich and poor.

"...it just seems like to a lot of people like cheap health care...something for the poor people in the country...my understanding now is that it is not really about your wealth..." (set 3)

"I think primary health care is attempting to make that gap between those that are very affluent and those who are really like not doing so well in this country, to sort of make it a smaller gap." (set 3)

Somewhat related to this, there did not seem to be a consensus on whether PHC is an approach for generalists or for specialists as well, and the assumption that specialists do not need or use the PHC approach was identified as an incorrect one as it indicates a limited understanding of the PHC approach.

"...some people want to become GP's...I think primary health care would help them tremendously, but a lot of people don't want to become general practitioners...I want to specialise and go into surgery, so the whole PHC thing, is it really going to help me that much?" (set 3)

"...it shouldn't just be for generalists, it should be for all health professionals...people who want to do neuroscience or whatever, I think it's a problem if they're feeling that they don't need primary health care, because every health professional should." (set 4a)

PHC had political connotations for some, one student in fact identified communist elements in the approach. These perceptions signify that these students are seeing that health care goes beyond the interaction between doctor and patient, and that there is an ideological component to the PHC approach.

"...it takes its ideals kind of from communism." (set 4a)

The common misconception of PHC as primary care came through on a few occasions, and one student mentioned the association between PHC and rural medicine and that the PHC approach is not often associated with tertiary health facilities.

"The moment we see primary health care, I don't know, for some reason our mind just says rural. You don't think tertiary hospitals..." (set 4b)

My own impression as the interviewer and focus group facilitator was that at times, when students were speaking about PHC, they were speaking about the new curriculum, and that for them, the line between these two is somewhat blurry. This impression emerged in some of the students' comments:

"Does PBL necessarily mean PHC?" (set 4a)

"...we don't get many lectures and then half of our lectures are primary health care, but they're actually not though, I think what people perceive to be primary health care..." (set 4b)

Understanding of PHC

Based on the observation made above that students' perceptions of PHC are generally accurate, it follows then that their understanding of the approach would be reasonably good. This however cannot be presumed, thus making it necessary to look at their understanding in more detail.

A small number of students commented that PHC was not simple or easy to understand, and described it as complicated and difficult, although one student felt the opposite, maintaining that it is an easy thing to understand.

"It's just not an easy concept, it's just not clearly defined, it's not something you can just take hold of, internalise and then you've got it." (set 4a)

"...it's quite an easy thing to understand and to learn..." (set 4c)

In terms of their knowledge about the PHC approach, many students seemed comfortable with, and in one case surprised at the amount of knowledge they do have, although some seemed to feel this knowledge is to some degree incomplete, not extending that far beyond the definition of the PHC approach.

"...we found that we were learning while we didn't realise it...we were all afraid...would I know? But many of us, we actually knew, we were quite surprised at the end of the day....I feel great confidence in the concept of it..." (set 3)

"...when people speak of primary health care, and you ask people about it, basically what they do is regurgitate the definition..." (set 4a)

A number of students seemed confident in their understanding of the PHC approach, and described their understanding as "good" and "deeper", while others claimed to have an "average" or "basic" understanding, or felt that the understanding is there, but that it is more theoretical than applied.

"...it's more ingrained in us, the concepts of primary health care...I think we do have a deeper understanding of it..." (set 4c)

"I think a pretty good understanding. It should get better as time goes on as we apply it and put it into practice, but I think right now it's still just a lot of theory, not enough exposure to the application." (set 4a)

Some also remarked on the limited nature of this understanding, admitting that they have not internalised the knowledge they have of the PHC approach, or that they have a general but not a specific understanding, or an understanding that would not enable them to recognise or implement the PHC approach. One student acknowledged that she was putting off understanding the PHC approach until she needed to use it at a later stage, possibly implying that the approach is not useful at this stage of her academic career, which would suggest a limited perception of the PHC approach.

“...we do actually all know it off by heart, the little diagram and the whole thing, but I think when it comes to actual understanding, I don't know...it's not an understanding for me, it's more something I've learnt...I don't think it's something that I've actually taken in and made a part of me.” (set 4a)

“I think a lot of people...know what it is but don't know what it is. They can say it but they...wouldn't know how to go out there and implement it or recognise what it is...” (set 4a)

Some students admitted that they found the PHC approach vague or that they were confused about the approach while others claimed that they were unsure about what they were supposed to know regarding the PHC approach or that they were not clear on how to apply or implement it.

“...I think...like a large amount of people in the class have a broad understanding of how it works and what it is, but the implementation of it all, I think that is what's confusing for me...how to implement it correctly or effectively, that's the tricky part...” (set 4a)

Particular aspects of the PHC approach were problematic for some students, even if they had a general understanding, and quite a few students mentioned confusion around the terms 'comprehensive' and 'selective'. Other students were confused about multidisciplinary teams and the definitions of the various levels of the referral systems within the PHC approach.

“...I probably have the basics of it, but there is still things that we're still learning about the whole approach which I probably haven't grasped totally yet...I think some of them...for me, are slightly not 100% sure, because there is not a clear cut definition of it.” (set 3)

Students mentioned a number of factors that had added to or enhanced their understanding of the PHC approach, and many of these were to do with the BHP course done in their first year, and as part of this they mentioned readings and diagrams, group exercises, discussions and group work in general, visits to health facilities, final group presentations, and the exam essay questions.

[How it was taught] "I think that played a major role in my learning, because if it was like we were given lectures and somebody was telling us this is what is happening and this is what happens and they're not saying practically, we wouldn't believe it and we'd actually have no idea of what this is all about. I think the visits were very important and doing it in groups makes it very easy to go through it." (set 4a)

Some of those students who had had more experience of exposure to actual health settings (both part of and external to the UCT curriculum) explained how this exposure had enhanced their understanding.

"...I went to a rural area in the Eastern Cape, and as much as I didn't understand it when we were studying it last year, I just got a feel of it and sort of understood it better when I saw how important it was there and how much they needed it..." (set 4b)

Students also pointed out factors that had hindered their understanding of the PHC approach, and these included contradictory messages from their readings as well as from their lecturers and other health professionals; aspects of the Alma Ata definition of PHC, including the fact that it is long, complicated and somewhat vague; terminology of the PHC approach; and the inability of BHP group facilitators to provide clarity on certain issues.

"I got the feeling that at Alma Ata...the doctors themselves were confused, that's why they used vague language...So unless that definition is revised and sort of tied down in certain areas, it leaves too much room for play, you're not going to get people who understand PHC ever, because seriously, I can recite that stuff off to you, but...it has no meaning to me, it's just words on a page." (set 4a)

Conclusion

This section has shown that although there are a wide range of perceptions of PHC among the students, by and large these perceptions seem to be relatively accurate. Where misperceptions did emerge, these were often countered with more accurate portrayals of PHC. Most importantly students do generally refer to PHC as an approach and on the whole do not limit it to the primary level of care, which is a common error. Many of the other descriptors - system, scheme etcetera - do support this notion of PHC as an approach. However, words such as 'idea', 'concept', 'theory', 'ideology' and 'philosophy' do possibly evoke more ideas of thought than of action, and could be depicting PHC as something intellectual rather than practical. It should be noted that many of the students who used these terms were second-year students who had thus far

received largely theoretical input on the PHC approach. The less frequently mentioned perceptions, such as the unconventional and political nature of PHC, as well as the fact that it is foundational, far-reaching etcetera, are all indicative of a sound understanding of PHC, and in some cases suggest a certain measure of insight into the approach.

Overall, students also appear to have arrived at some point of understanding of the PHC approach. Those that have expressed some confusion around the approach or felt that their understanding was limited were mostly second-year students at the start of their second year, thus having only recently completed the BHP course and been exposed to PHC. Any confusion or limit in their understanding at this point is to some extent expected or at least understandable as, in comparison with older students, they have had far fewer opportunities of clinical exposure and hence opportunities to observe the practicalities and implementation of the PHC approach.

Having established that the students' perceptions are for the most part accurate, or at least appropriate for their level of learning, and that there is not a general lack of understanding, it is possible to explore the students' attitudes towards and their views of certain aspects of the PHC approach with some measure of assurance that these attitudes and views are not premised on flawed assumptions or erroneous notions of what PHC is. However, some confusion still exists in the minds of some students regarding PHC and the PHC approach is admittedly complicated and vague for some, and this means that there is a possibility that some attitudes and views may then be unmerited, although they should and will be acknowledged.

Theme 4 - PHC: for and against

Introduction

This section addresses the students' attitudes towards the PHC approach, and includes their own as well as their classmates' attitudes. Those factors that have influenced these attitudes will be explored, as well as any changes that have occurred in these attitudes. Students' feelings about the PHC approach being promoted at UCT will also be covered, along with any comparisons that students made between UCT and other universities, particularly with regards to the position of PHC in medical curricula.

Theme outline

- Attitudes towards the PHC approach: personal and class attitudes; why it is important to learn about the PHC approach.
- Feelings about the PHC approach being promoted at UCT.
- Influences of and changes in attitudes towards the PHC approach.
- Comparisons with other universities in terms of the inclusion of and emphasis on the PHC approach.

Personal attitudes towards PHC

Students in all groups had an overwhelmingly positive view of the PHC approach, and their attitude towards what it stands for seems to be good.

“...I feel positive about it, about the idea and the philosophy and where it comes from, it’s an indication that someone...they saw a mistake and so they’re trying to fix up things...I do feel positive about it...the philosophy itself, if you actually follow it, if every country contributed and did exactly what is recommended, I think it would be a brilliant thing.” (set 4a)

Very few students claimed to feel negative towards the PHC approach, and most of this negativity was to do with their view of PHC as a subject as “boring”.

“...there’s nothing positive about this whole approach...I still feel very negative.” (set 4a)

“...obviously you can’t make it exciting, there’s just nothing you can do about it...” (set 4c)

Some students expressed mixed views of the PHC approach, maintaining that PHC might not be the first choice for some, but that this does not necessarily imply a negative view of the approach:

“...I don’t actually see myself in this specific field, so...I get a bit irritated with it because it’s not in my field of interest, but that is not to say I don’t agree with it.” (set 3)

Throughout the groups, students do seem to have an awareness of the importance of learning about the PHC approach, and this largely centres around how PHC has broadened their perspective. In their discussion of this they use phrases such as “see another side”, “clearer picture”, “broader view”, “better picture” and “broader perspective”, which suggest that their original picture, view or perspective was somewhat limited or narrow. Based on their expectations of what they were going to study and that the PHC approach was an unexpected component of this, it is possible

that after students have come into contact with the PHC approach, they come to some realisation that the anatomy and physiology that they were anticipating as a major component of their course could have only introduced them to part of the 'picture'.

"I think that it allowed for us to see another side of medicine...it allowed us to go to the clinics to visit...also to get that whole new perspective...this sort of brings the whole thing into context, gives you a clearer picture of what you're getting into..." (set 4a)

"...it gives you a broader view, so it helps you, not just in your learning, but also when you get out in the world, that when you meet a person, you are more interested in not just them, but where they come from and finding out how the health of the community is and what you can do to help out, perhaps even advocate for that community." (set 4a)

Apart from broadening one's perspective, individual students mentioned other valuable aspects of learning about the PHC approach, such as preparing and providing a foundation for future learning and interaction with patients and also raising awareness among students of the situations that they will face. This second point in many way relates to the broadening of perspective mentioned above, but this particular comment was mentioned in the context of a discussion in which students were debating whether learning about the PHC approach was not limiting students to working in a South African environment and that learning about this approach was completely incongruent with some students' motivations for studying medicine.

"Ja, I think it does [serve as a foundation for the future], because I think when...we start working with patients properly and once we have...the knowledge that's required, we can start looking at other things, like at PHC, we can start seeing...how it is applied, how can we try and apply it." (set 4a)

"...I think the outcome that it would set to achieve, even if it's to a lesser degree, is to sensitise the people that there are such and such situations out there, even if you don't desire to be a primary health care orientated type of doctor...you can't just be a scientific doctor and ignore all the other factors that influence people in terms of their living conditions..." (set 4a)

Views about PHC being promoted at UCT

Related to their attitudes towards the PHC approach are students' views about the fact that UCT has opted to offer a PHC-driven curriculum. Many students seem to feel positive about this decision, which is based on the apparent strength of PHC as an approach, the fact that it could enhance their abilities as a doctor and the need for UCT to keep up with international trends.

"...I think it's a good approach for them to be focussing on. I think it's probably the best approach that there is to focus on and now that we're like educated about it, we'll probably make more proficient doctors, because we'll know about that and then we can maybe build on that." (set 4a)

"...it does make sense, because the world over, I think primary health care is something that is coming into focus...so it wouldn't really make sense if the University of Cape Town wanted to obtain progress with the whole world and then they actually leave out something as important as that." (set 4a)

A number of students felt that the PHC approach should be promoted by UCT in order to adequately prepare them for work in South Africa.

"I think it's very important to focus on it, because PHC is what the government is trying to implement and therefore it's the context that we'll be working in..." (set 4a)

"I think it's an enlightened way of doing it, it's looking at the situation of South Africa and saying, 'what do we need to do as a university to help?'" (set 4a)

A few students did question UCT's decision to promote the PHC approach, and their concerns were that other approaches (none were named or mentioned specifically) could be sidelined, and that the 'hard sciences' were being marginalised, which could be detrimental to the knowledge students feel they need.

"...I was thinking, am I at a disadvantage perhaps because of primary health care?...it made the sciences take a back step...having primary health care as a primary thing here it university...the whole structuring around it, I'm a bit sceptical...would I know everything that I need to know?" (set 3)

A fair number of students raised their concern about whether or not their degree would be internationally relevant and internationally recognised. They based this concern, not necessarily on the fact that the curriculum is PHC-driven, but on the emphasis on the South Africa situation, and argue that because South Africa is a developing country, they will be restricted to working in developing countries.

"...I got worried because then I was thinking, is this a degree for an African doctor, or is this a degree for an international doctor? ...It's like restricting you to a Third World country..." (set 3)

"Most of the health problems that arise in South Africa are due to social problems, and lots of emphasis has been placed in both PBL and BHP on social circumstances and all that stuff...which once again applies to South Africa alone or like a developing country alone..." (set 4a)

However, some students did point out that that both diseases of affluence and diseases of poverty can be found in South Africa, and that there is extremely wide range of

health care offered in South Africa, thereby preparing UCT students for work in both affluent and impoverished areas.

“...we’ve had some very much First World medicine in terms of research, in terms of surgery, in terms of equipment and all those sorts of very private hospitals that are on a very high, top world standard. And then we’ve got other people who are in other areas where children are dying of diarrhoea because they’re not even getting ORT or something basic like that.” (set 4b)

Two students expressed little sympathy for those who feel that what they are learning is not relevant for them, suggesting that these are students who do not want to stay in South Africa and help bring about positive change in health care.

“A lot of students say ‘why am I learning this because I don’t think I will have to use this?’ But then my response is that, to me it’s just you are in South Africa, you’re doing medicine and I suppose if you’re not going to want to stay in the country, be part of the solution to the problem, then tough luck, hey.” (set 4b)

When students were asked whether they feel they are doing an inferior degree, one group of second-year students was almost surprised by the question, one student saying that it was in fact superior. However, in spite of this vote of confidence, other students did voice their concerns regarding this issue. Some of these concerns revolved around the sufficiency of their knowledge, while one concern was about the perception of their class as future doctors as they were the first class to enter the new MBChB curriculum.

“...there’s always this big joke amongst some of the members of the class, ‘ja, if you know that the doctor graduated from UCT in 2007, don’t go to them’...I don’t want my year known as this ‘pap’* year, people who don’t know what they’re doing simply because UCT decided to do an experiment. I don’t think that’s fair on us at all.” (set 4c)

Class attitudes

Although many of the class’s views of the PHC approach are reflected in the students’ comments discussed above, students were specifically asked if they felt there was a general view among their class of medical students regarding the PHC approach. Students gave a range of positive and negative responses, while some maintained that a general view was not obvious.

* An Afrikaans colloquialism for ‘weak’.

"I don't think there's a general view...I think it's probably a broad range of opinions." (set 3)

The majority of comments regarding positive views in their class seemed to come from younger students, and fewer third and fourth-year students spoke of positive views in their class. This is possibly owing to the fact that these older students have moved beyond the theory of PHC to the point of application, and although they may be positive about the theory, they do find the application and implementation of the PHC approach problematic.

"...the basis of human rights and equal share for all, I think most people at medical school believe that's a good basis, like it's founded on principles that I think most people believe in." (set 4a)

"...I think a lot of people are enthusiastic about the ideals enshrined in it, but as for its application, people view it to the most part of my experience with very wary suspicion." (set 4c)

Negativity around the PHC approach seems to hinge mainly on the assertion that PHC is a boring and unexciting subject.

"...with my friends...or most of us, view that it's kind of a negative one... and it's a view unfortunately that I sort of share in...it's not really such an exciting thing." (set 4a)

"...even before you get to fourth-year, you are taught that your primary health care block is going to be the boring, s*** block..." (set 4c)

Interestingly, two second-year students gave seemingly contradictory comments regarding their class's attitudes towards the PHC approach. Clearly both of these responses are generalisations, and are probably to a large extent based on their own attitudes towards PHC. The first comment could be a naïve assumption that is not based on much evidence, in terms of speaking to other students about their attitudes towards PHC. However, based on previous discussion, it is possible that the "positive attitudes" could be referring to students' views that the PHC approach itself is good in theory, and that the second comment could be alluding to PHC as a subject that is taught, and the fact that students feel it is boring and unexciting.

"I think it's all positive attitudes towards it." (set 3)

"...everyone I have spoken to that is in first-year has had a complaint about primary health care...I have yet to hear a person say that they enjoyed primary health care." (set 3)

A couple of students have made insightful observations of the resistance towards the PHC approach, and have suggested that this resistance has less to do with the approach

itself, and more to do with students' expectations of studying medicine, which as has already been established, did not for the most part include the PHC approach.

"The class moans about it a lot...but that is because I think when we think of studying medicine, we're expecting to get into the science of it. I think it's actually just a case of impatience. But everyone does actually understand what is going on and why it's needed and that it will be helpful, it's just we're having a hard time seeing the big picture, we want things to move on a little bit more quickly." (set 3)

Positive changes in attitudes

Some second-year students did acknowledge that their own personal attitudes as well as the attitudes of their classmates towards PHC have changed in a positive direction, and this change was not attributed to a particular event or aspect of their course, but seems to have more to do with an increased understanding of the approach and of why it needs to be learnt.

"...it's only when you actually read the facts you realise that there is evidence backing this up...it comes from a scientific basis, and when I discovered that, then it made me think of PHC completely differently and it's made me more in support of it." (set 4a)

"...when we started, that was the peak of the whole resentment thing, and it's been going down...people are just getting into it and they are carrying on with it, and they are getting the understanding of why we need to know it, and I think the resentment's going down, it's ok, it's getting better." (set 3)

In comparison to these second-year students, third and fourth-year students spoke more of reaching a point of acceptance with regards to learning about the PHC approach. For those against the PHC approach, this acceptance could be more a matter of resignation, whereas others seemed to have moved beyond this point and made a decision to make the best of it, and some have come to appreciate it. Notions of 'acceptance' and 'appreciation' do seem to underline the students' perceptions of PHC as an approach, and it is possible that these are related to the fact that students begin to see its relevance and are also able to observe some of the practicalities of the approach in their third and fourth-years. These changes in attitudes are reflected in Figure 4.

"I think in first-year we were very overwhelmed...I really didn't enjoy it. It got better...Becoming a Health Professional was better and then Family Medicine I enjoy. So I think it's also a change of attitude on my part, like you begin to realise and see the value and you're going to come to terms with it, and you just make the best of it as well from your side." (set 4b)

“It is almost as if I really have no kind of choice in that matter, so it becomes a part of you. And then you just learn to appreciate it and accept it.” (set 4c)

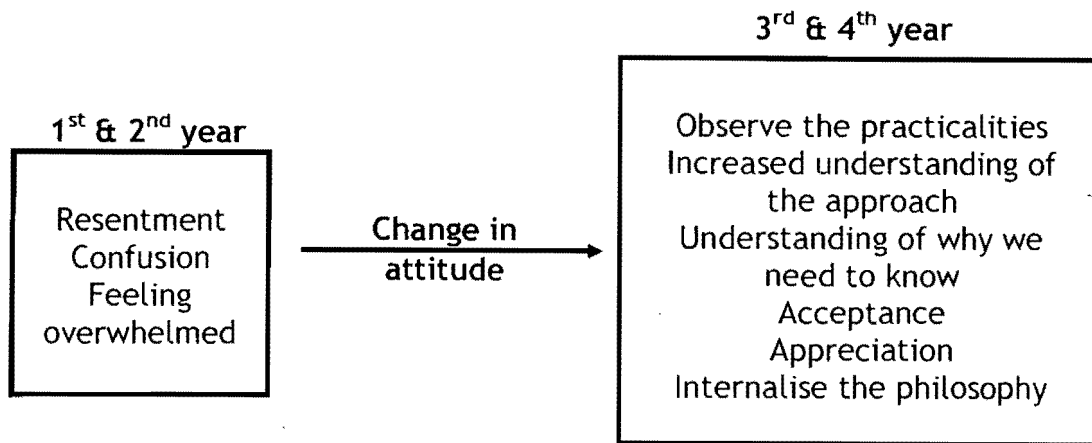


Figure 4: Changes in students' attitudes towards the PHC approach

The value of clinical exposure, particularly within the Obstetrics block in fourth-year, was emphasised as playing a vital role in shifting attitudes towards PHC in a more positive direction, as it allowed them to observe the benefits of the PHC approach. One student claimed that this helped him to “touch base” and “connect with” the theory of PHC. These terms that he has chosen do have somewhat of an interpersonal connotation, thereby suggesting that PHC as an approach needs to be understood experientially, meaning that students need to have some experience of the PHC approach before they will be able to fully understand it and hopefully implement it at some stage.

“...just being for these few weeks now in the Obs block seeing the PMNS system, and how like for example the system is running and you can see even in the health care setting how many patients there are, how full it is and how the system actually helps to alleviate many of the problems that health care workers at facilities find themselves in...before we never thought about these things, it never occurred to us or anything...now we can actually speak about it and not actually feel like you're wasting your time...we can actually touch base with it, actually connect with this whole theory.” (set 4c)

Acceptance and appreciation of the approach may also be due to changes happening within the students at a cognitive level, as two students spoke about how the PHC approach can become part of their thinking, or at an emotional level, as one student refers to “growing in” what “PHC stands for”, as opposed to understanding it

academically, which is possibly what first and second-year students feel is expected of them.

“I think it has become part of our thinking as well, I think it has become almost like second nature to us now, where we see a patient we think about more alternative things like social things, the psychosocial issues...” (set 4c)

“...it’s a whole different change of studying; it’s not an intellectual thing. Because it’s not an intellectual thing, there’s this frustration at having to learn it as an intellectual thing the whole time. So the shift is going towards what PHC stands for and perhaps actually growing in it instead of building an intellectual framework of it.” (set 4b)

A few third-year students noted the significance of group discussions with fellow students as opportunities to change perceptions regarding the PHC approach:

“...to actually sit in a group and discuss something like primary health care, and then you actually have the opportunity to change people’s perceptions...” (set 4b)

Influences on attitudes

Students were asked to comment on the factors they believed to have an influence on students’ attitudes towards the PHC approach. They responded with a range of factors, some of which were related to the medical school environment, such as the PHC approach itself, how PHC was taught, the views of other students and staff at UCT fourth-year health promotion projects. Other factors not related to the university, included personality, students’ background and exposure to health facilities, and clinical exposure outside UCT.

In terms of the nature of the PHC approach and how this might influence students’ attitudes towards it, one student described PHC as a “lot more subtler form of medicine”, and suggested that this could be unnerving for some as it lacks the boundaries and the framework that seem to be associated with the hard sciences. He maintained that this less concrete nature of the PHC approach makes it harder to quantify, making it more difficult to retain control when functioning within this approach. One could easily imagine how the ambiguity and insecurity surrounding the PHC approach could lead to more negative attitudes. In addition to this, he also mentioned that in light of the university’s changing selection policies, students might feel that PHC has been introduced to lower the academic standard.

“...it’s a lot more subtler form of medicine...that might make people scared because there’s not a safeguard, there’s not a structure, you don’t really know what’s happening, you’re not in control as much and also it’s difficult to see the effects, people want to see effects and they want to see things...with the whole thing of changing towards people from underprivileged backgrounds being able to come in and sort of diluting and helping people from the bottom up...it’s there to make things easier maybe or there to sort of incorporate everyone and it’s not as intellectually sound and not as high-classed.” (set 4b)

Another student raised the point of students’ motivations for studying medicine and considered that negative attitudes towards the PHC approach may be related to people’s motivations not matching up with what the PHC approach involves, in terms of a greater proportion of work within communities.

“I think everyone’s different and everyone has different goals in why they want to be a doctor, and I think the primary health care approach makes it more difficult. I think there’s more challenges because you’re going to have to go out into communities rather than being in a hospital where everything is nice and orderly...perhaps some people in our class are happy to do that but others don’t feel as comfortable maybe.” (set 4a)

A number of students felt quite strongly that the way in which the PHC approach was taught had a negative influence on their attitudes towards the approach, even if they felt that the PHC approach is good in theory. Students’ views of how the PHC approach was taught in the curriculum will be addressed in more detail further on, but are mentioned here to highlight the role these teaching methods have on students’ attitudes towards PHC. The force with which the PHC approach was presented, the lack of organisation in the course, repetition, time spent on the course, and the activities that were part of the course were all said to have had a negative influence on their attitudes towards the PHC approach.

“...I think it’s also been shoved down our throats, and people tend to resent things that are shoved down our throats, over and over and over again...” (set 4a)

“...BHP, going on from BP, we’re coming to varsity, we’re finally feeling like adults and we’re sitting there being told we’ve got reflective journals and doing role plays, and we just all thought ‘what’s going on now? I’m not a child’...so we entered BHP with a negative attitude which might not have necessarily related to Public Health or primary health care.” (set 4c)

In spite of this negativity surrounding the teaching of the PHC approach, the visits to communities and health facilities as part of Becoming a Health Professional in first-year were said to have had a positive influence on some students’ attitudes towards the PHC

approach. One student felt quite sure that attitude change would take place if students were to see the benefit of the PHC approach on their visits.

“...after going to Mamre I do think that it made my impression of PHC much better than the people who went to Brown's Farm and Khayelitsha.” (set 3)

“If people see the benefit of primary health care, there's no reason why they shouldn't change.” (set 4a)

There was no consensus among students on the manner in which socioeconomic status (SES) can influence attitudes towards the PHC approach. Most students seem to divide students quite easily into two categories, probably for reasons of simplification: 1) affluent and 2) impoverished or disadvantaged, and remarked on the impact of this socioeconomic state on students' understanding of the need for the PHC approach in certain areas, their willingness to work in communities and help those who might not have access to health care, their perception of their own need for the PHC approach, and their impression of the feasibility of the PHC approach.

It was believed that those from impoverished backgrounds would more readily see the need for the PHC approach and would understand how this approach could help, but may also see the PHC approach as unrealistic because of their circumstances. On the other hand, it was believed that those from affluent backgrounds might not fully understand the need for the PHC approach and would not necessarily see it as the system they would use. However, if they were relatively unaware of the circumstances in disadvantaged areas they may be more likely to believe the PHC approach could work.

“...your SES and your background and your culture and all those things...I think that contributes to the experiences you've had in life and that in turn builds your perception of life, and PHC is part of that, in that if you're coming from a very impoverished background and you've had life difficult and you've seen how people have suffered, then you will want something like PHC...while if you're coming from a very affluent background and you haven't suffered as much then...you'd still want to help everyone, but you won't understand possibly as much as someone from an impoverished background...” (set 4a)

Other students acknowledged that the link between attitudes towards the PHC approach and SES is not easily determined, and that an affluent background does not imply a negative attitude towards the PHC approach. These students proposed that people from more affluent backgrounds may be more interested in the PHC approach because they are not desensitised about the conditions in disadvantaged areas and they may in fact be aware of the need for the PHC approach in these types of areas.

“...it might be the other way round, in that people from more affluent backgrounds take more of an interest because they haven’t been kind of desensitised about everything.” (set 3)

“...[people from more disadvantaged backgrounds] they’ve probably seen the other extreme to what people who aren’t in that sort of disadvantaged area have seen. But I think also people that are advantaged would also feel that it’s a good need, because they are well aware...of the situation in the disadvantaged area, and I think that they realise the need for something like this primary health care approach.” (set 3)

For two students there were similarities between students’ backgrounds that existed in spite of their differences. The first was students’ common goals and aspirations for meaning in life that transcends their background, and the second was that one is likely to encounter a more curative approach in both affluent and disadvantaged health care settings, and that students from both these types of settings will enter medical school with a similar expectation of a curative focus in the curriculum and hence may have a similar attitude to the PHC approach.

“...I used to think that that [background] has an affect on how people do things or not, but I’ve gotten to know a lot of people from very different backgrounds and like a very broad spectrum of people, and one thing that comes out is that people actually realise that there’s something more to life than, I don’t know, striving for the best. It’s just that a lot of people that I’ve come across from a very wide range of backgrounds have a similar type goal in life. They want their life to have meaning more than success in anything like that, so they all seem to be thinking in a similar direction.” (set 4b)

Students’ experiences in general were identified as a significant influence of students’ attitudes towards the PHC approach, and more specifically, their experiences of health services and whether they had had exposure to private or public sector services. The implication seems that students who have had experiences with the public sector will more readily see the relevance of the PHC approach and hence have a more positive attitude towards it.

“...I think you realise the need more when you have experienced what it’s like to not be in an ideal type state where things don’t come that easy...I think then you realise that you’d like something from the powers that be to get things to you so that life can be a bit easier...So I think depending on your situation and what you have experienced, it plays a huge role in terms of how you see it...” (set 4a)

The role of personality emerged again and was said to have a strong influence on students’ attitudes, a stronger influence than background according to some. People who are positive about the PHC approach were depicted as empathic, compassionate,

self-sacrificing and having a desire to help and empower people. In contrast, people against the PHC approach were described as self-serving and ambitious regarding wealth and success.

"I get the feeling there's something that's deeper...There's something that always struck me was the fact that the people who are against it didn't really have a heart for people. They were mostly people who would look after their own self first and who want to get to the top and who want to make a lot of money and who want to be very successful in life. Whereas the people who were for it were more people for people, people with a heart, people who want to do anything that is possible to actually go out there and help people and make sure people have power to do things for themselves." (set 4b)

A small number of students, outside of their time at university, had some clinical exposure in rural areas in the Eastern Cape and felt that this exposure had influenced their views of the PHC approach in a profound way. This was by helping them to appreciate what they are being taught about the PHC approach and by drawing attention to the need for the PHC approach in these rural areas.

"...I believe you really get to see the impact that access to all these things...or lack thereof, really has on a person. So you know, by us studying the whole approach, but not actually being affected because you go back home, you've got running water out of the tap, you've got a flushing toilet, you've got access to emergency care should you need it. It doesn't really ring true until you're actually in that situation and you find that some people actually don't have it easy." (set 4b)

Some students claim that their attitudes towards the PHC approach were influenced by the negative views expressed by staff and other students at UCT and it does not seem as if these views were countered by more positive ones from the same groups of people.

"...I've spoken to some doctors, they teach here, and they also didn't like primary health care, and they're quite prominent in the faculty...obviously you get affected by those views and opinions, because you know the people and you trust those people...you've got people from UCT telling you something different to what UCT is telling you...that is a bit unnerving." (set 3)

"...you speak to students who are a year above you to a couple of years above you, and they're like...'you've got PHC, ag shame'...and it's straight from then, and you're like 'oh, this is obviously not great'...I think it's more who you know...and what their feelings are that influences you a lot..." (set 4c)

Other influences on the attitudes were mentioned by individual students and positive influences included wanting to have access to health care that is of a high standard should the need arise believing that the PHC approach will help to ensure this, and the health promotion projects carried out by fourth-year students. Negative experiences of

PHC implementation at a health facility were said to have a negative influence on attitudes. Students' expectations of medical school were also believed to have an impact on attitudes towards the PHC approach, and the student who made this point did not elaborate on what particular expectation was being referred to, but based on what has already been discussed, one could assume that students who have no expectation of learning about the PHC approach would be more likely to develop a negative attitude towards the PHC approach.

"...not only are we doctors, but we might be patients at some point as well...I'd like to know that I can get good quality health care when I go to the doctor, so I'll immediately participate in changing and implementing this whole PHC." (set 4a)

"I think doing the [health promotion] project, for me, made a big difference, because you spend like three years getting the theories, theories, theories, and it sounds fantastic in theory but I never really thought it would work so well in practice in such a resource-limited environment..." (set 4c)

Comparisons with other universities - PHC

In comparing UCT to other universities in South Africa, students had the general impression that UCT was unique in the nature of its focus on PHC, some describing it as "way out" and "extreme", and felt that other universities had a more scientific focus. The universities mentioned were the University of Stellenbosch, the University of the Witwatersrand, the University of the Transkei, the University of the Free State, and the University of Pretoria. The knowledge or even the assumption that this is the case seems to be discouraging for the students, forcing them to question what UCT is doing and not doing.

"We're the only ones being taught PHC." (set 4a)

"...other universities, I don't think they have been so reinforced..." (set 4a)

Fortunately, some students brought perspective to this issue by highlighting the fact that all universities are working towards the same ultimate goal as well as mentioning the advantages of the UCT curriculum and the areas in which they were excelling in comparison to other universities' students, such as a greater understanding of the impact of socioeconomic conditions on health and better knowledge and understanding of the PHC approach. One student also pointed out the qualities that were being gained at the expense of the "details".

“Personally, I would be willing for a trade-off of maybe not being taught as much as Stellenbosch, but having...a much better perception of reality and being much more useful as a doctor. I would be willing to not know a few little minor details...to be able to serve people much, much better by knowing this kind of approach...” (set 4a)

Conclusion

From what has been presented in this section, it would seem that students have a generally positive attitude towards the PHC approach in theory and that there is also a common awareness of the importance of this approach, thus supporting this positive attitude. Although there were some concerns raised about the fact that UCT has chosen to promote the PHC approach, students on the whole were also positive about this decision as well. In terms of class attitudes towards the PHC approach, there were a range of views expressed, some of which were contradictory and therefore did not seem to clearly match the personal attitudes.

These contradictions raise the question of whether personal and class attitudes towards the PHC approach may be different or whether there are some students that assume that the class has a negative attitude because they have a negative attitude, and this is quite likely as those students who expressed their own negative attitude also spoke of a negative attitude among the class. It is also possible that these negative class attitudes are more reflective of students' feelings due to unmet expectations about the curriculum as well as impatience with the manner in which the curriculum is progressing, points raised by some students, particularly with regards to pace and the fact that students want to get on with doing 'medicine' so that they can start feeling like doctors. Although negative attitudes towards the PHC approach do exist, the section has also brought to light the fact that there is a possibility of changes in attitudes and that students may come to accept and appreciate the approach.

This section has also highlighted the range of factors that impact on attitudes towards the PHC approach and significant in this section was the lack of consensus on the influence of SES on these attitudes. This may be indicative of the fact that SES is not a particularly strong influence on attitudes and that students are basing their comments on this issue of supposition rather than what they have actually observed. Students may also have a limited understanding of how SES can influence attitudes and beliefs, which

is an already complex issue, and therefore may be basing their arguments on unsubstantiated evidence.

Lastly, students' impressions that other universities in South Africa do not have the same focus on the PHC approach is problematic in the sense that it may be hindering their ability to place the PHC approach in a South African context. The reason that this could be the case is that although this approach is sanctioned by the government, and there seems to be awareness of this, the fact that other universities are not endorsing the PHC approach as strongly could downplay both the need for and importance of implementing this approach in South Africa. Students' perceptions of UCT's emphasis on the PHC approach also seems to lean more towards the belief that something is lacking rather than something is being gained, and this could diminish their faith in the new curriculum as well as their confidence in UCT as an academic institution.

University of Cape Town

Theme 5 - PHC: views of the approach

“...during apartheid, for example, a cross-cultural marriage, a cross-racial marriage would also seem idealistic, and that's because it was definitely not possible at the time... So I think although some things are idealistic, the status quo needs to be challenged and needs to be pushed, and it does seem almost impossible, but it is a massive challenge that faces health care in general.” (set 4a)

Introduction

Whereas the previous chapter looked at students' attitudes towards and perceptions of the PHC approach quite specifically, this chapter will look at how these attitudes and perceptions may be reflected in the students' views of the PHC approach. What this will cover is what they believe to be strengths and weaknesses of the approach, including their view of the PHC approach as idealistic and the conflict between the theory and the reality of the approach. It will also present their views on some of the PHC principles, the choice between selective and comprehensive PHC, and comprehensive care. Lastly, it will describe the students' opinions of the role of doctors in the PHC approach.

Theme outline

- Views of the PHC approach: strengths and weaknesses of the PHC approach, idealism of the PHC approach, theory versus reality, comprehensive versus selective PHC, comprehensive care, PHC principles, and the role of doctors in the PHC approach.

Strengths

Students pointed out a huge variety of what they believe to be strengths of the PHC approach. Many of these were to do with certain aspects of the approach, but some were more related to the approach in general. Most of the aspects of PHC that are described as strengths of the approach are discussed in more detail further on in the chapter, but will be mentioned relatively briefly under this section in order to acknowledge that students spoke of these as strengths.

As an approach in general, PHC was praised for the fact that it has a broad range of impact as it looks beyond just those who are ill, and is concerned with that which is

affecting the majority. The approach is also believed to be a helpful framework that can be applied to health systems in order to bring about positive change.

“...you can reach a wider variety and things will be a lot more structured and people will have access to it...the greater health of the community instead of just the sick people...the sort of approach to reach a broader spectrum and help more people...to make things more accessible and affordable to the general public.” (set 2)

As an approach, PHC is said to signal the need for change and improve situations, and this is perceived to be a strength, especially within the South African context. One area for change in South Africa was mentioned, and this was the poverty gap, which the PHC approach is said to address.

“...I think it does call upon a change, because it actually highlights what was and that automatically says there’s something wrong and then it offers something else...” (set 4b)

“...in South Africa there’s a big difference and a big gap between the rich and poor, and primary health care has sort of come in between and brought the two together...” (set 4b)

A number of students felt that a strong point of the PHC approach was the way in which resources were used, and that this was facilitated in part by the referral system that ensured that patients were sent to the appropriate level of care, and that human resources at each level were suited to the care being provided. Money could then ultimately be saved through better utilisation of resources.

“I felt this PHC system was actually using the human resources pretty well...like say for example at the MOU [Midwife Obstetric Unit], you don’t really need a doctor there, as long as the nurse is competent to know if she needs referral.” (set 4c)

Another strength of the PHC approach was the fact that it is community-based and that it looks not only at the individual but at the community as well. The perceived advantage of this community focus is that help that is directed at different communities is more likely to be derived from each community’s needs and characteristics, and that a focus on individuals within their community should also provide a better context for understanding those individuals.

“...the fact that because primary health care is like community-based, so different communities have different values, have different ways of thinking, have different ways of doing things.” (set 4b)

Linked to the emphasis on community, the PHC approach was also commended for empowering people through education, by encouraging people to have faith in their own abilities, to take responsibility for their own health and to make decisions about their own health.

“...I just liked the fact that it placed a lot of emphasis on people, the whole community and population, and it places more emphasis on everyone’s responsibility for their health...all the promotion and prevention, they’re really trying to get information out to the people so they can take more responsibility...People will have the knowledge so they have to make choices for themselves...” (set 4a)

Students also saw the holistic perspective of the PHC approach as an advantage in that it takes into account not only the biological, but also seeks to uncover the root of problems, and acknowledges the impact that factors such as education, living conditions and the background of patients can have on health. The principle of intersectoral collaboration, which advocates the involvement of other sectors (for example, engineering, education) in health, was thus noted as a strength of the PHC approach because it aims to address these other factors in order to bring about health.

“...it views the whole perspective...it’s not just focused on medical and biological things. It’s more holistic...it looks at the root of the problems, like the background of the patients...or other social and economical issues surrounding a patient’s illness or the health status of the country.” (set 3)

Other PHC principles were also seen as strengths of the approach, and those mentioned were multidisciplinary teams (the collaboration of disciplines within the health sector), affordability, equity, accessibility and cultural acceptability.

“...the whole cultural acceptability thing is so important in the whole South African context...” (set 4c)

A number of students felt that comprehensive care and particularly the prominence of prevention and promotion, was a strength of the PHC approach. Again students raised the importance of identifying causes of disease and taking into account the various factors affecting health so that disease might ultimately be avoided.

“...it’s concentrating on first preventing something that *can* be prevented. A lot of stuff can be prevented, and I like that aspect of it, that it’s dealing with the root or the cause of the problem, and not just how to cure it.” (set 2)

Some students felt that the PHC approach has a positive impact on the doctor-patient relationship, in that it will give them more insight into what their patients feel and will encourage doctors to be attentive and supportive to their patients, taking active steps to helping them.

“...they’re going to take time to listen to your problem and address it and the rest of it, so ja, it is important and that’s a sort of positive approach of having primary health care.” (set 4b)

The fact that the PHC approach does not elevate doctors above other health professionals is described as a strong point of the approach, and for these students it seems more important that health professionals are considered equally valuable.

“...it kind of levels the playing fields in terms of health professionals, because the doctors aren’t like the pinnacle of everything anymore.” (set 4a)

A number of other strengths of the PHC approach were mentioned that could not be grouped with any of those above, and these include the fact that the PHC approach gives medical students a ‘reality check’ regarding what medicine as a career entails, that it is perceived to be an approach that allows for flexibility, that it highlights the importance of the involvement and contribution of political leaders, that it has a positive effect on students’ thinking, and that it improves students’ practical skills.

“...I like the fact that it’s still new, I like that it’s not something concrete...there’s a lot of room for a bit of flexibility...you’re working with people, so there’s nothing concrete, nothing that is definitely going to work all the time.” (set 3)

Weaknesses

In addition to the strengths of the PHC approach, students also pointed out a number of weaknesses, which covered a range of issues. One student did however admit that because the PHC approach addresses so much, it is difficult to identify its weak points, while another expressed the view that the PHC approach is not the standard against which everything should be measured.

“It just covers all concepts of health in a sense, so it’s very hard to find weaknesses.” (set 4a)

“It’s not necessarily the golden standard.” (set 4b)

The weaknesses that students mentioned generally related quite strongly to the implementation and application of the PHC approach, and it was stated that students are aware of the difficulties of implementing the PHC approach. One student felt that it was problematic that there was not a working example of PHC. It should be noted though that not having knowledge of a working example does not necessarily mean one does not exist.

“...the fact that the approach hasn’t actually worked anywhere is a problem...I don’t think there is actually a functioning PHC system that has brought health for all or that is working like that, it kind of decays into bureaucracy and into little breakdowns...” (set 3)

Some students mention specific difficulties associated with implementation, and the PHC approach was criticised for being time consuming, impractical, taking time to yield results, not yielding results that are easy to measure, and being logistically challenging, particularly when it came to important issues that needed addressing.

“...this doesn’t give immediate results, so it’s...in a way discourages health workers as well, because I should imagine they want to see some results if they’re trying something new...” (set 4a)

“...I don’t see how it addresses problems necessarily like how is it going to address that not everywhere is getting medicine, or that there’s not enough in the field...there’s not these things being done...” (set 4b)

In addition to these difficulties with implementation, the PHC approach was also judged to be too complicated, and that this would affect the time it took to implement the approach. It also may be too complex for those who do not come from an academic background, hence making it less practical and problematic to implement.

“...it’s too complicated to initiate and be successful very quickly. It would take a very long...very long period of time to actually make that a success...” (set 2)

“I think one of the weaknesses is it’s complicated to understand, especially for people who don’t have an academic background...the concepts are complicated unless you have sat down and actually read it and no one can explain it to you, and that’s what makes it a bit impractical.” (set 4c)

Still related to the implementation of the PHC approach, some students felt that a weakness of the approach was that it fails to take into account the characters, goals and aspirations of those who need to be active in its implementation, and that common aspirations or wealth and comfort are incongruous with the philosophy of PHC.

“...PHC doesn't take into consideration what people are. People want to make money, people want to look after themselves first...” (set 4a)

“It's almost idealistic in the sense that it's a system that kind of presumes that people are generally kind and want to help out other people, but in reality...you don't want to really compromise your comfort, and I feel that it fails to cater for that.” (set 4a)

Linked to this, others felt that the PHC approach does not adequately deal with social issues and people's mindsets that can play a significant role in influencing health of individuals and communities. Some of these mindsets and community perceptions will be discussed later.

“Primary health care...it doesn't allow for that, to change the minds of people.” (set 4a)

“...say the HIV problem, some of the issues that need to be addressed are social issues...for example the whole gender inequality problem, like that's really got to be addressed, but it does not seem to be pushed in the principles of PHC.” (set 4c)

Another weak point of the PHC approach is that it is costly because of its broadness and the fact that it spans a number of sectors, and that because of this, adopting a selective approach to PHC becomes far easier.

“I think it's very cost intensive just because it's an approach, which means that it's not restricted to the health sector. It's really got to be driven from the very highest level and such things are costly.” (set 4a)

“It is so easy for it to become selective...I think that's the biggest weakness. But the only way we can overcome that is with lots of money and we don't really have lots of money...” (set 3)

Some students believed that the PHC approach leaves room for corruption, and that that is particularly relevant in South Africa, a developing country, because of certain issues typical to these types of countries. One way of dealing with this could be more global input and collaboration between global health bodies and individual countries that are attempting to implement the PHC approach. However, it was one student's impression that this input and collaboration are absent yet important for the progress in the implementation progress.

“I think it also allows for a lot of corruption...Corruption's actually a problem everywhere but I think one of the reasons why in Third World countries is because of the lack of organisation and administration, and that like need to control, that lack of control at least over things...” (set 4a)

The perception of the PHC approach as being “Third World” is stated as a weak point of the approach, because by adopting this approach, one may not have sufficient knowledge to be able to work in a private facility.

“...it is like a Third World approach...I want to work somewhere else in a private institution, then maybe you are going to come short a bit in the knowledge section...” (set 3)

Another criticism was that the PHC approach is not applicable in more rural areas because of the lack of resources in these areas, and it has already been mentioned that the PHC approach is cost intensive.

“It’s not applicable in all...like Cape Town has many resources, so it’s easy to implement it in Cape Town. But go to Eastern Cape...I don’t think it will be applicable because you don’t have resources...” (set 4c)

A few of the criticisms of the PHC approach were to do with specific features of the PHC approach, one being the emphasis on the role of the community, where a student articulated his view that this may be time consuming and challenging from a cultural perspective in terms of changing behaviours and beliefs. Another student expressed his concern about how the PHC approach would cope with an epidemic, and this would relate to the emphasis in the PHC approach on prevention and promotion, posing the question of whether this emphasis could be shifted should the need arise. A couple of students also felt that the referral system is problematic, mostly because it requires patients to move from facility to facility, which can be inconvenient, especially if transport is a problem.

“...I don’t know so much if it’s very effective to go through the community. I know that that’s the only way you’ll probably reach a lot of people, but I think it might take a long time, because there’s a lot of cultures that exist, and they have firm beliefs. And I think it’s very difficult to go into a community and just tell them ‘this is wrong’, and ‘do it like this’...” (set 2)

It is important when considering these weaknesses that the students have raised that one is able to separate those that have more to do with the health system that is attempting to adopt the PHC approach, even though these are often hard to separate, and one student mentioned this alongside her criticism of the referral system.

“...the referral system that comes with primary health care. You can often get patients caught up in this back to front referral...But I don’t know if that’s so much a weak point in the primary health care

approach as much perhaps the system and the way it's been implemented and the kind of bureaucracy and red tape that comes with the system." (set 4b)

Idealism of the PHC approach

Across all groups, one of the students' most dominant views of the PHC approach was that it is idealistic, both some of the principles and the approach as a whole, which is seen to present an almost perfect scenario. Some viewed this idealism as a weakness, while others felt this idealism served a purpose. Opinions that it is idealistic did not appear to preclude some from having a positive attitude towards the approach.

"It's very, very good. But, the application of it, I don't know if that's possible, because it seems to be really idealised, because it seems perfect if you can do it in that way for every person." (set 2)

"...it's like the definition of health. It's so idealistic that it almost doesn't exist." (set 4a)

Some students specifically mentioned that PHC is an idealistic approach particularly for the South African situation, because of the economic circumstances of much of the population and the fact that we are a developing country and may not have sufficient resources at our disposal. But given time, some feel it could ultimately work.

"...it looks like we're aiming for like a utopia kind of thing, and it's like looking at South Africa right now, it's like 'whoa, that is so impossible,' but I suppose slowly but surely it can be done." (set 4a)

A few students spoke of the personal impact that striving for or believing in an ideal can have, especially when the ideal is confronted with the reality. From their comments it is easy to understand the feelings of disillusionment that are felt when expectations that have been built up are not met.

"...we get these amazing, idealistic ideas that you think 'wow, that's pretty cool.' Then you go to a hospital and all your expectations are just shattered and blown out of the water within an hour of being there and you see the reality of what's going on inside the hospitals and health care systems, and there's just this huge void between the theory and the reality, and I think that's why so many people are disillusioned because they are just in no way related." (set 4c)

In spite of all these comments depicting rather negative feelings about the idealism of the PHC approach, there were students who felt positively about it. One student warned against equating 'idealistic' with 'impossible', and others claimed that the attainment of these idealistic goals of the PHC approach could happen if the right things were put in

place, people worked hard to achieve it and people had the right attitude towards it, that is, believing that it is possible. Furthermore, difficult goals should not be the justification for not even trying to achieve those goals.

“...it is so good and if we work at it, I think anything can be achieved but it depends on peoples’ attitudes towards it...” (set 3)

“...if primary health care is difficult to achieve, that shouldn’t be a reason not to actually attempt at achieving it.” (set 4a)

Some students felt that it was necessary to have an idealistic goal to work towards and that setting the standard high would mean that one’s ultimate endpoint would be further than if one had set a lower, more realistic target.

“...a lot of the things are idealistic right now, but I think we need to have something to work towards...I think if we limit our goals, then...if we don’t achieve them, we’re going to fall at a really low place. But if we make it something that’s great, a utopian ideal to get to, then if we do not make it like right to that point, then where we fall...it will be halfway there...” (set 3)

“It needs to be idealistic though because you need to have a goal that you are working towards. You obviously need to have the ideal and then you need to have like goals that you can reach...” (set 4c)

Other students argued that idealism was indeed necessary in the health sector, as the status quo needs to be challenged regarding health care and that fundamental issues such as human rights and showing respect to people of other cultures require ideals that need to be aspired to.

“Especially with something like health care where human rights are so involved, you can’t be anything but idealistic with that.” (set 4c)

“...especially as doctors, let us rather have ideals in our heads and try to treat people in a culturally appropriate way...” (set 4c)

Theory vs reality

The other dominant view of students regarding the PHC approach was the conflict between the theory and the reality of this approach (see Figure 5), and in many ways this builds on the students’ view of the PHC approach as idealistic, because if the students were able to see the PHC approach in reality and in practice, they would most probably not view it as so idealistic.

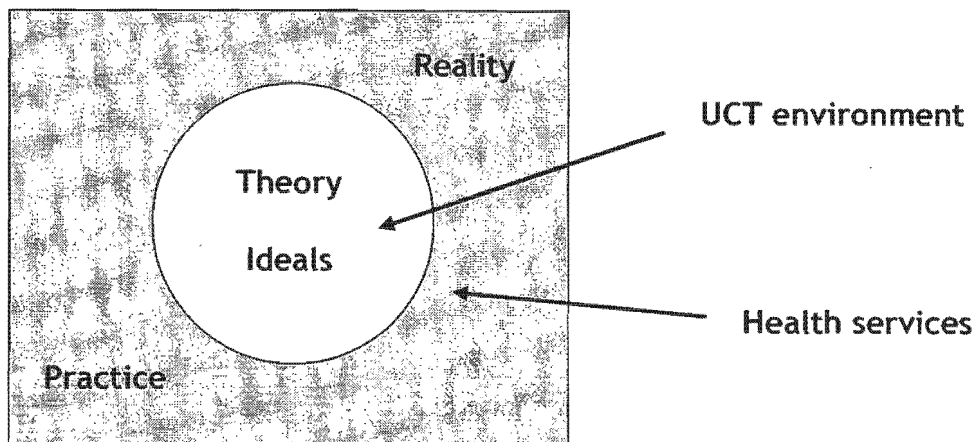


Figure 5: Contrast between the theory and reality of the PHC approach

Regarding this conflict between theory and reality, the theory also relates to the ideals of the PHC approach, and students did not seem to have a problem with these ideals as the terms they used to describe the approach were ones like “perfect”, “good idea”, and “great idea”. This is then at odds with the reality and the practicalities of the approach, and whether or not it is being implemented. Some of the students’ comments indicated that they think the theory would be difficult to put into practice, while others seemed to base their views on what they have seen in reality and the incongruence of this with the theory they have learnt. A few students also spoke about feeling upset, frustrated and disheartened as a result of this tension between theory and reality.

“...they are always telling you what it is and that it has to be done like this and this and this, but it is very idealistic because that doesn't happen in practice, and I think that is going to be a big frustration for us because they give us all the ideals but then we have the real world, and guess what, it is not like that.” (set 4c)

One student had a different perspective on this because of her experience of doing a health promotion project, and while she mentioned the tension between theory and reality, she found that the theory worked well, even in an environment with limited resources.

“I think doing the project for me made a big difference because you spend like three years getting the theories, theories, theories, and it sounds fantastic in theory, but I never thought it would work so well in practice in such a resource-limited environment.” (set 4c)

Students’ difficulty with the gap between theory and reality could be attributed to the idealism of the PHC approach, but it may also have something to do with the fact that

students find things of a theoretical nature problematic for the very reason that they are theoretical and not a statement of fact. Because of this, students may perceive that the PHC approach is a statement of how things *are* and not how they *should be*, which is what the approach is proposing.

Comprehensive vs selective PHC

There seemed to be some conflict of opinions around the adoption of a selective versus a comprehensive PHC approach, and some advantages of a selective approach were put forward. Students in favour of a selective approach argued that it produces measurable results, and that it is an appropriate or indeed a necessary strategy for tackling certain diseases that are considered to be major problems, such as AIDS.

“...the whole thing with selective health care, like I think it works. There are certain problems that are major within our health care system, and if we first tackle those...and once they're under control, then you could introduce primary health care...” (set 4a)

Other students were less approving of the selective approach, and acknowledged its efficacy in comparison to the comprehensive approach, but maintained its unfairness and incompatibility with the philosophy of PHC. Some seemed somewhat resigned to the reality of the selective approach, reiterating the perception of the idealism of the PHC approach in its entirety.

“...yes, it [selective PHC] is effective and it does prevent deaths and stuff, but does it really like improve the whole community's health?...I think selective primary health care is a good thing in a way in that at least stuff's getting done with limited resources...I think lots of doctors think it is enough just having those selective things when it is really not.” (set 4c)

Comprehensive care

With regards to comprehensive care, students mostly spoke about what aspect of comprehensive care was most important - promotion, prevention, cure and rehabilitation. The majority of students who put forward a view about this argued that prevention was the most important, many of them mentioning promotion and prevention together, and some claimed that all were important. The main justification for this was that by promoting health and preventing diseases, cure and rehabilitation could be

avoided, while a few also maintained that focussing on promotion and prevention was especially important in areas where access to curative treatment is difficult.

“...they all are extremely important but I think a lot of emphasis is being put on promotion and prevention which could be a very important one to prevent having to go into cure and rehabilitation.” (set 3)

“...as long as it addresses the prevention and the promotion part of it, because I feel it’s really necessary because people are struggling everyday, they are not healthy and they can’t go to clinics because they are far away...” (set 4a)

Those that argued for the importance of prevention claimed that it is essential when it comes to diseases for which there are no cures or where cures have not proven to be very successful, and that through prevention, more lives can be saved and the quality of people’s lives can be enhanced.

“...diseases don’t have cures, at the moment, like AIDS, obviously HIV, even most cancers, there’s no high success rate. So obviously it makes sense to focus on prevention because that can go a long way in preventing diseases that we can’t do anything about...” (set 4a)

“...the whole thing...prevention is better than cure, like if you can stop something at primary level and kind of have screening programmes and vaccination programmes and that kind of thing, then obviously it’s going to save a lot more people’s lives and just improve the quality of their lives.” (set 4b)

Other students however presented an opposing view, arguing that a more curative focus was necessary, and this is to deal with the high number of people who are already diseased, making those a priority in terms of finances and resources. This curative focus would also make more sense to communities in which people are already suffering from disease and want help for those that are sick.

“...at the moment curative I’d say is the most important, because when you look at finances, when you look at staff, we can’t really afford to send a lot of our resources into promotion when we’ve got people who are already diseased and they need to be cured, and especially because the community does not understand why we would concentrate on trying to change their behaviour instead of helping them when they’re sick...” (set 4a)

With regards to the cost of focussing on one or other aspect of comprehensive care, the comment above indicates that promotion would be resource intensive or that considering the paucity of staff and financial resources, priority should be given to curing those who are already diseased. A contrasting view was put forward by another

student, who maintained that health promotion should be the priority because of the high cost of cure and rehabilitation.

“I think promotion...we’re not one of the First World countries, so we don’t have the finances to be dispensing all sorts of medication, and rehabilitation and cure are quite expensive.” (set 3)

These contradicting opinions are obviously not based on any kind of cost-benefit analyses, and students have not gone into the logistics of the resources required for any aspect of comprehensive care. These views are most probably based for the large part on students’ experiences and observations, and it is quite possible that both students are correct, depending on what perspective one is looking from.

In terms of which health professionals are responsible for the different aspects of comprehensive care, it was recognised that this may be determined by the environment or the need that is presented, and that it would be unrealistic to expect all health professionals to be involved in all aspects of comprehensive care, but more feasible for each discipline to focus on one aspect. Two students even suggested that promotion should be the responsibility of sectors other than the health sector. Regarding the aspect that doctors should focus on, consensus was lacking, and while doctors seem to be associated most strongly with the curative aspect, those students that commented on this seemed quite reticent to limit doctors to cure.

“...I think doctors should be well-rounded...I think they should take on the promotion and prevention thing, but I think we all know mostly doctors are there to cure...I think it puts more pressure on doctors if they expect doctors to do everything, but doctors should try, and where they can, to do as much as they possibly can.” (set 3)

This reticence could have something to do with the fact that students receive extensive input on the importance of addressing all aspects of comprehensive care and that the PHC approach does emphasise prevention and promotion. Reflecting back on students’ perceptions of medicine as well as their expectations about studying medicine, it is likely that students enter their medical degree with an idea of a doctor in a largely curative role, and that as much as this view may be challenged by what they are learning, many of them may not have fully discarded this original notion. It is also possible that many of these students do not fully comprehend how prevention and

promotion apply to a doctor, and may not have yet been able to assimilate their picture of a doctor with the sometimes abstract or confusing tasks of prevention and promotion.

Intersectoral collaboration

Intersectoral collaboration appears to be a principle of PHC that students feel generally positive about, and a number of them stated its value, maintaining that it will improve the effectiveness and efficiency of health care and will also alleviate some of the burden placed on the health sector to bring about health. In many of the students' comments about intersectoral collaboration, it was evident that they acknowledge the impact of environment and living conditions on health and sanitation, and water and education were mentioned frequently as important factors to address. However, despite the praise for intersectoral collaboration, some students did question its practicality and the reality of it occurring.

"...the wide influence of what impacts on your health, like the fact that if a person gets a decent house with good water and a decent education, that will have more impact on a person's health than any doctor can ever wish to have on it..." (set 4c)

"...it sounds like it makes sense to get the engineers involved and sanitation and water and mix that with like the medical doctors and have them all working together, but I don't know how practical it is...That's one of the things I think is very ideal." (set 3)

In their discussion of this principle, students also raised the question of why medical students seem to be the only ones learning about the PHC approach, and that if this approach included other sectors then surely they should be learning about it as well. This issue seemed less to do with a sense of unfairness, but more to do with the fact that as long as students in other sectors such as engineering are not aware of how they fit into the PHC approach, they will be unaware of the significance of their contribution.

"...they should be [learning about PHC] because then they can see what role they play in the system, the cycle of health, and how their contributions will impact to the positive upliftment of the people where health is concerned." (set 4a)

One student remarked that forcing engineers to learn about the PHC approach, would be unfair as it would not feature in their expectations about studying engineering. This comment seems almost uncanny in light of the fact that PHC did not feature in most if any of the students' expectations about studying medicine, and also in light of some of

the students' remarks, which will be discussed later about the PHC being "shoved down their throats". Although this student did not make this connection, it is possible that she is alluding to either her or the class's feelings that many of them may also have asked the question: "what am I doing here?"

"But also at the same time...like someone wants to be an engineer, you can't really shove primary health care down their throats, or politics, because that's not what they wanted to study, they'll be like 'what am I doing here?'" (set 4a)

Multidisciplinary teams

When asked about the principle of multidisciplinary teams, the majority of second-year students interviewed were positive and seemed to agree that the concept of working with a team of other health professionals was good as it allowed for mutual support as well as the pooling of skills and ideas, which would ultimately lead to a more holistic treatment of the patient.

"I think it's very important, because a person is more than just being cured of one disease, they need all aspects of their life looked after and I think a multidisciplinary team can handle that better than one person." (set 3)

However, some students admitted that they were unsure about the application of this concept, and this could be because it does not seem to be something students have frequently seen in practice, leading to the belief that it is unrealistic, particularly in South Africa because of a lack of funding. However there were a few students that had observed health professionals working together to best treat the patient.

"...it's also very theoretical because when it comes to these clinics where you've got maybe one physio and four hundred patients and two doctors..." (set 3)

"...doing ward rounds...they discuss together about the patient, and also during meetings...different health professionals come together, then they discuss the patient and then they decide what's the best management for that patient." (set 4c)

Regarding multidisciplinary teams, some students also spoke of the role of other health professionals. Nurses were given particular mention as playing an integral part in the PHC approach, mostly at the primary level, but were often still referred to in relation to

doctors who are described in a more senior role. The importance of community health workers was also noted by a few.

“Primary health care shows the need for nurses and the importance for them...it shows the need for community health workers and stuff, and how important actually...almost more important than doctors they are...” (set 4a)

This last comment raises the issue of hierarchy among health professionals, and many students acknowledged that the PHC approach, and the concept of multidisciplinary teams in particular, challenges the existing hierarchy that places doctors at the top, requiring a team approach that includes other health professionals, the community, as well as the patient and their family. This shift in power was depicted as a predominantly positive move, although potentially unnerving for doctors who were possibly expecting to be in a position of authority, and some students did question the wisdom of completely doing away with any form of hierarchy as this could possibly breed a lack of respect for doctors.

“...I think it also changes the whole hierarchy, because in the past it's like a doctor is up there, is like the god. The doctor knows everything, so now it's like...I don't know, maybe doctors are also feeling unnerved in that they're not going to be the ones to be looked up to for all the solutions. In fact they're going to be part of the team with everyone else.” (set 4b)

Community participation

The fact that the PHC approach is community-based has already been cited as a strength of the approach, and in addition to this, a number of students mentioned the importance of the principle of community participation and of involving communities in the health care system. Those fourth-year students who had recently carried out a community health promotion project as part of their Public Health block seemed to be especially aware of the value of community participation, sometimes because of the lack of it. However when it was evident, it was said to have a positive impact on the effectiveness and sustainability of the projects they were involved in.

“...I realised that the primary health care approach was made more real by the participation of everybody, the community participation...Initially I thought well, it was just like a concept, but when I actually got to see it in action with respect to our projects and how everybody participated together...I thought, well maybe the idea to primary health care is community participation...” (set 4c)

In spite of the value of working with communities, some students were more circumspect about this, highlighting the importance of the community's desire to become involved in the health care system.

"I actually think the community is more important than anybody else because no matter what you do, if the community isn't along with you, nothing's going to get done. But at the same time, it is also very difficult because how do you get the community involved if they don't really seem to want to become involved?" (set 3)

A lot of what students said about communities and community participation related to the importance of empowering communities - empowering them with skills so that they can generate income and empowering them with the knowledge of the role they can play in the state of their individual and their community's health. One student spoke of empowerment and education together, and pointed out that these need to be concurrently aimed at all levels of communities in order for it to be more effective.

"...I think the key thing to do, probably empowering them...because a lot of people are not aware that they are in full control of their health and it's actually their decision whether they are going to be healthy or not...they need to be told that it's up to you..." (set 4a)

"...empowering and educating the community, it needs to be done on various levels simultaneously...you can't just go to the adults and teach the adults about this, this and this, you need to go into the schools and to the young ones. You need to go to the middle age and the old age..." (set 4b)

Linked to this notion of empowerment was the contention that communities need to play an active role in attaining and maintaining a state of health and wellbeing, and integral to this is the community taking responsibility for their own health and wellbeing rather than looking to doctors and the government for this. Students also maintained that communities also need to be included in health promotion and prevention efforts, and their inclusion in these activities could help boost the community's feelings of responsibility. Along with these points, it was also emphasised that communities should be encouraged and enabled to speak out about their needs and the issues that are concerning them.

"...once you start making them part of the process, then hopefully that will also lead to them taking responsibility for their health..." (set 4a)

"...the community must have a say in issues affecting its own health, I don't think anyone would disagree with that..." (set 4c)

Again reservation was expressed about the role of the community and the difficulty of involving them and getting them to take responsibility for their own health. These remarks seemed to relate more to disadvantaged areas where other issues and problems may be deemed more relevant.

“...I find that there is a common denominator for example, even if you’re in Cape Town, there’s places like Khayelitsha and so on where people won’t really take initiative for their own health, and in Gauteng for example, there are a lot of townships and so on and Limpopo etc...” (set 4a)

“...you can barely get a person to take their medication which is going to actually make them better, now try and get them to actually come and be involved in the health care system and perhaps help others, it’s going to be way too much effort, not necessarily for me, but for them, the community...they’ve got lots of other problems going on.” (set 4c)

A number of students also mentioned that community members do not know about the PHC approach, and this seems to cause particular problems for the referral system in that people do not seem to be informed about how the system works.

“...most communities at this stage don’t know what primary health care is.” (set 4a)

“...just think of people who have absolutely no idea where to go, how to get it started, so there’s a lot of lack in that area...” (set 4a)

The issue of community perceptions and the mindsets of people came out as an important one, and students seemed to feel that these have some bearing on the successful implementation of the PHC approach. It was acknowledged that health professionals’ perceptions of a community’s problems and the community’s perceptions of their own problems may not be the same, and it has already been discussed how communities need to speak up about their own needs. In addition to this, it was mentioned that if patients in communities are not adhering to the advice given to them then the PHC approach is not going to be as successful. This highlights the existence of perceptions and mindsets and how these need to be acknowledged in order to maximise the benefits of the PHC approach.

“...if you do go to a community and you ask them their problems, they’re probably going to be very different from what you thought their problems were going to be.” (set 4a)

“...if you only educate the doctors, the doctors know what is supposed to be done, but if the patients out there don’t follow it, you can’t exactly do what’s supposed to be done.” (set 4a)

Where students have mentioned these perceptions and mindsets, it is often in relation to areas that are more rural and impoverished, and the people in these areas, according to one student, do not seem to be in the right frame of mind for the PHC to be successful. This is a rather ambiguous declaration, but it does make sense when other remarks are considered that spoke of apathy and a lack of initiative in these areas, as well as a lack of appreciation for and an understanding of the value of the efforts being made. This is felt to be due to the low levels of education in these areas.

“The government cannot just fork out money and build as you say the 1000 houses, and build the very prim and prestigious hospitals bang in the middle of Langa and build parks and make it very like New York maybe. They can’t do that because the problem doesn’t lie within the structure that you’re going to build, it lies within the mind of the person who’s going to be in that structure. We first have to educate people...if you have a person who’s not educated, they won’t understand the value of the building that you have built. To them it’s just another building, that’s why you get run down places...they’re run down because the people that are using them don’t appreciate them, they don’t understand the value of them.” (set 4a)

Community perceptions around the importance of cure have already emerged in the discussion of comprehensive care and it is clear from other students’ comments that emphasis on prevention and promotion, or even an interest in the psychosocial issues of a patient would not make sense to many because these aspects of care are not perceived to be treatment. Treatment is perceived to be curative in focus and to involve medication and there seems to be some pressure to produce results as quickly as possible. An emphasis on promotion and prevention could possibly even lead to disillusionment with the health sector.

“...from where I come from, like my grandmother for example, if she went to a doctor and the doctor told her she should get rest, exercise, she wouldn’t be comfortable with that. She would be more comfortable if the doctor gave her medication. So people are more geared towards damage control than prevention and promotion.” (set 4a)

“...people still perceive doctors as to be paternalistic and to tell them what to do...and I think the community perception...we are just going to cure stuff...” (set 4c)

Other community perceptions were to do with the efficacy of doctors as compared to nurses, and that people’s help-seeking behaviour may be governed by this belief, causing them to seek help at facilities where there will be a doctor who is believed to be able to help them more. This perception may also contribute to perpetuation of the hierarchy of health professionals mentioned earlier.

“...certain perceptions need to be changed at the community level, because you find that certain people think that being seen by a doctor is more effective than being seen by a sister...” (set 4a)

Still on the topic of help-seeking behaviour, some students felt that people’s decisions about which facility to go to is not determined by whether or not that facility is at the appropriate level - primary, secondary or tertiary - but is determined by the patient’s expectations of their needs being met by the doctor. Their decision may also be based on what has historically been the case, rather than what is true for the present situation.

“...the thing is for people, they just see a hospital or a clinic, they don’t have that thing that it’s specific for such and such. They will go and they expect whatever it is that they take to the doctor to be a priority...” (set 4a)

The history of South Africa and where this country has come from can definitely not be ignored when looking at community perceptions and mindsets, particularly not the mindsets and perceptions of those that have been previously disadvantaged and may still be living in this state. Some students have associated this disadvantaged position with a low level of education, but one student felt it had to do more with the state of disempowerment that people from this type of background have had to live in for so long, and that taking ownership for one’s health can be incredibly daunting for those who have never been encouraged to take ownership before.

“...you are dealing with people a lot of the time who have very much less education than yourself...that person has this idea in their mind of ‘the doctor’ who sees their problem, writes the script and off they go and get better. And suddenly the doctor is giving them decision making power and that is very scary...” (set 4c)

“...because we have got a history of disempowerment, like you are not allowed to think for yourself and now all of a sudden, here we walk up to them and we want them to think for themselves and to decide for themselves...It isn’t even anything to do with education level, it is just they are so disempowered...” (set 4c)

Although the role of doctors is discussed extensively later in this chapter, students did make a number of comments on the role of doctors in communities and what their responsibilities were when working in these types of settings. Students’ feelings about this range from those who believed it was essential to those who felt that doctors do not have time for community involvement. A few students were less ready to put forward an opinion on this, and claimed that a doctor’s involvement in the community they are

working in will be determined the nature of that community, the responsiveness of the community members, and that it will be a personal decision based on one's motivation to be there. This last point is definitely relevant for those doctors who choose which community they want to work in, but for many doctors, because of internship and community service, this choice is not in their hands, and this point may then not apply.

"I think it all depends on the size of the community, on the wealth of the community, on the problems facing the community." (set 4c)

"...if you've taken the decision to serve a particular community, then I think you will decide yourself...nobody forced you to do it so you can do as much as you want, and another thing...how much people respond to you, that will determine how much effort you also put into their wellbeing." (set 4a)

Students in favour of doctors' involvement with the community stressed the importance of doctors being familiar with the surroundings they are working in, which includes the people, and being able to build a relationship with the members of the community so that the community feels their doctor is approachable. This ability to "connect with" the community is even deemed to be more important in some cases than an extensive knowledge of disease.

"...I think it's important if you are working in a community, to get to know your community...they're the people that you work with constantly, and if you form a relationship with them...in a small community, I think they're going to have...they should take on a role as a person who the community can approach...a doctor should be just someone there who knows the community and who not just stays by themselves and a very sour person...don't make yourself this foreign person who just comes in to help the disadvantaged or whatever..." (set 3)

This relationship that the doctor builds with the community needs to be one built on respect and trust according to some students, and without discounting the knowledge and expertise that doctors possess, doctors need to have an attitude of humility and an awareness of that which the community has achieved without them. One student also highlighted the value of building relationships and working together with prominent and influential members of communities, particularly in African communities.

"I think in a lot of African communities that have...for example priests and the elderly women and church committees, choirs and traditional healers, they have a lot of respect for those people and they have a really big influence on the lifestyle of people and the things that they do...get to know who are the people of authority, people who are respected...we do have lots to offer that they don't have...but at the same

time...there's so much that the community has been doing by themselves for so long without Westernised doctors or doctors who have learned the scientific way...we work together with them..." (set 3)

Other students emphasised the importance of doctors' community involvement because of their ability to educate communities, and also so that they can get a realistic idea of the extent of those who need treatment, which will help them develop better insight into the diseases that their patients present with by having an understanding of the backgrounds of their patients and the factors that may be contributing to their ill health. Some students reasoned that community involvement will not only help them to provide more appropriate treatment, but will also ultimately be more fulfilling for the doctors themselves as a failure to do so may cause doctors to feel that their efforts are fruitless and a waste of their energy.

"...if you don't, then you are literally going to be seeing a lot of people and you are going to be treating them and you still see people dying in the community and you will see your work going nowhere, because you're not going out there and finding out what the problem is really, what the root of the problem is. So you actually need to actively go out there and get involved and get to know the people in the community and get to know who has great influence over who and why and the way things work in the community. You need to be actively involved for yourself..." (set 4a)

In contrast to all these arguments for doctors' community involvement, there were a number of students that felt that this was asking too much of doctors. The reasons they gave for this were that doctors do not have enough time to go out and be involved in communities, and that the time that they do have needs to be prioritised for more important duties; that it is not practical, and this could be related to time; that for doctors placed in a community unfamiliar to them, interacting with that community may be extremely challenging; that the impact that a doctor can make on a community, working on their own is insignificant; and that there are not enough doctors to be able to treat patients and go out into communities, but that others could be trained to focus on the community side of things.

"...you must think of where that doctor's going to be coming from...how equipped am I going to be emotionally and as a person away from home, away from the luxuries of my own personal life, away from everything that is familiar to me, to be faced with this unfamiliar territory with people, and then trying to relate to them, to understand their problems with all of that and apply everything that I've learnt medically as well? It's a very demanding task I think." (set 4a)

Other PHC principles

A few of the other PHC principles were mentioned apart from being described as strengths of the PHC approach. One student emphasised the importance of acceptability, and equity and accessibility were also deemed to be important, but concern was expressed regarding the evidence of these. One student did remark on the apparently good accessibility to primary level facilities, but since this student was referring to facilities in Cape Town, this observation only serves to underline the point made by another student on the discrepancies between provinces.

"I'm just worried about the whole problem of equity in the sense of access to health services...because if I look at Western Cape and compare it to the Eastern Cape, there's like huge discrepancies concerning how people are able to access health..." (set 4c)

The role of doctors in the PHC approach

Apart from their role in the community, students also discussed the role of doctors in general within the PHC approach. Some of the students' comments were responses to a question in this regard, while other remarks emerged as a result of the discussion, and on the whole, doctors were seen to play an important role within the PHC approach. The majority of students' comments about this issue were to do with the role of doctors in the PHC approach in general, although a couple of students did remark on doctors' more practical responsibilities and highlighted their role in the referral system as well as their role in health promotion.

"I think they can play quite a fundamental role...doctors play an enormous role..." (set 3)

"...I think that doctors definitely have a bigger role than just the clinical or diagnose this patient and get them fixed up..." (set 4c)

There seemed to be an acknowledgement by the majority of students that the PHC approach does change or at least impact on the role of the doctor, and that this is problematic for some students who feel that the approach requires too much of them in terms of the skills they need to have and the responsibility they need to bear.

"...I find it problematic that they try to broaden our job, our future job description so much, because yes, I really think that promotion and prevention are much better than having to cure patients but I don't know

if it's necessarily the job of doctors to promote this...they're just broadening our job description intensely with the responsibility..." (set 3)

"...it's [PHC] a bit taxing on doctors, I know a lot of the students are feeling, ok, what are we supposed to be here? We are supposed to be counsellors and psychologists and doctors and friends and health rights crusaders all rolled in one, and that's a bit idealistic and that's a bit too far out there." (set 3)

The view was expressed that health professionals also become more burdened if other sectors do not play their part in the PHC approach. A couple of students questioned the actual involvement of doctors in intersectoral collaboration, but while the one student felt that learning about this principle was meaningless for doctors, the other felt that even if doctors were not directly involved, they needed to have an awareness and understanding of those aspects of their patients' living conditions in order to treat them effectively and appropriately.

"...how to deal with patients and their social circumstances, it helps but it doesn't really address the problem because you can't exactly go and build 1000 houses for the people to like improve their social conditions. So as a doctor it has no meaning in the end of the day." (set 4a)

"...I think if you make yourself aware and you understand that these people don't have taps in their homes and they don't have electricity all the time, then you make a decision based on the real lives of the people." (set 3)

A number of other students seemed more accepting and positive of the change in the doctor's role as a result of the PHC approach, even if it is more challenging than was initially expected as it goes beyond the curative and even the medical, to incorporate the political, economical, social, emotional and spiritual. Even if these students accept that this is the case and that doctors are no longer exempt from certain duties because of their perceived superiority, it is still expected to be demanding, particularly on an emotional level, as one is required to engage more with patients.

"Not even as a doctor, even as a student you get this impression that you need to start thinking about ways of helping people and working with government...and thinking politically as well. Some of us, we don't do politics...But now...I kind of noticed that in order for me to understand the exact situation in South Africa, I have to take into account the politics and economics and that sort of thing." (set 4b)

"I think more is demanded of doctors, because that old method of just treating the patient is out, the whole thing about hierarchy being dropped as part of the PHC system...it means that we have to get down and dirty now, it's not about just being the doctor that dispenses medicines." (set 4c)

Some students were a little more specific about what they felt a doctor's role should be as a result of these increased demands and responsibilities, and they maintained that

the PHC approach requires doctors to be more creative and dedicated, and that doctors should be able to think more laterally, be able to motivate and empower others to think for themselves, and be able to instigate the process of action by teaching others what to do as opposed to doing it themselves.

“...as doctors I think you’ve got to be a lot more perhaps creative and dedicated.” (set 4b)

“...I think you must be, as a medical practitioner in the real world, be more like a motivator and instigator, get people to think for themselves...then get them to do it themselves as opposed to you doing much so that you can focus on the clinical stuff.” (set 4c)

As a part of this broader role of doctors within the PHC approach, there also seemed to be recognition of the responsibility that doctors have to bring about positive change in the health care system, to inform patients of their rights and to maintain a broad perspective on issues.

“They are not just there to be a diagnostic tool, they have a lot more to consider nowadays, and they have a larger responsibility and they tend to know more about the individual’s rights than the individuals themselves, and that puts a responsibility there, to make sure that the person know that they’re entitled to certain things and issues.” (set 3)

A few students felt that this responsibility extended to using one’s position as a doctor, which as much as it has undergone change, is still one of status and authority, and should be used for the good of patients and communities by advocating for and activating change where it is needed.

“...a lot’s got to do with it actually just not so much your expertise and what you know, also a lot’s got to do with just perhaps the ‘respect’...you get from, for example nurses and the community...and so you really can get a lot done with that kind of respect and...the status as such...you’ve got a lot of almost authoritative power and it seems to make things happen and change things...” (set 4b)

In contrast to these somewhat inspirational beliefs, one student expressed his view, which was not contested by those in his group and he implies that this view is shared by others, that this expansion of the doctor’s role in the PHC approach has bred confusion, uncertainty and insecurity in terms of what they will actually need to do one day as doctors. These kinds of feelings at this stage are not the types of feelings that can be shelved and dealt with at a later stage when one is qualified, but will undoubtedly have some kind of influence on the views of those who are feeling this way, and may very

well give rise to a negative attitude towards the PHC approach because of the unpleasant feelings that are evoked.

“...there are certain things that they talk about that need to be done for people socially, but that's not what we do, and there will be things that we can do but we don't know how...we don't actually know how our lives will be, what our position in a hospital, for example, will be and what we'll be in charge of organising and what our role is in implementing it. Is our role just to be there, or is it to actually organise something? We don't know what's going on really, we don't know where we stand.” (set 4a)

Despite the fact that most students felt that the doctor's role within the PHC approach is broadened, there were some students who felt that their role was in fact reduced. This was based on the fact that the PHC approach encourages the sharing of responsibility for health, it focuses on prevention and promotion, it promotes multidisciplinary teams who can help to share the workload, and it does not require doctors to be at facilities where their skills are superfluous thereby allowing them to devote their time to areas where they are necessary.

“...for example at the MOU [Midwife Obstetric Unit], you don't really need a doctor there, as long as the nurse is competent to know if she needs referral...” (set 4c)

Lastly, a couple of students emphasised the fact that without doing away with the autonomy of patients, doctors should still fulfil the role of someone who can give an educated opinion or advice to patients.

“...yes, patients must be autonomous and yes, they must have a say in what happens to them. But you do actually spend six years studying...to know what is going on with their health and their body and in their minds...you still have to give an opinion because it is worth a lot. That's what you are there for.” (set 4c)

Conclusion

What has been discussed in this chapter should have given a clearer idea of students' attitudes towards and perceptions of the PHC approach through their views on the approach. Students did mention a number of strengths of the approach, which seem to indicate a positive attitude, and the weaknesses mentioned are largely to do with the implementation of the approach. Two views that came through strongly were that the PHC approach is idealistic and that there is a disjuncture between the theory and the reality of the approach. This latter view was not generally perceived to be something

positive, and neither was the view of the PHC approach as idealistic, but there were some students who felt that idealism had its place.

This chapter has also covered the students' views of some of the PHC principles and the issue of comprehensive versus selective PHC, as well as what students perceived to be the more important aspects of comprehensive care. Lastly, the role of doctors in the PHC approach was addressed and seemed to be a pertinent issue for the students as their role in the PHC approach is not specifically outlined, but there is definitely an implication that within the PHC approach the role of doctors is widened.

From this and the previous chapter it should be clear that there is an interrelation between the students' perceptions, understandings, attitudes and views of the PHC approach, which is shown in Figure 6 below. This diagram also indicates that as certain factors come into play, attitudes and views may be influenced by a number of factors, and which may in turn alter perceptions and understandings of the approach.

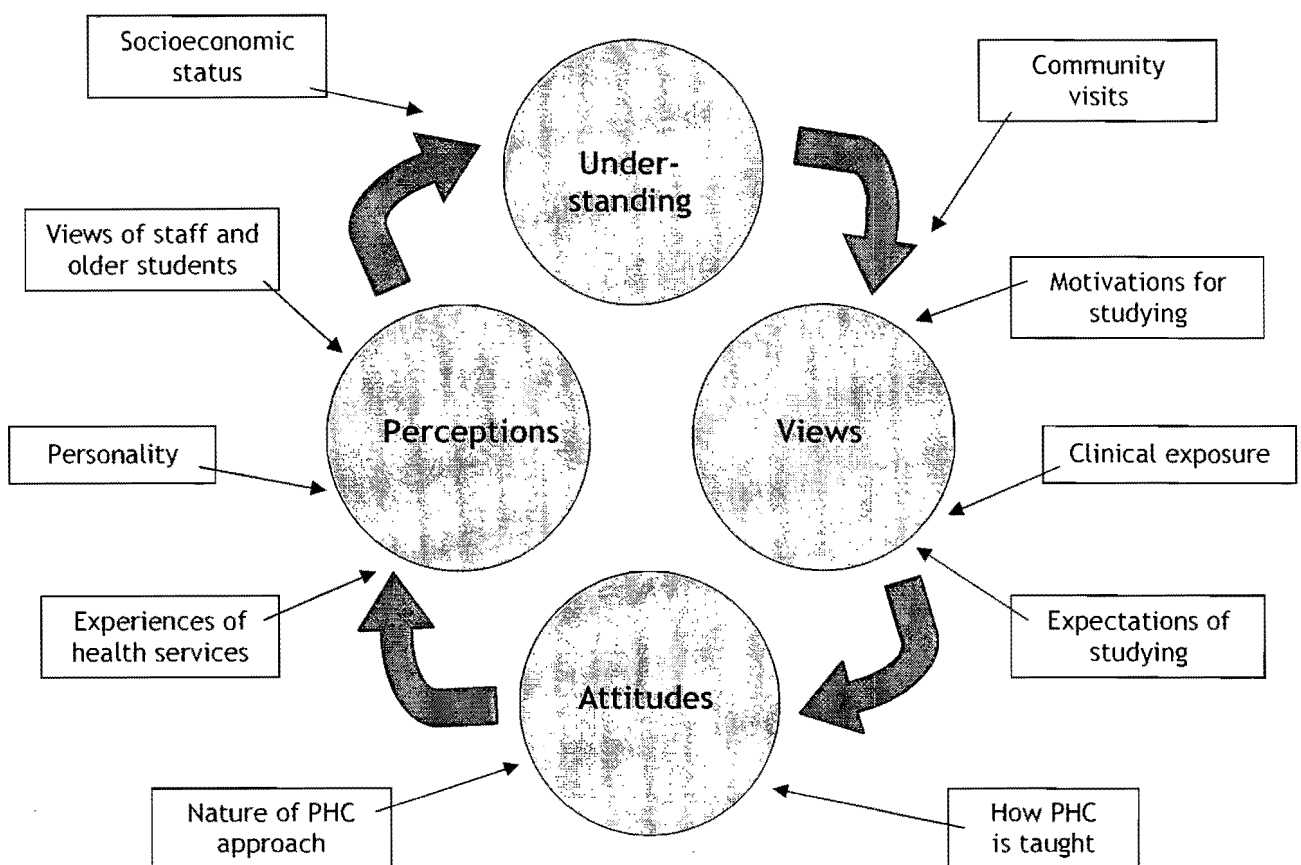


Figure 6: Interrelationship between perceptions, understanding, views and attitudes

Theme 6 - Medicine and PHC in the South African context

“I think also that we really needed some system like the primary health care approach in our country, because in the past the health system was very fragmented in apartheid years and that left a country that was poor and people that were dying of diseases that could be prevented or treated successfully... I think it's something that our country needs...” (set 4c)

Introduction

Students' views of the PHC approach cannot be examined in isolation, and it is vital that these views are located within the context of South Africa and the environment in which they are going to be working. Students' views of this environment also need to be considered and this includes the political dimension of the South African context, which emerged as a strong feature of some discussions.

This chapter will cover the students' views of health and health care in South Africa, including their opinions on the applicability of the PHC approach for South Africa and the working environment for health professionals in South Africa. Along with this, students' impressions of the implementation of the PHC approach in South Africa will be covered, the obstacles to implementation and the success of this approach, as well as what is required for the proper implementation and success of the PHC approach. Related to this are students' feelings about being trained in a new approach, but ultimately working in a setting that has not necessarily adapted to this approach.

What is also dealt with in this chapter is how the South African government features in issues of health and the PHC approach, and this incorporates the students' dissatisfaction with and criticism of the government, as well as their perceptions of the government's role and responsibilities regarding health care. This leads on to the students' discussions around the public and the private sector and the differences that they have noticed between these two sectors, including their views on the appropriateness of the PHC approach for each sector, working within these sectors, and reasons for choosing to work in either the public or private sector.

Theme outline

- Students' views of health and health care: need for change in the health system, applicability of the PHC approach, and working conditions for health professionals.
- PHC in South Africa: the implementation of the PHC approach, the meeting of an old and new paradigm, and obstacles to and requirements of the implementation and success of the PHC approach.
- Government: dissatisfaction with the government, government's role and responsibility, what the government is currently doing.
- Public versus private sector: differences between the sectors, the appropriateness of the PHC approach for each sector, working in the public sector, and reasons for choosing to work in either the public or private sector.

Students' views of health and health care in South Africa

Need for change in the South African health system

Although some students were not specifically asked about their views on the state of health care in South Africa, there did seem to be a general acknowledgement among the students that it was not good, and that there is a need for change, even if there have already been positive changes in some areas. Rural areas and townships were identified as being areas that were particularly in need of change, and students showed an awareness of the role that South Africa's history of apartheid has played in the state of health care in these areas and the existence of inequity.

"...it's really, really poor here in South Africa in certain places. When you're even in the townships of the big cities, you can find some really, really, really poor health care." (set 2)

"I think because of apartheid and things like that, there's a huge discrepancy between the standard of health care you can get, not even in private, but a state hospital like Groote Schuur, and somewhere in the rural areas and in the townships..." (set 2)

Applicability of the PHC approach for South Africa

A conflict of opinion existed around the applicability of the PHC approach to the South African situation, and those who argued against it maintained that socioeconomic issues, such as the low level of employment and education, make the PHC approach unfeasible in South Africa.

“...especially in our country, it wouldn't work...we have a high population of unemployed people, people that are at the grass-root level and were expecting to have optimum health care for them within a short space of time, and I just don't think it's going to work.” (set 4a)

“It will be very ideal for a First World country where they have everything to properly implement it and to go for it and levels of education are up there so that everyone can understand what's happening...I think in a country like ours, we just need to implement it and wait it out and see what happens.” (set 4c)

This first comment does have an element of truth in it, although in a way it misrepresents the PHC approach, as this approach does not claim to necessarily produce results in a short space of time. The second comment does pick up on the need for resources in the implementation of the PHC approach as well as the fact that this approach is perceived by some to be complicated, but also shows a misunderstanding of the approach in that the PHC approach does not require high levels of education in order for it to work, but rather advocates the importance of education.

There did seem to be many more students that were in favour of implementing the PHC approach in South Africa, and agreed that it is a good and important approach for South Africa. Most of the students that made these comments did not qualify why they felt it was a good approach for South Africa, but those that did referred to South Africa's status as a developing country and the need to focus on all areas of the country, which relates to previous comments about the state of health care in more disadvantaged areas. It is quite likely that those students who did not specifically refer to these issues were indirectly alluding to them.

“I think it's a good approach, especially in developing countries...South Africa is a developing country, and this would be quite a good approach of health for all, especially in a country like this.” (set 4a)

Apart from seeing the PHC approach as a good approach for South Africa, a number of students felt it was also necessary and relevant. Again, these students did not necessarily state why, but the socioeconomic issues mentioned previously did seem to be implicit. There were other students, however, who did explain the need for the PHC approach in South Africa, linking this need to consequences of the apartheid system that has bred inequity in terms of health and access to health services.

“...our country comes from a history of struggle, apartheid and everything, so there's a lot of people, a great number of people who are still marginalised, who still don't have the access to the resources that

they're supposed to have. So because of that, we do need such a system or an approach that aims to target people that were previously disadvantaged..." (set 4b)

Other students felt that even if the PHC approach was a good approach, it needed to be adapted more to the South African situation and that in implementing this approach there needed to be more consideration of South Africa's issues. Along similar lines, a few students believed that the PHC approach could be refined during implementation, particularly those aspects of the approach that do not appear to be successful.

"We need to adapt it to South African society...maybe it's worked elsewhere; it doesn't necessarily mean it's going to work in South Africa." (set 4a)

Some students felt quite strongly that the PHC approach is less applicable in the poorer provinces and those provinces with more rural areas, and the justification for this was the lack of resources in these provinces. Following on from this, the need was expressed to take more consideration of this fact and to provide more resources for these provinces. Related to this, some students pointed out the fact that there may be some that have an incomplete or narrow view of the need for the PHC approach, referring to those who have not been exposed to rural areas and may mistakenly believe that what they have seen in and around Cape Town may be as bad as it gets. They also highlight the need to raise awareness of the situation in rural areas, and argue that physically going into these areas is the most effective way to raise this awareness.

"It's not applicable in all...like Cape Town has many resources, so it's easy to implement it in Cape Town. But go to Eastern Cape...I don't think it will be applicable because you don't have resources...there's not systems and all these things, so I don't think it will work..." (set 4c)

"...the facilities that we went to, like when we went to Mamre, many Capetonians will look at that and will think maybe 'poor background'. But where we come from, those people are more than well off. Like with us, by poor we mean no food, nothing on the table...minimal number of clothes..." (set 4b)

Working conditions for health professionals

On the whole, students seem to have a rather bleak view of the working conditions of health professionals in general in South Africa. These impressions are largely referring to conditions within public sector facilities, and it is probable that students are referring mostly to nurses and doctors, as these are the health professionals with whom they have had the most contact. The main complaints students have about these conditions are

the long hours, the lack of or low numbers of staff, the low pay, the short amount of time given to patients, and the fact that staff are overworked.

“I know they have terrible working hours...” (set 2)

“People are understaffed, they are underpaid...” (set 4a)

Students highlighted the effects of these unfavourable working conditions, and these were frustration, decreased motivation and passion for one’s work, stress and burnout, dissatisfaction, being detached, less compassion, disillusionment, and a helpless attitude that may lead to apathy. They claimed that these effects would then impact upon the care that health professionals provide their patients, and that eventually patients would suffer as a result of poor working conditions in facilities.

“...they feel so ground down by the system themselves, the years and years and years of being mistreated, of being underpaid, all of this has made them detached and they have lost their compassion.” (set 4c)

“...the wages that people receive are going to ultimately have a direct effect on the care that they give and...their work, not only because of them being disgruntled, but there are so few staff...that they actually can’t afford the time to give what they should give...” (set 4a)

Many students seemed to be particularly aware of and concerned about the difficulties that doctors are facing in South Africa at the moment. In some groups, students voiced their opinions on this issue rather vehemently, but in others the issue hardly emerged, although no one had any praise for the conditions under which doctors are required to work in South Africa. Generally, they acknowledged that doctors in the public sector can expect to work under poor conditions with limited resources and a relatively low salary, and can anticipate feeling stressed, frustrated and unappreciated.

“They look frustrated, they work long hours, no one appreciates them.” (set 4b)

The South African government seemed to be a central feature of these students’ discontent, and some put forward the argument that the government is responsible for making it difficult to stay and work in South Africa by not improving these conditions, to the extent that leaving the country or avoiding the public sector appear to be the most viable options. Others also felt that more could be done to attract doctors to work in areas where the primary health care approach is needed the most.

“Definitely the government now is doing a very, very great job at making us leave the country. They’re doing an excellent job. They want to fix everything, but they want to fix everything on other people’s expense, not on their own.” (set 4a)

“...I understand that you have to get doctors to those places, but they need to find a more effective way of doing it and making it more appealing, because it’s just not appealing.” (set 4a)

From other remarks on this issue, it is evident that students and doctors are feeling disillusioned with the government, as well as a strong sense of unfairness about the fact that doctors are implored to be patriotic, motivated, hard working, and uncomplaining, while the government is not fulfilling their end of the bargain. One student brings this back to the PHC approach by arguing that in light of this unfairness and poor treatment by the government, doctors are not going to be motivated to play a role in implementing the PHC approach, which is in fact what the government is hoping doctors will do.

“...in medical school, my friends and doctors I’ve spoken to...they feel that the government is screwing us over as it is, we’re so badly treated as it is, now we’re expected to go out of our way to go above and beyond the call of duty and really get communities involved...if your doctors are unhappy and they’re pissed off, then how are they going to go out of their way to implement any kind of initiatives?” (set 4c)

There was debate in one group of fourth-year students on the role of finances and resources in improving this situation, and some students felt that if resources were made available for equipment, medication, higher salaries and incentives for doctors, doctors would be willing to work in the public sector. Other students opposed this view by questioning the ability of money to change attitudes and by proposing that higher salaries may simply raise the standard of living for doctors and draw them further away from the philosophy of the PHC approach. In this and other groups, students also deliberated over what would be a reasonable salary for doctors to receive, but there did seem to be agreement on the fact that a doctor’s salary should reflect that time and energy that is put into studying medicine.

“...if it had equipment and if all the things of primary health care are in the places that you go and work at, you will be excited to go and work there.” (set 4c)

“I don’t feel that you get paid according to your expertise...I bet you’d find that on average, people in the business sector, people almost in every other sector would be earning much higher salaries...I think it’s fair enough that we say we get treated reasonably for the hard work that we put in.” (set 4c)

On completely the other end of the spectrum, there were a few students who felt quite adamantly that in spite of the working conditions, doctors should not leave South Africa,

but should stay in order to help to improve the situation. It is probably worth noting that these students were only one semester into their academic career, whereas the previous comments were made by older students who are likely to have a slightly more realistic picture of what working as a doctor in South Africa entails. The first-year students' comments are also probably indicative of the idealism of students at this stage that has already been mentioned, but may also be reflective of these students' personalities and a greater desire to serve and make a difference in South Africa.

"I believe that the situation in this country is such that you actually need to force doctors to stay in, otherwise everyone's just going to leave, and this place is just going to get a lot worse than it is....I know that the working conditions that doctors are under aren't very good...But I think people will probably die and situations will get a lot worse if the doctors just leave the country..." (set 2)

PHC in South Africa

The implementation of the PHC approach in South Africa

Regarding the implementation of the PHC approach in South Africa, a number of students were of the opinion that the approach had not been fully or properly implemented, and bearing in mind that the difficulty of implementing the PHC approach has already been identified as a weakness of this approach, these comments are not surprising. Apart from the issue of implementation, other students also felt that the PHC approach is not seen to be working, and attributed this to either poor implementation or slow progress.

"...most of the primary care places you go to or secondary or whatever level you are going to, aren't actually implementing the primary health care approach..." (set 4c)

"I don't know whether it doesn't work now because it's in its initial stages or it doesn't work because it just isn't working." (set 4a)

Some students did mention that the approach or aspects of the approach could be working or are working in certain areas, and examples were given of areas in the Eastern Cape, the community of Mamre in the Western Cape that some first-year students had visited, some SHAWCO [Student Health and Welfare Centres Organisation] clinics that are run by students, a MOU (Midwife Obstetric Unit) where health promotion was taking

place, and the Peninsula Maternal and Neonatal Service (PMNS) system in Cape Town that is an example of an effective referral system.

“...in the Eastern Cape where I come from...it's been a huge improvement and that's basically because of the primary health care approach that we started implementing...” (set 4a)

“I think that this PMNS system here at the moment is a good example of primary health care and it's probably the only one that's running so well in the country...” (set 4c)

The meeting of an old and new paradigm

Owing to the fact that many of the students felt that the PHC approach has not been implemented fully or properly or that it is not successful, there also seemed to be a general understanding amongst the students that they will have been trained in the PHC approach but then will be working within a system that has possibly not undergone similar changes and is still operating with an old paradigm.

“...we were coming with the kind of bottom up approach and they wanted the top down approach, and they just weren't interested in hearing any of the things that we found. And maybe that's a danger as we hit the working world as the next generation of medical professionals who had a different sort of training where we are going to meet other people who just aren't interested...” (set 4c)

It was also accepted that it will be difficult to reconcile the old and the new, and this was a concern for some, particularly in the sense that it could hinder the students' belief in the new approach to which they have been introduced. One student however adopted a more resigned attitude and seemed to be content to work within the system as it is and wait until the PHC approach is in place.

“It's a big problem because it stops us believing in the new and it just makes us revert to the old, and it's so easy to revert to something that's so much easier to do than an approach where you actually spend time with patients and it's more patient centred than the old...” (set 4c)

Apart from these difficulties and concerns, some students did express a more optimistic view of this meeting of the old and the new. One student espoused a more long term perspective, and he argued that by introducing the approach at a tertiary education level, there was more chance that changes could take place and that the PHC approach would be successful. Another student also viewed this issue from a long term point of view, and reiterated the resistance of both individuals and systems to change, but that

in time, doctors who have been trained in the PHC approach would become more integrated into the health care system.

“...in order to change the mindset, I think that it’s a very good way to start by targeting the people that are studying and who are going to be working in the future years, so that at least by the time they do go out, the mindset is already there. Now we probably won’t work in the perfect primary health care type of strategies, but at least if we’re thinking that way then at least things can change, because we are the people who are going to be out there and we’ll need to somehow make that change and be more accepting of whatever changes that need to be done...it’s really about the long-term vision...” (set 4a)

This issue of the new joining with the old relates strongly to the issue of staff at UCT and health professionals’ awareness, understanding and views of the PHC approach. A lack of education in the PHC approach, a poor understanding and a negative view of the PHC approach could make the process of integration more difficult. Some students did feel that many health professionals were not educated in this approach or were not aware of its importance, and that at times it felt as if their own understanding of the PHC approach exceeded that of some of the staff with whom they came into contact.

“...do the nurses, the people actually at the ground level know about the whole approach, like the importance of it?” (set 4c)

“...sometimes you go in and you feel that you’ve got a better understanding than the people that are teaching at the moment, obviously not the primary health care people.” (set 4b)

In terms of the views of staff members and health professionals, a few students did mention those who were in support of the PHC approach, but that these are not always the health professionals that have to implement the approach in a clinical setting. More students mentioned staff and health professionals who were not in support of the PHC approach, and it would seem that many of these individuals are an older generation of professionals and could be classified as “old school.”

“...I’ve spoken to some doctors, they teach here, and they also didn’t like primary health care and they’re quite prominent in the faculty...” (set 3)

Some reasons were offered for this negative view, and the dominant reason was that the PHC approach runs contrary to a great deal of what these professionals have been trained in and are familiar with. Negative views of the PHC approach may then be a product of the insecurities and fear felt by these individuals that are faced with the PHC approach and the need to change. Drawing on the perception of PHC as a “Third World”

approach, some health professionals may also feel that adopting the PHC approach could lower the standard of medicine that exists in the private sector. Related to this, other health professionals may find the PHC approach not scientific enough because the PHC approach requires one to understand broad concepts as opposed to clear-cut definitions.

“I realise that a lot of people who don’t know primary health care and who have not really known it feel threatened and they feel very insecure about it and they try to do a lot of things to bring it down and try to come up with excuses as to why it doesn’t work.” (set 4c)

“...the main target group of people that this idea is trying to be sold to is people like clinicians...and these people don’t think in very broad concept terms in general. They think ‘what exactly has to happen?’...it’s important that there are clear definitions of what it actually is if...these scientific people are going to buy into this kind of approach...” (set 4a)

Obstacles to the implementation and success of the PHC approach

Following on from the assertion that the PHC approach has not been fully or properly implemented and is for the most part not seen to be working in South Africa, students pointed out the existence of various obstacles or barriers to the implementation and success of the PHC approach, such as disorganisation within the health system, a lack of infrastructure, along with difficulties with manpower, administration and logistics. Government malfeasance and the lack of political cooperation were also put forward as political obstacles to the implementation and success of the PHC approach.

“...I think the one main thing that is a problem in South Africa is the infrastructure. That needs to be changed for the approach to be properly facilitated and for it to be effective.” (set 4a)

“...embezzlement, corruption, all those things that come into it that won’t make primary health care very effective because of those holes that you have all around.” (set 4a)

Some students felt that the implementation and success of the PHC approach were impeded by peoples’ unawareness of the needs of others, as well as their motivations for wealth and comfort, which were labelled by one student as capitalist, and hence in conflict with which she saw as the somewhat communist ideals of the PHC approach.

“...people who come from a family of affluence...they’re used to a life where they have all the health care available to them and some people are naïve enough to believe that ok, ‘I have this, why can’t everyone else have it?’” (set 4a)

"...we live in a capitalist society. And unfortunately communism failed, and technically PHC, it takes its ideals kind of from communism...People want to make money, people want to live in their comfortable homes, in their comfortable lives." (set 4a)

A lack of belief, confidence or investment in the PHC approach on the part of health professionals was also regarded as a potential obstacle since these are the people that are required to implement the approach. This lack of belief could be due to the perception of the PHC approach as idealistic as well as the fact that the success of the PHC approach is not evident for health professionals to see and therefore build their confidence in the approach. A lack of confidence may then result in health professionals not wanting to make the effort to implement the PHC approach.

"I think part of the reason why PHC doesn't work is because...everyone believes it's idealistic, as long as you believe it you won't reach it." (set 4a)

"...the truth is that seeing is believing, you can't believe in something that you're not seeing." (set 4a)

Some students also felt that the lack of finances and resources, as well as the lack of time that health professionals have with patients are obstacles to the implementation and success of the PHC approach, in that time is needed to fulfil some of the ideals of the approach, such as taking a full patient history that allows the health professional to gain an understanding of the factors influencing their patient's health. However, one student felt that a lack of time should not be used as an excuse, as the time that doctors do have is not always used productively.

"...I think the biggest problem in a hospital setting and clinic setting is that there's not enough time for the staff, be it the sisters or the doctors, to really interact with the patients in a way that goes with the ideals. I think time constraints are a huge factor that prevents it from happening." (set 4c)

"I know that there's always this whole story of there isn't enough time for doctors to spend a lot of time, but some doctors, you get there, they take your blood pressure, they prick you, they sit and stare at you while they wait for some secretary to come in, they don't ask you anything...You don't need a lot of time, just a bit of concern and a bit of connection with the patients, it really goes a long way." (set 4c)

Students did mention some other obstacles, such as the lack of human resources, the low level of education in some areas and the fact that people in these areas have a different perception of health to the health professionals, the focus on major issues such as HIV, and the poverty gap. One student also mentioned the more global issue of wars and claimed this could hinder the implementation and success of the PHC approach.

What the implementation and success of the PHC approach requires

Apart from obstacles, students mentioned a number of factors that the PHC approach requires in order to be implemented and successful. Support of the government, including financial support, was cited as being important, as was support from other sectors. It was also argued that doctors will need to work together in order to see the success of the PHC approach.

“...you can have these people that are committed within the health sector...but without government commitment to it, you’re going nowhere...” (set 4a)

“It doesn’t really work on your own, you can’t really take your PHC principles, start your practice and off you go. It’s going to take a lot of doctors together to make it work...” (set 4a)

In addition to government support, obtaining commitment from all those involved in implementing the PHC approach is said to be a requirement for its success, and it was emphasised by one student that this commitment needs to be wholehearted, otherwise it not worth implementing the approach at all. Some students acknowledged that successful implementation of the PHC approach requires time, as the changes that need to be made will not happen quickly.

“...half the primary health care system is as good as like no primary health care, because you’ll have to go all the way to get those kinds of results...if you’re going to do it, you have to do it properly...You have to get everyone involved and make a real, proper commitment to it, but otherwise as a little project, it’s not going to happen.” (set 4a)

Finances, resources and infrastructure were mentioned in the discussion of obstacles, but were also mentioned as requirements of the successful implementation of the PHC approach, and global collaboration was also mentioned as a factor that could speed up the progress of the PHC approach.

“...for primary health care really to be effective, we need to implement it globally...the international community I think is a very powerful tool in being able to achieve this approach, and if we could see perhaps the World Health Organisation becoming less bureaucratic in its running and perhaps more functional at a lower level...they collaborate an approach to each country’s health care, then I think we could make quicker progress and perhaps more effective progress as well.” (set 4a)

Government

The government's role in the implementation of the PHC approach has already come up, and was a significant feature of many of the groups' discussions. This gives some indication of the fact that students generally deemed this role to be an important one, and some students clearly stated their view that the government needs to not only be aware of the PHC approach, but should be at the forefront of its implementation, some going so far as to say the approach relies on the government, who should be committed and hard working in this process. Apart from their role in the implementation of the PHC approach, a few students further commented on the government's influence on and the political dimension of their academic and professional career.

"I think the PHC system's totally reliant on government, they have to get their act together..." (set 4c)

"...you realise how much politics actually mould things you're doing." (set 4a)

Dissatisfaction with the South African government

Students expressed a range of opinions about and feelings towards the South African government, and these opinions and feelings were predominantly negative and were said to be fuelled by input from lecturers, the media, and by the views of many of the general public. A few students even professed a lack of faith in particular individuals within the government, namely the President and the Minister of Health. The President's notorious belief that HIV does not cause AIDS seems to have lost him credibility among some students, and the Minister of Health was described by one student as someone who completely misrepresents his idea of what a health professional should aim to be.

"When the face of health care in South Africa is a woman who embodies the exact opposite of everything that in my opinion, that health care professionals should strive for...what effect is that going to have on everyone beneath her? When the head of our land still hasn't come out and said 'HIV causes AIDS'..." (set 4c)

Some students felt that the government is exercising too much control over both health services and health professionals. These students felt that the government should allow health facilities to be more autonomous and should also not impose legislation regarding where doctors are allowed to work, particularly those in the private sector.

"I think government almost has too much control over what happens. I think community or health care services should have much more say in what the government provides for." (set 2)

Other students felt that the government is not doing enough for the health situation in South Africa and is not prioritising health or the health sector or giving enough support to health professionals. One of the main concerns to do with this was around funding, and especially the fact that the government do not seem to be allocating funds to the areas of need or to what the students consider and what the government claims to be important. Particular concerns were the unequal distribution of funds to the different levels of health facilities, as well as the allocation of funds to international causes when there are local issues that are equally desperate.

"...they look at the health sector as an important sector but they prioritise other sectors over that, and I think that is a big problem..." (set 4a)

"...the whole tsunami thing, did our government give a million rand? I don't know how much, but they gave money to that, and then like here in Cape Town, people are dying, like a fire thing at the same time...they give a lot of money to overseas people to improve our image..." (set 4a)

Government's allocation of funds was mentioned frequently, with particular reference to their spending on arms, a presidential jet, parties and extravagant lifestyles. In light of other comments regarding the government's priorities around funding, the students seemed disillusioned with the government, and the reason for this could be that they are aware of the need for resources in the health sector, and are also aware that the government prioritising other seemingly unnecessary things over health will impact them as doctors in the future. Their dissatisfaction around allocation of funds further extended to the salaries that are allocated to health professionals in comparison to the salaries given to MP's, and how this unfairness only serves to widen the wage gap, which has already been established as an issue.

"...spending money on arms and jets and things...we haven't had a war for a while...They're spending millions on inaugurations and birthday parties..." (set 2)

"I also don't have faith...I remember the nurses were on strike along with the teachers...The government refused to give them, I think it was 6%, 7%...And then they gave them after fighting with them, but it was less...I think it was two months later all MP's were given a 15% raise. No one had to strike...I mean that's a government that you just cannot believe in." (set 4a)

Corruption and mismanagement are other issues within the government that are promoting a lack of faith in the government.

"I think our government just takes it too far... everywhere and with everyone there's corruption...but with our government...it's blatant...it's just in your face...there's just too much of it." (set 4a)

Lastly, there were some students who seemed dissatisfied with the government because of the apparent lack of funds for the health sector, and this was most probably evaluated in light of the government's ability to spend in other seemingly less urgent or less important areas. There were a few students who believed that money was in fact available but was being misspent.

"I personally think South Africa's a bottomless pit. You throw in as much money as you like, it's never going to fill up. No one knows how to spend it." (set 4a)

Government's role and responsibilities

In addition to expressing their dissatisfaction with the South African government, students discussed what the government's role should be as well as their responsibilities in implementing the PHC approach and ensuring that it is successful. Some of these suggestions were based on what students felt the government was not doing, and among these was the prioritisation of health and health care, as well as the provision of funding and resources to and support for the health sector. In order to access further resources and support, the government could in addition make an effort to obtain the support of the private sector.

"I think the government just needs to be more supportive towards the health sector in general." (set 4a)

"...they certainly have the ability to try and get private people, private organisations and private entities involved and on board...perhaps providing incentives for private people to get on board..." (set 4b)

Some students maintained that the government has a responsibility to initiate and oversee the process of integrating the various sectors in order to make the PHC approach more successful, and that this could even extend to requiring other sectors to do community service as already done by health professionals.

"...I think that the government should realise...that the health problems are not necessarily only related to the health sector but that they need assistance from other divisions and that in the same light, other students should also in a way be compelled to give back to society..." (set 4a)

It was mentioned in a previous chapter that general awareness and knowledge of the PHC approach is lacking, and some students highlighted the government's role in raising this general awareness and increasing general knowledge about the PHC approach.

"Government can try and get the whole country more enthusiastic and more aware of the primary health care approach...I think government in power at any stage in the country, it has the ability to create that sort of awareness, public awareness and public enthusiasm for a particular cause." (set 4b)

One other responsibility of the government was that of legislation, and the student who proposed this felt that even though some recent legislation seems problematic, the government still has a responsibility to draft legislation that will promote the implementation and success of the PHC approach.

"...legislation...Some of the policies that they come up with, well...you can see the positiveness of them, but at the moment they are really hampering progress, the pharmacy ones." (set 4a)

What the South African government is doing

Apart from all the dissatisfaction with and lack of faith in the government, a number of students had a different perspective on the government's involvement in the PHC approach. A few students even admitted that they do not actually know what the government is doing, and as a result of this possibly feel less qualified to criticise or make suggestions. Other students felt that a reliance on the government to bring about change is somewhat futile, and this is because of the extent of the change that needs to take place, the need for health professionals to take on some of the responsibility for change, and the fact that waiting over the long term can breed laziness and a sense of entitlement. One student pointed out that just as there is a reliance of the people on government, the government is also reliant on the support they gain from the business sector, and if the business sector is not motivated to bring about change in the health sector, then neither is the government.

"...people keep saying 'it's the government's responsibility...the government.' But I feel like it's up to the people to help themselves, because we cannot all rely on the government, there are so many of us and the government cannot accommodate us all, so we have to stand up for ourselves as well." (set 2)

"...people they always say that government and the state is backed by businesses...obviously the economy...is still in the hands of the minority, and so as long as those people aren't concerned with uplifting the majority, it's not going to happen." (set 4a)

The point was also raised by a few students that the government is trying to bring about change in the health sector, but that the extent of this change required is so vast that it makes their efforts seem inconsequential. However some students did mention examples of where the government's efforts are evident, such as the high expenditure on promotion and prevention strategies for HIV/AIDS, provision of houses, water and land, and the building of hospitals.

"...I think the government is doing something, but the major thing is that the task is just so enormous for the government...it makes what they're doing like a drop in the ocean." (set 4a)

"...government's trying to build houses for people, they're trying to get water everywhere, they're trying to give people land so that they can start farming." (set 4a)

In considering what the government is not doing or should be doing, some valuable and insightful points were made that in many ways helps to take the pressure off the government. One student pointed out that one should consider what the government is actually able to do and what is practical for them to do. Another student highlighted the need to consider where South Africa has come from and how this influences what the current government now has to work with, and related to this it was mentioned that this current government is relatively new and is therefore still on a learning curve.

"...our government is working with a country that was beaten the hell out of by apartheid. It was nailed to the wall...You can see there's been dramatic changes...it's a slow process, that you have to take into consideration." (set 4a)

Public versus private sector

The issue of the public and the private sector has emerged on numerous occasions already, and is something that is definitely on the minds of students in terms of their experiences of the health system in South Africa, their expectations of medicine, and their future plans as qualified professionals. It is thus important to look into the students views of these two sectors as well as their impressions of working in either sector.

Differences between the sectors

A number of students recognised the gap between the private and public sector, with some commenting on the vastness of this gap and arguing that it needs to be addressed

because of the unfairness of the situation. One student even regarded it as embarrassing that such a wide gap exists. Other students felt pessimistic about the reality of closing this gap because of factors such as the poverty gap, the lack of political cooperation, and wars taking place, especially in Africa.

“...I think the gap is just there, it’s pointless trying to close that gap because it just won’t. There are some factors that lead to that gap being there and if you really want to address the gap, you need to address those factors first...things like poverty...especially here in Africa, you have some wars that are going on and people are dying, not because they are sick but because they are starving because of wars, and sometimes it’s just because of ignorance. So I think it’s just a few people at the top who are uncooperative, a lot of people are losing their lives because of that.” (set 4a)

Perhaps the main difference between the private and public sector which was not that frequently acknowledged, is that private services are not available to those who cannot afford them. Linked to this is the accessibility of these facilities, with those able to afford private facilities having far greater access.

“...it’s great for the rich people...they have clinics, like their little Medi-Clinics every ten kilometres or something, but if you go to Brown’s Farm and places like that, people have to wake up at four in the morning, three in the morning to go to clinics.” (set 4a)

One of the core differences identified between the public and private sector was that the private sector is perceived as more business orientated and aims to ‘sell health’ to patients, which can mean turning patients away that are unable to afford this service. The public sector on the other hand is seen to be more geared towards wanting to serve the patients without necessarily expecting anything in return, making a difference in their lives through this, and by taking an interest in their background, thereby engendering a greater appreciation of the doctors in comparison to the private sector.

“...the public sector is clearly like a service, it’s service without expecting anything back, whereas private sector is based on totally different principles.” (set 4a)

“...doctors in the private sector view their patients as clients and they treat their patients as clients, whereas in the public sector they are patients and you are the doctor and you have more of a relationship with them and an understanding of their background and an interest in their background.” (set 4c)

Public sector facilities are described as having fewer resources and supplies, along with many more patients and longer queues, both of these features presenting a stark contrast with private facilities.

“You find that the affluent, they can have everything that they need. There’s no shortage.” (set 4a)

“The long queues and then after waiting for your turn, the medication isn’t there...” (set 4a)

Some students commented on the differences in appearance between public and private facilities, describing public facilities as dirty and unhygienic, and private facilities as nice looking and comfortable. A private facility was even compared with a hotel, with the facility being described as flamboyant, emphasising the vastness of the difference between these two sectors. In describing the appearance of a public facility, one student picked up on the atmosphere of the hospital, depicting it as dreary and having a “sense of illness”, and this impression was echoed by another comment that described the patients’ looks of despair.

“...the general cleanliness of the area...it’s the atmosphere of the hospital that’s really different...In the public hospital it was dreary, and there was a whole sense of illness...as if you’re just left there and there’s nobody attending to you...I think in the private it’s more comfortable...” (set 1)

[private facilities visited] “...they are like flamboyant almost, it kind of makes me sick at some point because you go in there and each floor has got its own decorating theme. I suppose if you have the resources...it looked less like a hospital, more like a hotel...” (set 3)

In terms of the services offered by each sector, some students commented that private facilities had a wider range of specialist services as well as a wider range of types of services because of the equipment and resources available. The quality of service and care in private facilities was also seen to be superior, due to many of the factors mentioned above, as well as the available resources and staff, with one student again likening it to a hotel in terms of the service offered. Private facilities were seen to run more smoothly in comparison to the chaos of the public facilities.

“If you have the money, you get better care, and if you don’t have the money, I suppose you get a lesser, inferior quality of care.” (set 4a)

“...I got the feel that in the public it was a bit more chaotic...people running around, and in a private...it seemed to be much more smoothly...it’s not as chaotic.” (set 3)

Explanations for this difference in the standard of care were offered by a few students, and these all tie in to the business orientation of the private sector and the perception of patients as customers or clients that need to be attracted to the ‘product’ and treated in such a way that they do not opt to go elsewhere to receive their services. This is seen to have an impact on the attitudes of staff in the private sector, as they will treat patients in accordance with this business orientation and in such a way that the

patients feel they are receiving value for their money. However, in the public sector, issues of choice, customer satisfaction in the quality of the service and value for money do not apply, although one student did note that staff in these facilities displayed dedication and a desire to “do right by the patients.”

“... if you can afford to go to a private hospital, if they don't treat you well you can go to another one which will treat you better...The public sector...no one has got a choice...If you're not happy with the service, don't get treated, tough...” (set 4a)

“... in the private you're paying for it and you're going to get very good service, like the whole attitude of the workers changes...in the private sector you're trying to draw people, so you'll give them better attention, better service, and then in the public sector, you have to wait in lines, there's a shortage of staff and other issues like that, but in general...the level of service is also much lower.” (set 4a)

The appropriateness of PHC for each sector

Regarding the appropriateness of the PHC approach for the public and private sector, the students had differing views, with some of these views indicating a better understanding of the PHC approach. Only a small number of students felt that the PHC approach was more applicable to the public sector, although one student did mention that this was the case because the private sector did not need the PHC approach, which is debatable. These opinions seem to be largely based on the fact that students did not receive much teaching on how the PHC approach applies to the private sector, and have relatively more exposure to public facilities. Only two students pointed out that the fundamental obstacle to applying the PHC approach in the private sector was that the PHC principles of affordability, accessibility and equity do not apply in this sector.

“I think in the private health sector if you try to implement primary health care...isn't one of the criteria of primary health care affordability, and everyone can't afford private health care so I don't know how that's possible.” (set 4a)

Some students maintained that implementing the PHC approach would take more effort and would be more difficult to implement in the public sector, and would be easier in a private setting because of the available resources, including time, and the high standard of care. These comments are difficult to evaluate because students do not specify which aspects of the PHC approach are better displayed, and it would appear that some students equate good service with the successful implementation of the PHC approach, which indicates a rather narrow view of this approach.

“...I think the other principles of primary health care are so much more better displayed in the private settings...there’s more money so patients are generally treated better and everything works a lot better, but at a cost, so only a small percentage of people can actually use that.” (set 4c)

Other students did emphasise that the PHC approach needs to be applied to both sectors, even if the approach was more relevant for the public sector, in order to prevent the gap between the two from widening even further, or as one student even claimed, closing the gap and achieving equity. Another student stressed the importance of some kind of relationship between the two sectors from a resource perspective, arguing that the private sector should be willing to offer assistance to the public sector.

“...there’s some principles of primary health care that can be applied and they can work really well in the private sector, a whole lot of primary health care actually makes a lot more sense in the public sector.” (set 4a)

Working in the public sector

A number of students commented on how it would be to work in the public sector, presenting it as a rather noble and admirable option. Some did, however, point out that it would entail hard work and that it would be stressful and emotionally draining, and one student mentioned that conditions could be different in different types of facilities.

“...if you’re in a government hospital, you’re working long shifts, and you don’t go home when you’re supposed to, and you don’t stop when you’re supposed to, and you’re constantly on your feet. Sometimes people forget that there are doctors that work that hard.” (set 1)

“...you’re just running around, because...there’s not as many people working...You’d probably be very stressed in a public hospital...” (set 1)

Despite these difficulties students, for the most part, depicted work in the public sector as “fulfilling”, “satisfying”, “inspiring”, “brave” and “sacrificial”, and that one has more of an opportunity to help those who are in need, make a difference in their lives, and can “attend to the bigger picture” regarding health and health care. Students did not elaborate too much on why working in the public sector would be more fulfilling, satisfying or inspiring, although one student did attribute it to that fact that one is more valued by one’s patients, but it could be due to the other factors that students mentioned, such as being able to be of more help or make more of a difference.

“...there’s almost this superiority, hard core image about if you’re working in the public sector, like you’re doing a brave thing, you’re doing the sacrificial thing...” (set 4c)

“...I still want to be involved in the public sector, because that is where the need actually is...” (set 4c)

Reasons for choosing to work in public or private

Students' future plans have already been discussed, but since the students' impressions of the differences between the public and private sector have been examined, along with their perceptions of what it would be like to work in either sector, it would make sense to then look at the motivations that lie behind the choice of whether to work in the private or public sector. Once again, the students referred to their own as well as other people's motivations.

The dominant motivation seemed to be financial, and a number of students argued that people would choose to work in the private sector because one would earn more there than working in the public sector. Along with this financial motivation, some students mentioned that working in the public sector was more demanding on one's time, whereas working in the private sector would mean more manageable working hours and more time, and therefore an increased quality of life.

“...if you really want to make money then you could go private...I think private you get a lot more time for yourself...more time for your family...But if you go into public then you have to give a lot more of yourself and a lot more of your time...I just think that public is more involved.” (set 1)

“...when people are working ridiculous hours in the public sector, I think it often drives them to move into private practice.” (set 3)

Some students also said they would choose to work in private facilities because of the way in which doctors in the public sector are treated by the government, and working in public facilities was depicted as more stressful due to issues such as working conditions, long hours and low salaries. This type of stress would not be present in private facilities as one would have access to the necessary supplies and equipment, and one would therefore be able to offer a better service to patients and build relationships with them as one would be dealing with a more manageable number of patients.

“...it would be much easier to work in the private sector because you've got the facilities, it's not going to be as frustrating, because you've got much better access to things.” (set 1)

“...if you’re working in a private sector you are more likely to see the same patients again and again and build a relationship with them...” (set 4c)

Other students argued that people would prefer to work in an environment in which they are familiar and is within their “comfort zone”. This was mentioned with reference to students who are from a more affluent background and are used to private services.

“...if someone comes from an affluent background and they’re used to going to clinics where as soon as they walk in, someone comes and talks to them and there’s a nurse and a doctor waiting, and you get the best health care, you’re not exactly going to want to work in an area where you get ten patients at the same time and you have to deal with so much pressure and things like that.” (set 4a)

Working in the public sector has already been described as an opportunity to help people, particularly those in need, and this was additionally mentioned as a motivation for some to work in the public sector, as this is where the greatest need is perceived to be.

“If you want to help people that need the help, then you might go the public way...” (set 1)

Apart from all these motivations mentioned above, it should be recognised that those who are already working in the public sector and have contact with the students may be influencing their choice of where they would like to work.

“...most people in our class now would say no, they want to work in the public sector just because that’s just been drilled into us so much...Because we get taught by all of those people who’re working in the public sector...” (set 4c)

Conclusion

What this chapter has shown is that students have a general awareness of the poor state of health and health care in certain areas in South Africa, and some feel that the conditions and issues associated with these areas would make the PHC approach not feasible in South Africa. However there are more students that feel that the PHC approach is appropriate for South Africa *because of* the existence of these areas, although some students argued that the PHC approach needs to be adapted to South African circumstances. Associated with this poor state of health care were the adverse

working conditions for health professionals in the public sector which were mentioned by students, and the predicament of doctors in this sector was especially highlighted.

In terms of the implementation of the PHC approach in South Africa, students seemed to be of the opinion that the approach had not been implemented as it should be and is largely unsuccessful where it has been implemented, although there was some mention of a few instances where it was seen to be successful. Related to this, students expressed an awareness that the system in which they would be working in the future would not have undergone the necessary changes to accommodate the PHC approach. Although some concern was expressed about this, it did not seem to be a major source of stress for the students, and some students felt that the change had to start somewhere. Students also seemed to be quite aware of the obstacles impeding this implementation and success, as well as those factors that were necessary or that would aid implementation.

It is evident from what was presented in this chapter that students do not see the government in a particularly positive light. Even though some students cautioned against blaming or relying on the government, there seemed to be a weighting on the government's role and significance in the PHC approach, and there was possibly an element of frustration with the fact that the government itself did not fully appreciate this role or their significance.

Lastly, this chapter reported on the students' discussions of the public and private sectors, the numerous differences between these sectors as well as their varied opinions on the appropriateness of the PHC approach for each sector. Students portrayed the public sector as a far less appealing environment, in terms of the facilities, resources available and the services offered, and did point out the hardships of working in such an environment. However, in spite of all of this, working in the public sector was still praised as the more meaningful option, although there were many factors that were said to influence people's decisions about the sector in which they would want to work.

Theme 7 - PHC and the learning environment

“I think that it’s a difficult process to go through and it’s not always apparent what’s happening. But the breaking down of paradigms is one of the most important things that we need to do at this time and it’s going to be a struggle and it’s going to be suffering...but I think that it’s an important time, that we almost need to go through that struggle and come out like a butterfly...” (set 4b)

Introduction

Placing the students’ attitudes and perceptions of the PHC approach within the context of their learning environment is essential and will hopefully provide more insight and clarity into these perceptions and attitudes. This chapter will help to describe this context and will begin by addressing the students’ expectations of studying medicine with regards to teaching methods, as well as whether or not these expectations were met. Following this, the students’ feelings about the new curriculum will be covered, along with the perceived benefits of this curriculum, and their views on the content and teaching methods of the new curriculum.

This chapter will also report on the students’ views of the way in which the PHC approach is taught to them. Apart from their general opinions of this, this section will deal with the timing of their introduction to the PHC approach, assessment of this approach, the issue of other approaches besides PHC, and their suggestions about possible changes that could be made regarding how the PHC approach is taught. Lastly, the issue of clinical exposure will be addressed.

Theme outline

- Expectations of studying medicine in terms of teaching methods, and whether or not these expectations were met.
- New MBChB curriculum: feelings about new curriculum, benefits of the new curriculum, views on content and teaching methods.
- The way in which the PHC approach is taught in the new curriculum, timing of input on the PHC approach, assessment of the PHC approach, other approaches besides the PHC approach, and suggestions for the curriculum.
- Clinical exposure.

Expectations about studying medicine - teaching methods

Before examining the students' expectations of the teaching methods of the curriculum, it would help to have some idea of whether or not they had any prior knowledge of the new MBChB curriculum, as an awareness of the changes that had taken place could definitely impact on their expectations of how they would be taught. Only a few students claimed to have heard about or knew about the changes in the curriculum and had an idea of what to expect, while some had heard, but still did not feel as if they were prepared or were still not sure about what they should expect.

"I'd heard that the programme had changed, so it wasn't like lecture based. But I really had no idea what I was in for. I didn't know what to expect." (set 2)

Although only a small number stated that they did not know anything about the new curriculum, this did seem to be a more common predicament amongst the students in the various groups, and some students felt that they should have been told about the changes so that their expectations could have been adjusted. One fourth-year student even felt that their class was "tricked" into the new curriculum because there was no information given about the new curriculum, while another mentioned feelings of disillusionment because of this.

"I think maybe many students feel like they have been disillusioned before coming to medical school. I found many students saying 'why didn't anybody come and tell me this before?' No one comes to you and no one tells you anything about it. Soon as you're in, you're too far." (set 4c)

Based on this lack of prior knowledge about the curriculum changes, it is not surprising then that group work and the courses that are based on group work, namely BP, BHP and PBL, did not feature in students' expectations. From other students' comments it is also evident that there are those that consider group work to be less 'academic', and it is possible that they associate 'academic' with being intellectually sound and rigorous. The general expectation seemed to be that the curriculum would have a more didactic approach and would be mostly lecture based. The notion of 'academic' resurfaces, implying that lectures are more 'academic'.

"...I was overwhelmed by the amount of group work that one had to do and that was different for me, different to my expectations..." (set 4a)

"...I thought it would still be lectures and academic style..." (set 1)

From these comments above, it is clear that many of the students' expectations in this regard were not met, and a number of students further emphasised that this was the case. One student however pointed out that expectations about how one will be taught will most probably never be met because students all arrive with different expectations, yet all have a common belief that knowledge will be imparted to them. In some comments the element of fear is mentioned with reference to unmet expectations, and this is described as fear of the unknown and of stepping into unfamiliar territory, which can be particularly frightening at the start of one's academic career.

"...you have this expectation that medicine is going to enlighten you to the medical stuff and I think that we all start there, we all think like the book of knowledge will just get into us and we'll know everything there is to know. I think that's our own unrealistic things. There's fear also about what's going to happen...So I don't think our expectation was met, I think it never would be met because everyone has their own ideas of what they want." (set 4c)

New MBChB curriculum

Feelings about new curriculum

Feelings of apprehension, confusion, scepticism and shock seemed to be common to students at the start of the curriculum due to the fact that the curriculum did not meet many of their expectations and because the shift to the new curriculum had been quite drastic. Some students spoke of feeling upset and overwhelmed by these changes, and one fourth-year highlighted the difficulty of being the first year of the new curriculum which meant that there were no older students to offer them reassurance, which they seemed to need.

"I think in first-year we were very overwhelmed just the way the course was and I was really not expecting it...I was very shocked. It was a lot of new things..." (set 4b)

"At first it was very difficult, confusing, and we were the first ones to be taught like that so we couldn't actually go to someone who has had the experience before and hear what their experiences were." (set 4c)

Some students stated that they felt part of an experiment, and the fourth-year students in particular mentioned feeling like "guinea pigs" as opposed to the "pioneers" that they were told they were.

“...they call us the pioneering year, but we are the guinea pigs...” (set 4c)

Other concerns about the new curriculum were also raised, and these were to do with the fact that UCT is apparently not able to afford to implement the new curriculum throughout the MBChB degree, making the current changes seem rather futile and evoking more confusion and fear. Some students were concerned that the benefits of the new curriculum are not readily visible, and that it may take some time before this happens, making it more difficult to have confidence in the way things are being done.

“...we need more doctors to actually facilitate us, which I have heard that the varsity cannot afford ...hence we're going to be switching back to the old curriculum after fourth-year...which is stupid, because then why are we doing all this? ...It's just confusing and it's also kind of scary because you don't know where you stand.” (set 4a)

It appears that after second-year, students' confidence and faith in the new curriculum does begin to grow, and they are able to take a more long term view of things, acknowledging that the process may be challenging and difficult, but that over time the end product will be valuable. Some students emphasised the need for students to trust the process that they are going through, and to trust the experience and abilities of those people who are responsible for the new curriculum.

“Sometimes it just feels like you need a type of faith to go through this, to have an idea and have a sort of hope, this is where I want to get to and this is where we are as a society as South Africa and this is where we need to get to. And if I start putting in my little part...somehow we'll get there...we can't quantify results, we'll need to wait and see what happens.” (set 4b)

Benefits of new curriculum

Students did mention some of the benefits of the new curriculum, and these are quite effectively summed up in a fourth-year student's remark that the new curriculum is making her “a more well-rounded doctor”. This seems to be based on the expectation that the curriculum would be dominated by the ‘hard’ sciences, and would not be particularly interactive, that is, lecture based. Therefore the fact that the curriculum does require students to look beyond the biological and to interact with others does make it likely that they will develop a wider range of abilities and characteristics. Some of the other remarks that support this notion of a “well-rounded doctor” were that the

curriculum is more practical, that it develops application and understanding rather than merely knowing, and that it enhances students' learning and thinking.

"...clearly you have to be able to do well outside, without being just like a walking medical dictionary. So I think it's good for human interaction and things like that." (set 2)

"You actually realise how much you actually know, like those people can regurgitate the whole textbook but we'll be able to apply the textbook." (set 4a)

Some comparisons were made between the outgoing, traditional curriculum and the new curriculum, and these mainly emphasised the advantages of the new curriculum. It was felt that students in the new curriculum have better interpersonal skills relating to the doctor-patient relationship as well as to working with other students, a willingness to speak up when something is not known or understood, superior clinical reasoning, and an ability to integrate information. On a more philosophical level, one student felt that the new curriculum made them feel more included in the processes of the curriculum, and that it allows them to "grow into" their profession, which implies a level of autonomy and freedom for discovery and experience.

"...we are more sensitive and more aware of patient needs and patient rights, and what you can do and...not supposed to do..." (set 4b)

"When asked questions say when we are in a ward round, we are sort of more clinically orientated....A bit sharper...We did our things like case wise, so we can integrate the knowledge and then you answer the questions properly...in terms of clinical reasoning, clinical practice, I think we'll be more." (set 4c)

Views on content

It was earlier established that students were expecting more 'medical' subjects to dominate their curriculum, and this expectation reappeared in students' views of the content of the new curriculum. Even though only a few students mentioned that they felt that the PHC approach was taking up too much time in their curriculum, most of them stated these opinions as the opinions of others in their class, giving the impression that this might be a widespread view. This sentiment was echoed in other students' comments that they felt that they could be or were at a disadvantage in terms of the quantity, complexity and depth of their knowledge, scientific knowledge in particular.

"...there's scaffolding in a building, if you don't have scaffolding, the building will fall over. I don't feel like I have that scaffolding..." (set 4a)

"I think we have definitely had times in our degree where there probably has been a generalised feeling that we all felt like we are so far behind where we should be..." (set 4c)

These opinions were countered by comments by other students who felt that the volume and depth of scientific knowledge taught in the outgoing curriculum was not actually necessary and the value of quality over quantity was emphasised. The importance of the motivation and ability to find knowledge were also stressed, the argument being that these should take precedence over the ability to remember a vast number of facts.

"My father, he's a doctor...and he said the amount of detail they used, it becomes redundant, like you don't need to know all that." (set 4a)

"I suppose you can never know it all. By the time we graduate...no one is going to know everything about every disease...if we do know a little bit less, then if you come across something, you know how to research it, you know that's always more important than remembering every fact about microbiology in first and second-year." (set 4a)

It has already been briefly mentioned that some students felt more positive about the emphasis on the biopsychosocial approach in the curriculum, and other student comments regarding this approach help to elaborate on this. Previous comments suggest that the majority of students start off not understanding the relevance of the psychosocial component as it is not something they anticipated to learn, but over the course of the first semester they begin to see the relevance of it as they are able to apply what they are learning to themselves as well as to those around them. In addition, because they are assessed on this component, they are required to take in this information and attempt to understand it.

"...as time goes on you understand it...it became interesting because you can use your own experience to actually try to remember some of the things." (set 2)

"The tests forced you to learn all those things...it's no point in fighting it, if I'm going to fight it, it's going to be a long three years. So I think I've just taken time out and just thought, is it really relevant or is it not, and I think I've just realised it is actually...it helps you to put your career in a better context in real life." (set 2)

It would seem that many students, at some point later in their first year or second year, begin to realise the value of this approach in interacting with and treating patients, and the resistance to it seems to start diminishing. By their third or fourth-year, students seem to have generally embraced the biopsychosocial approach and consider the importance of a patient's context, acknowledging the multiple factors that can

influence health. One student felt that this realisation would have come sooner if more experienced students had emphasised the value of this approach and explained why it needed to be learned.

“Initially...I thought the psychosocial was a whole bunch of nonsense, airy-fairy, touchy-feely thing, but I think now that we’ve become more used to it, and we’re not resisting it as much, I’m starting to realise the relevance of it, because a lot of things that exist, medical problems, are due to those psychosocial issues...I think it will make you a better doctor if you can have medical knowledge as well as the psychosocial knowledge...it will give the patient the best in the end.” (set 2)

“...health is not just physical wellness, it’s not just the absence of disease...Health involves much more than that. It involves that the person is physically, emotionally, socially well with themselves and within themselves. So a doctor, as much as I’ve got the training to free you from that particular disease, I have to find out the root cause of the problem usually and sometimes it’s not just physically...” (set 4b)

Views on teaching methods and group work

In terms of the students’ views of the teaching methods of the new curriculum, some students pointed out the disadvantages of a lecture based approach, in spite of the fact that this was what was expected of the curriculum. These students described lectures as boring, possibly due to the lack of interaction, their outdated and overly didactic nature, and maintained that concentrating in long lectures was difficult, and although they might be taught more, they would not necessarily learn as much as they were learning through group work.

“It gets very boring.” (set 4a)

“You’re just sitting there.” (set 4a)

In addition to these points, a number of students were positive about working in groups and teams, and highlighted what they felt were the advantages of group or team work: it can trigger personal growth when one’s flaws are identified and worked on in a group; it promotes social contact and the development of friendships; there is more freedom to ask questions or state one’s opinions than in a lecture setting; one is exposed to views other than one’s own, and one’s own views are challenged, forcing one to substantiate one’s own points but also learn from each other; it is more fun and interesting; it develops the necessary skills of team work; and it allows for the merging of the strengths of different individuals and the creation of team spirit.

"I think it is great the way we are learning to work in teams...learning to work with other people, I've learnt a lot about myself...It helps you identify your flaws and where you can improve yourself so that you can work with others." (set 3)

"I actually think it's a nice way to learn because you constantly have to be assessing your knowledge as well, and then also taking other people's opinions, so that you're not stuck in one way of thought. You are able to listen to other people as well and draw from them what they are saying..." (set 1)

There were also some negative views expressed about group work in general, and a few of these seemed to represent a more personal aversion to group work. Other opinions expressed again implied that group work was less academic, "a bit wishy-washy", and not worth the fees being paid. Reservations about group work further related to its prevalence in first-year which seemed to leave students feeling quite overwhelmed, how all work would be adequately covered, the ambiguity around the depth of the knowledge that is required, and the group facilitator's lack of knowledge and hence their inability to effectively answer students' questions.

"...you miss having a big group where you're told this is the depth of knowledge that you're supposed to know..." (set 4c)

"...in another sense it's not that nice because on the varsity's perspective they have to employ a lot of staff members to facilitate the groups and half the time the people that they have employed...do not necessarily know a lot about medicine, and even though they've been given briefing courses and all that stuff, it's not sufficient to answer all our questions because we're coming in totally clueless, but those people who are teaching us are clueless with a little bit of information." (set 4a)

There was some concern about the fact that the teaching methods in the new curriculum have a far stronger emphasis on self-directed learning and the responsibility that students' need to take for their learning, and that even if there are "safety nets" put in place, it is "scary" and creates uncertainty about students' preparedness when they are tested.

"I think it's a bit scary though that so much emphasis is placed on you and being responsible." (set 4a)

"...honestly I don't like it...the whole side of it where you get a case and you've got to go and research it on your own...it leaves you with a lot of uncertainty as to what I'm doing and whether I'm doing it right. And will I be prepared for the assessments and the tests?" (set 1)

How the PHC approach was taught

General

Students had a great deal to say about how the PHC approach was introduced and taught to them, and they expressed a range of views, both positive and negative. As has already been pointed out, Becoming a Health Professional (BHP) is the course in which students are introduced to and taught the PHC approach, and therefore the majority of their comments about how PHC was taught related to this course.

Some students admitted feeling initially negative about the BHP course, or mentioned some of the course's less appealing points and that there were complaints. However, these students claimed that this view had changed and that they felt the course was useful and beneficial and that it was well taught.

"...there were complaints and there were things, but I think all in all, if you look back, it was a very positive thing and you definitely did benefit from doing all the activities and the visits." (set 3)

Other more specific aspects of the BHP course that students appreciated included the teaching of interviewing skills, the variety within the course, the acknowledgement of their existing perceptions of the PHC approach, their involvement in their own learning, and the fact that other skills were being acquired, sometimes unknowingly, while they were learning about the PHC approach.

"I thought that just the whole way BHP works...the way they teach you, it's very different, but it's good because it helps you keep in that information...you're very involved in your own learning. I love that about it...you are learning so many skills while you're learning primary health care...we found that we were learning while we didn't realise it..." (set 3)

A number of students mentioned that they valued the fact that the PHC approach was taught in groups, and felt that this provided an opportunity where opinions were able to be shared, discussed and learnt from, and that this was more engaging and hence more likely to help them remember and understand the material. One student maintained that the teaching methods of the curriculum was suited to the PHC approach, and some students were very positive about the fact that the BHP course further gave them an

opportunity to work with students from other disciplines such as physiotherapy, occupational therapy and communication sciences and disorders.

“The fact that we actually had the opportunity to be in groups and always discuss it, I think opinions come out much better in such settings...” (set 4a)

“...what I did enjoy was working with the physio’s and the OT students.” (set 4c)

There were in addition a number of negative comments about the way in which the PHC approach was taught, and these included the fact that they found that it lacked direction, that it was unexciting, that it was not intellectually challenging or stimulating, that the group sessions for BHP were tedious, too long and drawn out, and that the material could have been covered in a much shorter amount of time. A few students felt that the PHC approach was not sufficiently placed within the context or framework of the South African health system, thus making the significance of the approach less apparent.

“...people wanted to be intellectually stimulated and challenging things, and so people were really craving actually learning very medical things...” (set 4c)

“...we weren’t given a framework, like this is a health care system that South Africa is using...and just given the broad overview picture...” (set 4c)

Some students criticised the BHP course for being too theoretical and not adequately explaining how the PHC approach was meant to be implemented or put into practice, and while one student felt that having knowledge without application is futile, another student felt that students first need an idea of the theory before learning how to put it into practice. Other students supported this stance by arguing that first-year would be too early for students to learn about how to practise as a doctor, and that the onus is on students to place the PHC approach in a practical context and to discover for themselves how the PHC approach will operate in reality.

“It was very theoretical...it wasn’t very practical...” (set 4c)

“But isn’t that up to us ourselves to try and put it in a practical context and sort of exploring it in our own heads, how it’s going to work, or how am I going to make it work for me?” (set 4a)

The use of words such as “pushed”, “drummed”, “shoved”, “drilled”, “indoctrinated”, “brainwashed”, and “forcing” suggest that students felt that the methods of teaching the PHC approach were too forceful, and some students felt that they had been

pressured into accepting the PHC approach. One student mentioned that the way the approach was taught made affluent students feel guilty and more impoverished students feel obligated to work in disadvantaged areas, and did not leave enough room for students to decide for themselves. Other students however, disagreed with this and did not feel that the PHC approach was forced on them or that they were pressured into accepting the PHC approach, but were able to have an opposing view, particularly because they were learning in a group setting that allowed for differing opinions.

“...if you come from an affluent society it sort of made you a little bit guilty and if you came from a more impoverished society it made you feel more like you had to stay there and work for your people sort of thing, but it didn’t allow for us to make up my own mind, it was only when I stood back and thought about it that I could do that. But ja, I did feel like it was forced down us a lot.” (set 4a)

“Not at all, because you were given the chance...you were given like space, because you work in groups you have the opportunity to have an opinion and say ‘well, I don’t fully agree with the way this works’ and to question why it’s a certain way, so I wouldn’t say we were forced.” (set 4a)

Some students felt that there was too much focus on the PHC approach in first-year, and that there was a lot of repetition within the BHP course as well as through the years which triggered annoyance and frustration among the students. However, a couple of students did feel that this repetition was beneficial in the sense that it ensured that they knew and understood the PHC approach.

“...first-year we could’ve spent less time learning about primary health care.” (set 4c)

“Maybe if we hadn’t kept rehashing it, we wouldn’t have known what was potting*.” (set 4a)

There were other students that felt that the way in which the PHC approach was taught was not suitable or appealing for medical students, who were said not to respond that well to small group teaching. One student highlighted the fact that students are still teenagers when they are introduced to the PHC approach, and that it is likely that they will have a “cocky” attitude and that their interests will lie in things other than academics. Students stress that these realities need to be taken into account, because if they are not and the PHC approach is presented in a way that is unattractive to students, there is less chance that they are going to develop a positive attitude towards the approach and be motivated to implement it when they need to. One suggestion was that more logical and factual information should be provided to explain the origin of the PHC approach and how it should be put into practise.

* “...we wouldn’t have known what was potting” is a South African colloquialism for ‘we wouldn’t have understood’.

"I think there's been a big mistake in the way we've been taught it...not the approach itself. I think if we're going to buy into it, the faculty really has to look at a way to teach us, whether or not it's the way that drills it into us the most quickly, the way that is most attractive to us because I think if we know it backwards but we're sick of it, I really don't think we're going to try and implement it." (set 4a)

There were complaints that the PHC approach should have been incorporated more into other subjects that students were doing at the same time, and that the lack of integration at times led to confusion.

"...it seemed like there wasn't much communication between the two main courses that we had in first-year...BHP...teaching us the primary health care approach...but then you have Life Cycle and Transitions in Health, and in the middle of learning about something, you will have this reading or this article, and it will be on a very specific section of primary health care and that will throw you off completely and you'll get all confused..." (set 4c)

Some of the fourth-year students commented on the disorganisation and the lack of communication between those responsible for teaching the PHC approach through the years, and that this led to repetition of information, which seemed to frustrate them.

"It doesn't seem like there's any communication between who is running the years about what they have been taught and what they haven't been taught. You go to lectures and it's like the fourth time you've heard this stuff." (set 4c)

A number of other comments were made regarding how the PHC approach was taught, and some of these suggested a feeling of resignation to the fact that the theory of the PHC approach is something that has to be learnt, that it is not going to be enjoyable, and that because of this, it is difficult to teach. Other students felt that the way that the PHC approach was taught was limited in the sense that it did not promote a critical appraisal of this approach. This could be true, but it could also be the case that in the BHP course in their first year, students may have been asked to think critically about the PHC approach, but the students may not have had the insight at that stage of their learning process to recognise that this is what was being required of them.

There were some students that felt quite strongly that the PHC approach was inaccurately portrayed in the curriculum as it was presented in such a way that it implied that the approach had been implemented and was successful, but did not adequately present the reality of the obstacles that were being faced in the process of implementation.

“I think in medicine it’s put across as this really fantastic great system that is out there, and I think it’s just beautified a little bit too much. I think people need to know that there are problems...don’t put it across as such a fantastic thing when it’s not actually working that well...” (set 4c)

Assessment on the PHC approach

The issue of the assessment of students’ knowledge of the PHC approach was raised, and a few students expressed their displeasure with the process of assessment. One student felt that the fact that the PHC approach was included in assessments was something negative, and this may be because of perceptions that it is not a scientific approach and therefore requires a different study method with which students may have struggled. Other students did mention that they struggled with the assessment of the PHC approach, particularly with regards to focussing on the specific aspects as opposed to understanding the broader picture and knowing what was required of them. It seems that these students found it easier to focus on and understand the general perspective, but this focus or understanding was not necessarily required in assessments. One student spoke of the difficulty of knowing what to study for the assessments on the PHC approach.

“I think the assessment of it was a bit harsh sometimes, because there was subjective marking. Sometimes it didn’t really test what I would know on a practical basis about what’s happening, because a lot of us knew the theory behind primary health care and things like that, but sometimes the topic was so narrowed down that you couldn’t take you general knowledge of something you know, and sometimes they were looking for a specific answer and if you didn’t give it at that point...” (set 4c)

In spite of these difficulties, the importance of assessing students on the PHC approach was argued, and the basis of this argument was that a subject that is not assessed will not be taken seriously by students. However, it was pointed out that even if a subject is assessed, there is no guarantee that students will take an interest in the subject, and it is quite possible that they will study the information only for the purpose of writing an exam on it. In addition, students did not seem motivated to study the PHC approach because of their impression that the assessments were easy and that studying would not substantially improve their marks.

“If someone would argue, like say if it’s not for marks then no one would take interest, then even if it’s for marks you just learn it and then you will not apply it, so even then you are not taking interest, you’re just doing it for one day, get the marks and then you just forget it.” (set 4a)

“Even the people that studied really hard for this and really learned the whole manual off by heart, what's the highest mark that they would...it's still just low 70's and then the people that did nothing got like 68, so there's not really a huge difference there...” (set 4a)

Timing of PHC input

The majority of students agreed that the PHC approach should be introduced at an early stage of their curriculum, as is currently the case. They argued that if the basics are introduced in first-year, then these can be built on and what has been learnt can be continuously reinforced. Early exposure to the PHC approach was said to give students an indication of what they can expect in the future and therefore help them to figure out their role with the health system, and ultimately prepare them more effectively for working in the future. These comments do suggest that these students have to some extent accepted that they will come into contact with the PHC approach in their academic or professional career and would rather be equipped for this eventuality.

“...I think it's good to do it from first-year because if you have the basics then you can just lay down...get more information each year.” (set 4b)

“I think it was quite a good thing to have it now because it sort of gives us a background of what we're actually getting into.” (set 4a)

Still in support of early exposure to the PHC approach, some students felt it would be impractical to learn about the PHC approach at a later stage because of the workload in these later years and the fact that there may not be people available to teach this approach in a clinical setting. Others believed that students should be introduced to the approach while they are “young and impressionable”, and while this comment was rather flippant, it does have an element of truth in it, as other students also emphasised the need to be introduced to the PHC approach before they have already cemented their values and world view, the implication being that the period between the ages of seventeen and nineteen is a critical one in which values are being established. One student felt that age is not necessarily the issue, but that exposure to a more clinical way of thinking, associated with the outgoing curriculum, would make students less receptive to the PHC approach. Taking the focus off age, another student expressed the view that students should be introduced to the PHC approach while they are already encountering a new curriculum at the start of their academic career, therefore starting with a “clean slate.” Lastly, one student maintained that one should take advantage of

the enthusiasm of young students as this same enthusiasm may not still be around at a later stage.

“I think to some extent age has...something to do with it. I think most people who come into first-year are seventeen, eighteen, nineteen, and they're at a stage in their lives where they are actually trying to mould and set down their values and get a good foundation for the lives and get direction in life somehow...when you're in your fourth-year and you only did it for eight weeks and what, you're...twenty-two, twenty-one...you've already started setting down your values and everything like that.” (set 4b)

In their argument for the introduction of the PHC approach at an early stage, a number of students compared this early exposure to the much later and more limited exposure in the outgoing curriculum. They argued that by separating PHC off into one block fails to acknowledge that it is an approach that is aimed at being implemented in all disciplines, and therefore makes the PHC seem less significant. Others maintained that introducing the PHC approach after three years of functioning with a curative mindset would make it not only harder for these students to understand the PHC approach, but also less likely that these students will adopt and implement the approach.

“...people in the old curriculum, I doubt that they know what the approach is or if they do, they get taught so late in their training that it...I don't know, you can't teach an old dog new tricks. So now they've been accustomed to providing health this particular way and now you're 'oh, by the way, there's this approach that does this', and that's like his fifth or sixth year, so it's not relevant to them.” (set 4b)

Some students did agree with the early introduction of the PHC approach but stressed that there should be continual reference to this approach throughout the curriculum as the things that are learnt at the beginning need to be applied at a later stage.

“You've got to get them right from the beginning before they start making their minds up about what they're going to be doing. But it's also important to keep going, like not to start...go big right in the beginning and then that's where it ends...if you don't keep bringing these issues up, not exactly in the same intensity, but on a good enough level for people to be thinking about these things and thinking about how to implement these things, then it's really useless...” (set 4a)

In a similar vein, there were students who were in favour of a more gradual introduction to the PHC approach, and would have preferred to have learnt about the PHC approach in stages. One student argued that this method would further stress the value of the PHC approach and would serve to generate less frustration amongst the students.

“...it almost seems as if it's ‘let's do this all now, get it over and done with so we can get to the real stuff’...I don't think that's really the way to go...if we went on a small bit-by-bit basis throughout, tried to even it out in terms of how it goes, I don't know how that will work, but I think it's a better way to go so that you don't frustrate people right from the beginning about it...” (set 4a)

There were some students who felt that the PHC approach should be introduced at a later stage, and this was because first-year students do not appreciate it, possibly because they are not yet mature enough to understand it or because it is in such stark contrast with their expectations of studying medicine within a biomedical framework. Other students argued that it would be more appropriate at a later stage when students are being exposed to clinical settings and will therefore be able to apply and adopt the PHC approach in a practical sense.

“...I think too much emphasis is being laid on primary health care for a first-year student...most of us would not be mature enough to understand and try to understand this concept, you're just learning it because you need to learn it, you don't want to learn it.” (set 4a)

“Why don't they teach it to us when it's more applicable...when we're going to be faced with clinical skills and patients and when we're going to have to start adopting this system?” (set 4a)

Other approaches

A number of students mentioned that they did not know of any approaches besides the PHC approach and some found it problematic and frustrating that they were learning about the PHC approach “in isolation” and did not have anything to compare it with.

“...all we've ever learnt at med school is the primary health care approach...” (set 4b)

“If we only had something to contrast it with.” (set 4a)

Some students felt that if they had been given other approaches, the teaching of the PHC approach may have felt less forced, and they would have felt more as if they had a choice in deciding to support the PHC approach. In this regard, one student pointed out that not giving teenagers a choice in the matter could provoke a rebellious reaction, whereas allowing them to consider different options and then make the decision for themselves would elicit a more favourable response and could in addition be more empowering for the students.

“...it's more just maybe a flaw, not a flaw as such but a limitation to how it was presented, just because I think people always crave to be able to weigh things up and then feel like they're making a decision for

themselves...it's almost like the rebellious teenager. If you tell us to like primary health care we're going to go 'oh, why should we?' and we're going to find all things why we don't. If you say 'ok, here's the one option, here's the other option of primary health care', then we can feel like we're making a decision for ourselves that primary health care is best." (set 4b)

Despite the feelings of some that other approaches were not presented, there were some students that felt that comparisons had taken place. They referred to an "old system", and described it as hierarchical, fragmented, "not together", and lacking in communication. Those working in this "old system" were said to be judgemental and not empathic. One student mentioned that there was the "apartheid approach" that was elitist, discriminatory, and inequitable, and focused on tertiary facilities.

"We sort of have the apartheid approach...in that sense that all the money was localised in your tertiary things...Ignore the five million and treat the hundred that have the money. It was discriminatory and it wasn't equitable and all those things...but I think that was not so much of a health care approach as more of a political approach that affected the health care." (set 4a)

Even if the PHC approach was to some degree contrasted with the previous health care system, this would probably not satisfy the requests by students for other approaches, because even if the old system were to be reformed, the students probably feel that there could be different approaches to bring about change.

Suggestions

When discussing how the PHC approach was taught, students put forward some suggestions of how things could be done differently. Most of these suggestions were a reiteration of suggestions implicit in their criticisms, for example being informed of other approaches besides the PHC approach; being presented with a less glorified and more realistic picture of the PHC approach; having the PHC approach located more explicitly in the South African context; having lectures on the more factual aspects of the PHC approach; reducing the time of the group sessions; and making the way that the PHC approach is taught more appropriate for the students who are being taught.

"...teaching us what's really happening with regards to primary health care..." (set 4c)

"Make it smarter. We're not little kids in preschool...You're talking to a bunch of very bright, very sharp, very on the ball people who know what's going on...we want stimulating stuff." (set 4c)

Some students claimed that they would really appreciate more input from those health professionals who are working in the health sector and could explain their views on the PHC approach. Those that have received this kind of input found it worthwhile.

“...I think it will also be interesting to bring in actual medical doctors that could say why they don’t like it, why they don’t agree with it and then also...professionals that say ‘well we agree with this and it works and this is why.’” (set 4a)

Lastly, in light of students’ complaints that they had not received enough input on how to implement the PHC approach, some students suggested that more practical exposure should be incorporated into the curriculum. One student mentioned that their exposure to the Obstetrics environment had proved helpful in this regard, and a few students suggested that the Rural Support Network (RSN) could be used to give students more “hands-on experience”. A suggestion was also made that first-year students complete health promotion projects similar to those done in fourth year as these proved helpful in terms of understanding and application.

“...it means more to me in terms of seeing how things actually really were in reality...I know for instance that the RSN project...a lot of the kids who go on or who are involved in it, they come back and...they’ve gained insight into the health system and how it is, so maybe if they could do that for all the first-year medical students and then in that, incorporate the Public Health module thing, PHC and whatever, so we could actually like get hands-on experience.” (set 4a)

Clinical exposure

BHP visits

As part of the BHP course, each first-year student would have the opportunity to visit a community (generally one that is more disadvantaged), a primary level facility, and a secondary or tertiary level facility; the majority of the facilities visited are in the public sector. Students were generally positive about these visits and the fact that some of the fourth-year students still speak of these visits suggests that they made a lasting impression on some students.

The reasons for these positive views of the BHP visits were numerous, and some students merely stated that the visits were important, while others felt they were interesting and

stressed the value of learning through experiences. The visits were described as thought provoking, and experiences that could bring about emotional growth, and part of this was the chance to actually see situations firsthand. Related to this was the opportunity to obtain a realistic view of the PHC approach in practice as well as insight into the health system, and this helped to make the PHC approach feel more real for some, allowing students to develop their own views on the success of the PHC approach.

“I think I’ll never forget the time in Brown’s Farm because we were with the community health workers at that time, and I think that was really a good thing to see the whole community getting involved with something...” (set 4c)

“What I think was so good about the visits, that we could all form our opinions on how we think that PHC is working. If we’d just been having lectures and talks, we wouldn’t have been able to form our own opinions, we would be hearing other people’s opinions, so it was good.” (set 4a)

On a less positive note, some students felt that the visits either did not show how the PHC system was working, or showed them that the PHC approach was not succeeding. One student felt that although he enjoyed the visits, he did not understand their relevance. This may relate to another student’s belief that the visits were more like tours and that the purpose of these visits was not always clear to them as students or clear to the health professionals that they encountered on these visits. There is an element of truth to this statement, as the logistics of arranging these visits (for over 300 students) must be a challenge, and due to the fact that students are in first-year and have limited skills, it would be even more of a challenge to arrange actual activities for these students in these communities or facilities. The visits therefore are in many ways merely an opportunity for the students to observe, with the understanding that clinical exposure will definitely be a large part of the curriculum at a later stage.

“...it was more like a tour...I think also that initially when we go to places when we are not actually going there for a purpose...they feel that they must show us this, show us that, and the people that actually work at the place don’t quite understand exactly what we are doing...” (set 4c)

Exposure in the clinical years

Clinical exposure enters a different phase when students begin to have contact with patients, and some of them spoke about these interactions. Some of this interaction can be difficult, and one student mentioned the feelings of frustration and helplessness that can be triggered when it seems that there is nothing that can be done about a patient’s

circumstances. Another student told of how factors such as time constraints, pressure, lack of sleep and the fact that patients were in pain can change one's attitudes towards patients from pity to indifference in a relatively short space of time. Other students related more positive interactions, and these involved delivering a patient's baby and the impact that their assistance can have on the patient.

"...someone who's sitting there in front of you, completely...like tears are flowing and completely distraught, and ok, we know how to counsel the patient, how to deal with a patient like that, but when there is nothing that you can actually do for the patient's situation, how do we deal with that helplessness?" (set 4c)

"...having your patient say thank you, and that patient will never...even if he or she forgets your name, but she'll never forget that doctor who helped me deliver my baby...when you go home you're like 'wow, I actually helped a person, I made a difference.'" (set 4c)

This phase of clinical exposure also involves more interaction between students and staff, and what students mentioned about this interaction was all negative. Some fourth-year students that had conducted health promotion projects found that staff lacked enthusiasm and showed no interest in helping to solve the problems that needed to be addressed, leaving them feeling disappointed, more frustrated and less motivated. Other fourth-year students that were busy with their Obstetrics block were more disillusioned by the realisation that the empathy and compassion they wanted to show the patients did not seem to be valued by the doctors and particularly the nurses with whom they had contact, and that their empathic skills were viewed with condescension and seen as a waste of time. These students found this disappointing and further stated that there seems to be no place for compassion and empathy in some clinical environments as these are skills that are strongly stressed by the new curriculum.

"...I was disappointed because the clinic that I worked in, the sisters there were so unenthusiastic and it was so demotivating because we were like 'yes, we've got all this time on our hands and just tell us what you want us to do', and they couldn't even do that." (set 4c)

"The doctors and nurses I found viewed all our empathic skills as sort of quirky little naïve traits that we'll soon grow out of...it was almost like we were wasting our time and we would soon become as disillusioned and detached as they were..." (set 4c)

These somewhat negative impressions of staff seemed to be further corroborated by the way in which patients, particularly in the public sector, are treated by staff, and how advantage is taken of patients' vulnerability in these settings. One student even argued that patients are so accustomed to this poor treatment that if they are treated

differently than this treatment is somehow not effective. This does negatively impact on the students' own attitudes, as a student explained that the anger at seeing how patients are treated eventually breeds negativity in them, dispelling the positive attitude with which they may have begun.

"...most patients are actually used to being treated bad. Some of them won't even feel like they're being treated if the nurse doesn't shout at them, and then now they see these doctors coming 'how do you feel?' and they'll be like 'excuse me, I think I may go to another doctor', and that's the scary part."
(set 4c)

"...it gives medical students a really negative opinion and a really negative feel just to see how patients are treated...I went in there with this amazing attitude and it's going to be great and people are going to be treated with respect and care, and I went and saw the attitudes and eventually you become some angry inside about that that you just turn into this negative person...attitudes are rubbing off..." (set 4c)

Importance in curriculum

From all these comments above, it is clear that exposure to clinical settings is important and necessary, and even those comments that are less positive do not seem to dispute this. This importance appears to not only relate to the PHC approach and seeing the reality of the implementation of this approach, but may also enhance students' understanding of the functioning of the health system (including interactions with patients and staff) in which they are going to be working in the future, as well as their understanding of the types of communities in which they might find themselves working one day. A comment made by a third-year student highlights the importance of this practical exposure that goes beyond providing students an opportunity to use the knowledge and skills they have learnt, but presents them with an experience that will remain with them long after facts have been forgotten.

"You can never forget an experience. Definitions come and go." (set 4b)

Conclusion

This chapter helped to put the PHC approach into the context of the students' learning environment and the new MBChB curriculum at UCT. Students' expectations about teaching methods were addressed, and it was clear that these expectations were not met. Their feelings about the new curriculum were discussed, and it is evident that

feelings were initially rather negative, but became more positive as students progressed through the years. Some of the benefits of the new curriculum were mentioned and there were a few comparisons made between the new and the outgoing curriculum with regard to the strong points of the new curriculum. Students' views on the content of the new curriculum were also covered, and these also seemed to undergo a change as students began to see the relevance of what they are learning. With regard to the teaching methods used in the new curriculum, there was a range of positive and negative views expressed about the dominance of group work in the curriculum.

This chapter further covered students' views of how the PHC approach was taught, and again these views were varied. There were negative views regarding the assessment of the PHC approach, but the majority of students were in favour of the time that they were introduced and taught about the approach. It was mentioned that it would have been helpful to have had other approaches with which to compare the PHC approach, and students did make other suggestions of how the teaching of the PHC approach could be improved. Lastly, the issue of clinical exposure was addressed and some students mentioned positive experiences and spoke of the value of this exposure, but there were some negative experiences of clinical exposure and these related mostly to students' encounters with health professionals.

Questionnaire results & Key informant findings

Questionnaire results

Introduction

This section of the chapter will report on the questionnaire administered to first-year students (n=193) at the start of their academic year (see Appendix D). As this questionnaire was administered long before students would have been introduced to the PHC approach, it deals mainly with the issues under the first two themes: 'What is medicine and what is a doctor?' and 'Why medicine?'. The demographic information obtained from this questionnaire has been included as an appendix (see Appendix F).

What is medicine and what is a doctor?

Perceptions of medicine and doctors, expectations of being a doctor

The questionnaire did not ask respondents specifically for their perceptions of medicine as a career but did address their expectations and fears about being a doctor and also briefly addressed their perceptions of doctors. When asked if they had a positive or negative perception of doctors, 97% of respondents stated a positive perception, and 79% said they would describe doctors as 'caring and understanding', with only 4% describing them as 'arrogant and insensitive'. Seventeen percent of respondents chose the option of 'other', and there was variation among these descriptions with some students acknowledging both positive and negative characteristics of doctors (Figure 7).

Perceptions of doctors

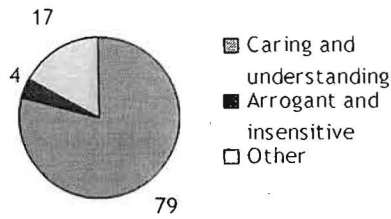


Figure 7

Regarding the respondents' expectations and fears about being a doctor (Figure 8), expectations of job satisfaction, mental and intellectual stimulation and fulfilment all came out very clearly, with 94% of respondents expecting to 'find great job satisfaction as a doctor' (33% agree, 61% strongly agree, 5% neutral), 93% anticipating mental and intellectual stimulation (39% agree, 54% strongly agree, 7% neutral), and 93% of respondents anticipating that 'being a doctor will be a source of fulfilment' (38% agree, 55% strongly agree, 5% neutral). Other expectations included financial security (52% agree, 16% strongly agree, 25% neutral), an 'improvement in social standing' (42% agree, 11% strongly agree, 35% neutral), regular employment (51% agree, 25% strongly agree, 20% neutral) and future success (32% agree, 53% strongly agree, 13% neutral).

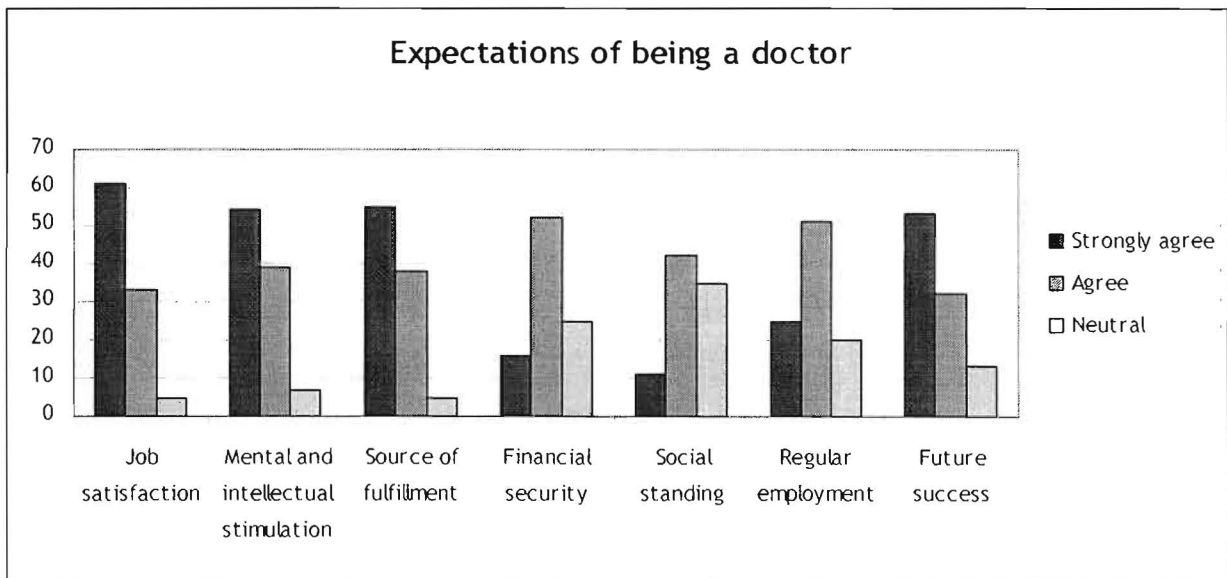


Figure 8

Respondents' concerns about being a doctor (Figure 9) did not come out as strongly, with 55% of respondents expecting that 'being a doctor will involve much frustration' (44% agree, 11% strongly agree, 25% neutral), 88% anticipating having to 'make many sacrifices in my life' (49% agree, 39% strongly agree, 10% neutral), and 49% of respondents were concerned about their 'exposure to AIDS/HIV' (32% agree, 17% strongly

agree, 31% neutral). There were other issues that many respondents did not indicate that they were particularly concerned about, such as where they would work one day (32% agree, 12% strongly agree, 24% neutral), the negative impact of being a doctor on their future family life (17% agree, 5% strongly agree, 25% neutral), and communicating effectively with their patients (15% agree, 2% strongly agree and 22% neutral).

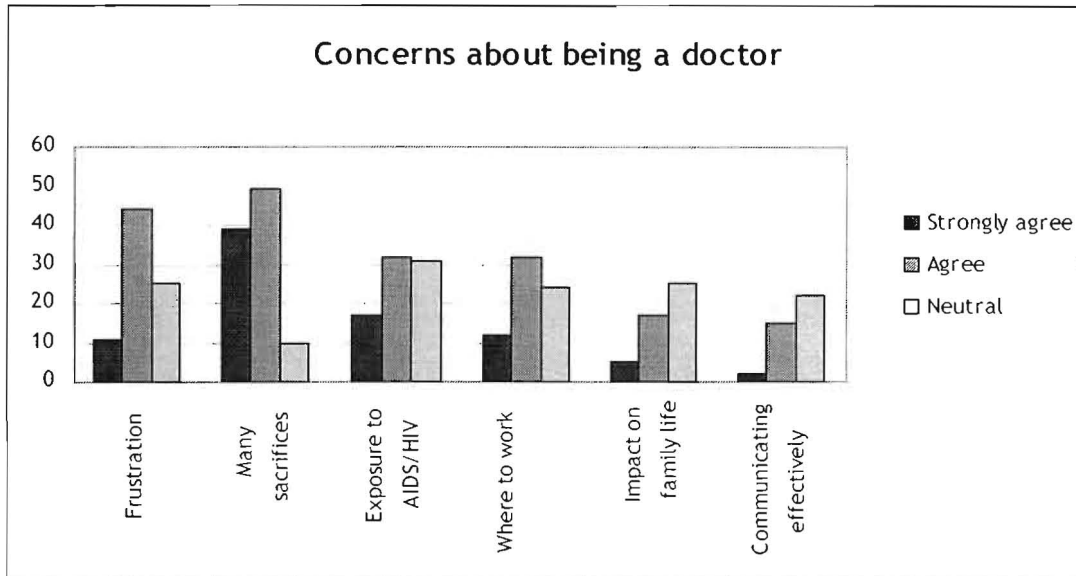


Figure 9

Expectations of studying medicine

The statements in this section were more around students' general expectations of studying medicine as opposed to the curriculum's content and teaching style. In terms of the workload of their degree, 60% of respondents were 'worried about the volume of work that we will have to get through' (45% agree, 15% strongly agree, 24% neutral), but regarding the length of the MBChB degree, only 8% did not know if they would 'be able to study for such a long time (6% agree, 2% strongly agree, 15% neutral). On a more personal level, 91% were expecting to 'grow emotionally' as a result of their studies (28% agree, 63% strongly agree, 8% neutral), 72% were expecting their 'views to change' as a result of their studies (51% agree, 21% strongly agree, 22% neutral), 81% were expecting to 'face many emotional challenges' during the course of their studies (53% agree, 28% strongly agree, 15% neutral), and 69% were anticipating 'a lot of stress in the next 6 years' (51% agree, 18% strongly agree, 24% neutral) and this stress could also relate to the expected workload (Figure 10).

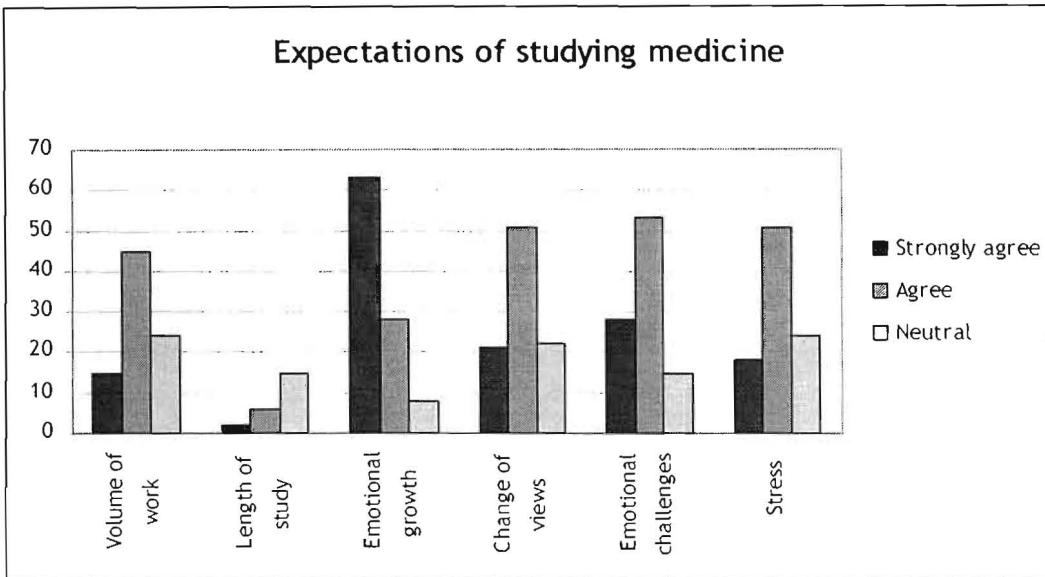


Figure 10

In terms of the respondents' familiarity with PHC approach (Figure 11), 8% indicated they were 'very familiar', 24% admitted to knowing 'a bit about it', 30% claimed to have 'heard of it', and 38% said they were 'not at all familiar'. Even though these results suggest that many of the respondents have at least come across the PHC approach, it is possible that there might be misconceptions and misunderstandings around what PHC is, but this was not explored in the questionnaire.

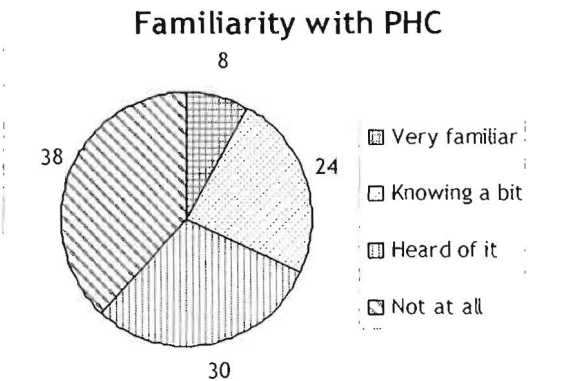


Figure 11

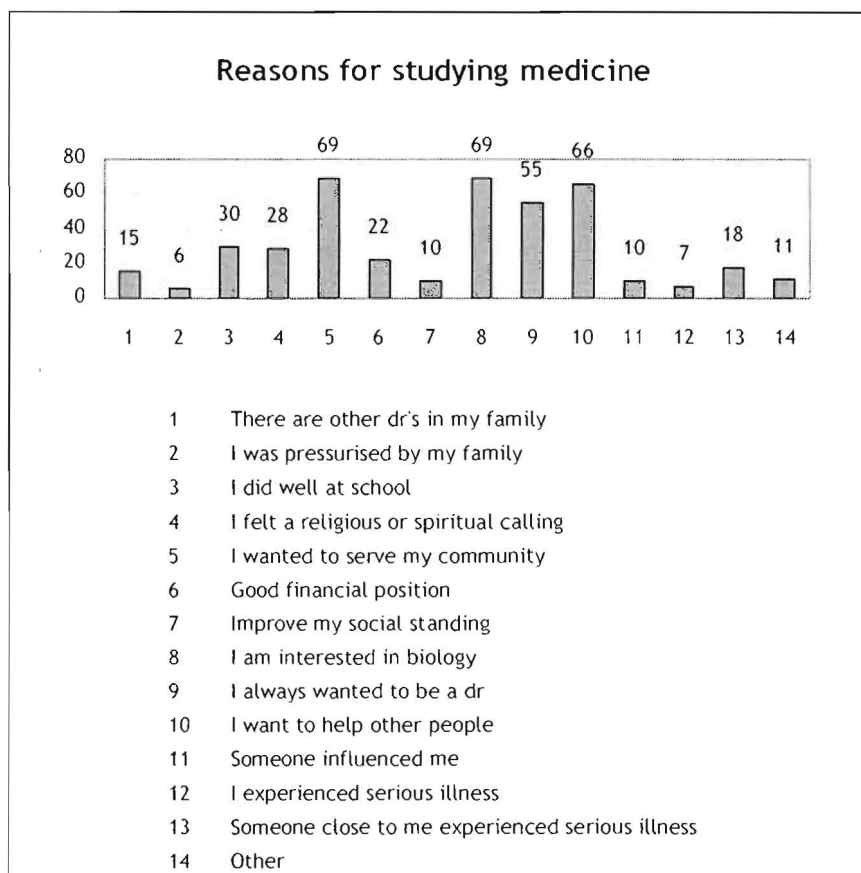
Why medicine?

Reasons for studying medicine

Respondents were required to select from a list the reasons why they chose to study medicine, and could choose more than one option. The four most popular reasons were: 'I wanted to become a doctor in order to serve my community' (69%), 'I am interested in biology and how the human body works' (69%), 'I want to help other people' (66%), and

'I have always wanted to be a doctor' (55%). Less popular reasons included 'I did well at school and felt medicine was a good academic choice of study' (30%), 'I felt a religious or spiritual calling to become a doctor' (28%), 'I believe that being a doctor will put me into a good financial position' (22%), 'Someone close to me experienced serious illness / injury, and this motivated me to study medicine' (18%), and 'There are other doctors in my family' (15%). Other reasons that were not frequently chosen were: 'I believe that being a doctor will improve my social standing' (10%), 'Someone I know strongly influenced my decision to study medicine' (10%), 'I have experienced serious illness / injury, and this motivated me to study medicine' (7%), and 'I was pressurised by my family to do medicine' (6%). Eleven percent of respondents indicated that they had other reasons, and the majority of these were altruistic, including working in areas of need as well as spiritual motivation (Figure 12).

Figure 12



Future aspirations

Regarding their future aspirations, respondents were asked to indicate where they would like to work after completing their internship and community service, and could choose more than one option from a list that included 'private sector', 'public sector', 'city / large town', 'small town / rural village' and 'other'. Forty-two percent of respondents chose 'private sector', 39% chose 'public sector', 19% selected 'city / large town' and

19% selected 'small town / rural village'. Ten percent of respondents chose the option of 'other', mentioning a range of reasons, or stated that they were undecided (Figure 13).

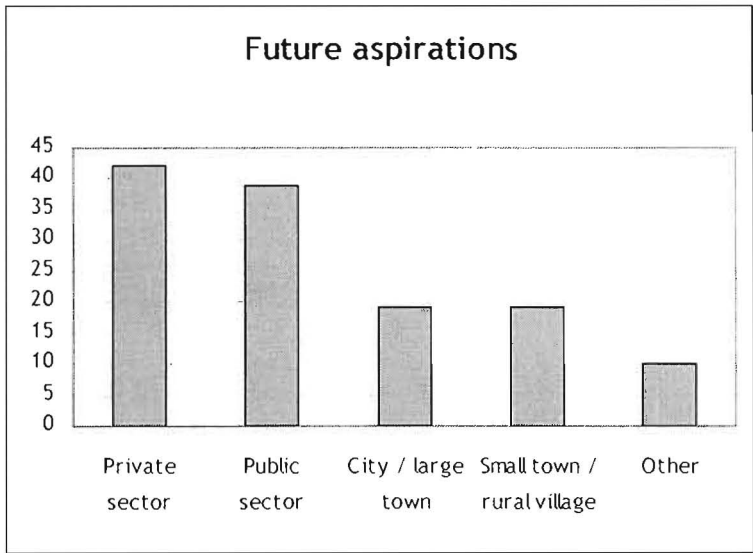


Figure 13

Respondents were also asked if there were any fields of medicine that particularly appeal to them and that they would consider specialising in. They could indicate more than one speciality from a comprehensive list or could indicate any other field not mentioned. The most popular specialisations were surgery (34%), paediatrics (33%), neurology (27%), and cardiology (23%). These were followed by forensic medicine (15%), genetics (15%), sports medicine (14%), general practice (13%), trauma (12%), research (10%) and plastic surgery (10%). All other specialties mentioned (including 'other') were selected by less than 10% of respondents (Figure 14).

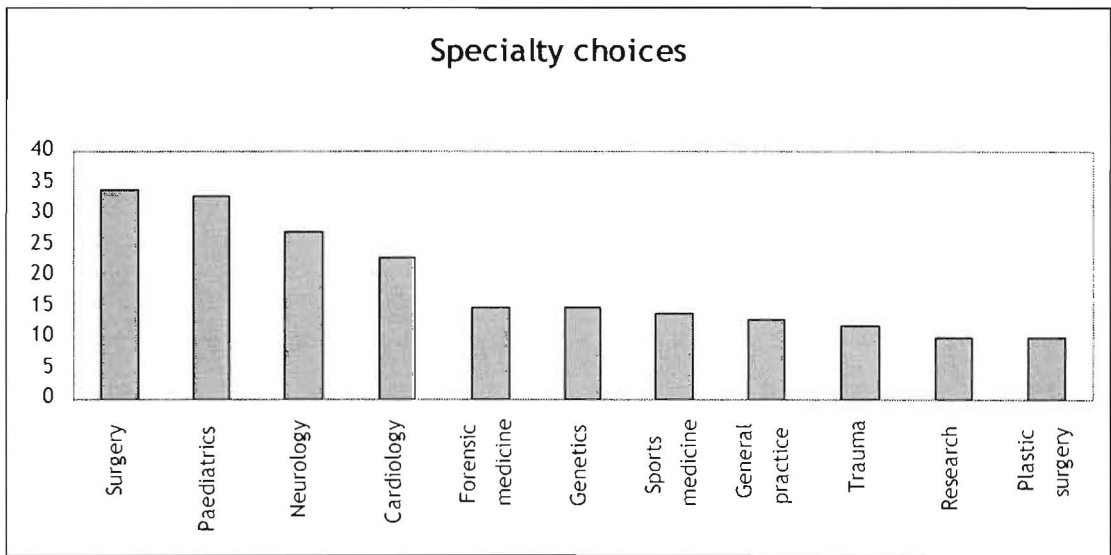


Figure 14

Conclusion

This section has covered a number of issues encompassed by the first two themes which look at what medicine is as a career and why it is chosen, and has presented the questionnaire responses which have corroborated many of the students' interview and focus group responses. From these questionnaire responses it would seem that students have a positive perception of doctors and of medicine as a profession, and although there were some concerns expressed about being a doctor, these were balanced out by other positive expectations. In terms of their expectations of studying medicine the main expectations were a heavy workload, stress, and to be influenced on a personal level.

With regards to reasons for studying medicine, the most popular choices showed a range of motivations from the altruistic, an interest in biology and the human body, and a long-standing desire to be a doctor. Lastly, there seemed to be no dominance in the choice of where students would like to work, but in terms of fields of medicine that are appealing, the most popular fields were specialties that are often given a lot of exposure in the media and tend to be commonly associated with the medical profession.

Key informant findings

Introduction

Key informant interviews were conducted in this research in order to help place students' responses in a broader context, encompassing both the UCT and the South African academic environment. This section will report on the views of these key informants and their relation to the students' views, and will be presented under the seven themes that framed the students' responses. There were other issues that were uncovered in these key informant interviews, but will not be discussed here, such as community-based education, medical curricula, internship and community service.

Theme 1 - What is medicine and what is a doctor?

Perceptions of medicine

Key informants did not discuss their own perceptions of medicine, but did mention some of the more common perceptions among students and in society in general. The glamorised view of medicine was highlighted, and that fields of medicine such as surgery that are portrayed as being more 'exciting' and 'dramatic' in comparison to fields that are less glamorous but just as essential. It was also mentioned that medicine is no longer as strongly associated with status and wealth, and that because of this, motivations to enter a career in medicine were now more service oriented. The importance of role models in shaping perceptions of medicine and doctors was also discussed, and that because the PHC approach has not yet been fully implemented in health systems that students are exposed to, students have not been able to observe doctors functioning within this approach, but have had many more role models in specialist positions as well as doctors who focus on individual, clinical medicine.

"...people who enrol for medicine here will be people who have a certain perception of a doctor as somebody who does individual, clinical medicine. And historically we haven't taught doctors how to operate in the PHC framework, so that behaviour will not have been modelled to the students before, so clearly the expectation would be that they would be focussed largely on clinical issues." (Prof. J. Volmink)

What makes a good doctor

In terms of how they would describe a good doctor, key informants mentioned characteristics that painted quite a holistic picture. The importance of interpersonal skills was stressed, and these included listening skills, team work, communication, compassion, empathy, patient-centeredness and the ability to look beyond the patient to their family, their community and the context they are coming from. The importance of being a 'lifelong learner' was emphasised, along with a willingness to admit mistakes and ignorance and seek help when necessary, which links to the ability to be reflective. In addition some stressed an awareness of human rights, ethics, respect for life, social justice and equity, and related to this, an ability and willingness to advocate on behalf of those who may not be benefiting from this social justice and equity. Knowledge, technical ability, an understanding of and ability to apply research evidence, and skill in

diagnosis and treatment were all identified as significant, although these aspects of clinical competence were mentioned in the context of all these other skills and were even seen to be secondary to other characteristics in some instances.

“You can teach a monkey to open an abscess! ...But where you really require cognitive skills and higher skills, is to be able to interpret what somebody tells you and put the right context to it...”

(Prof. D. Hellenberg)

“...to have a heart, to care. Because if you care, you’ll not be negligent. You might make a mistake out of ignorance, but you won’t be negligent.” (Dr. E. de Vries)

Expectations about studying medicine - content

Key informants did seem to be aware of the general expectations that students arrive with at medical school, and made some observations about what could lead to these expectations, mentioning the role of students' parents, and that their expectations also need to be managed. The secondary education that students receive was also said to be a factor that needs to be considered as it places a strong emphasis on subjects such as mathematics, physics, biology and chemistry for students that are interested in studying medicine. Students may then develop a familiarity and a sense of accomplishment and comfort with these types of subjects, which then make the psychosocial content of the curriculum and the fact that it is less defined somewhat problematic for students.

“...parents have this expectation that my child is going to be doing cardiac surgery or you know neurosurgery, something like that.” (Prof. D. Hellenberg)

“...in order to become medical students they had to go through matric chemistry and maths, physics, biology so I think it’s a comfort zone for them, this body of factual knowledge that you study and master and that moves you the next step upward...” (Prof. D. Prozesky)

Theme 2 - Why medicine?

Reasons for studying medicine

Students' reasons for studying medicine did emerge in some interviews, particularly the fact that reasons may have changed because of the working conditions and restrictions that are doctors are faced with, and that the “brightest people” and those looking for wealth and status will choose to pursue other careers. One key informant also questioned the sincerity of some of the more common reasons that are offered by

matriculants hoping to be accepted to study medicine, but also conceded that the idealism reflected in these motivations may be genuine because of their age and perhaps their naiveté.

“...everybody wants to go and serve the poor and everybody has always wanted to be a doctor ever since they were born, and everybody wants to mitigate the suffering of humanity. Those interviews are boringly identical and I suppose some people own up to...but perhaps at that stage they really do believe that, I think one should do them the justice of saying that.” (Prof. D. Prozesky)

Future aspirations

Regarding students' future aspirations, the issue of doctors working in rural areas seemed to be the most pertinent, and two of the key informants have published research on the likelihood of students from rural areas returning to work in these areas. The probability of this happening was indirectly challenged by one of the key informants who put forward other motivations for doctors choosing to work in rural areas. He referred to the times when the rural health services were missions based, and attracted large numbers of doctors, who were driven by a spiritual motivation to work in rural areas, often settling there with their families for a number of years. The point he raises is that these doctors were largely from white, middle class background, and were all trained in an old system that was not community-based and maintained an emphasis on cure.

“...there's a whole host of factors that determine that, the working conditions, the kind of person that the doctor marries and that person's work expectations, so many other things and I don't know exactly how you tease the two out and what the influence is of the training and what the influence is of the other...but I suspect it's very largely the other things, because we were all trained in the old paradigm but yet in the whole of Kwazulu-Natal there must of been more than a 100 South African doctors...working in rural areas and in mission hospitals and they went there for other reasons...” (Prof. D. Prozesky)

The other issue around students' future plans that came up with one key informant was specialising. In light of his comments, the students' eagerness to specialise seems rather unrealistic as he stated that 20-30% of graduates will specialise, but also remarked that this figure might drop because of the increased length of internship and community service. He also felt that some students have a naïve view of some specialties, mentioning general surgery as an example, and are not aware of what would be required

of them, which could be a reason why so many students seem to readily express their desire to specialise in the beginning stages of their academic career.

“...after 2007 they're going to have to do two years of internship and one year of community service, which makes their course nine years long. So still to specialise after that is going to take a *lot* of guts and money probably...So I think in fact specialisation will decrease...I've spoken to a lot of the kids that are coming through now, there was a lot of enthusiasm for doing something extra, postgraduate...but they were not aware of the implications of that for them...” (Prof. D. Hellenberg)

Theme 3 - What is PHC?

Perceptions and understanding of the PHC approach

On the issue of perceptions of the PHC approach, most key informants mentioned the common misperceptions of the PHC approach, which in their opinions seem to exist among health professionals, staff and students. Some of these common misperceptions are that PHC is limited to primary care, that it is an inferior standard of medicine practised by “barefoot doctors”, and that it was an idea that was “thought up by radical left wing government”. A possible explanation that was put forward for the misperception that PHC is the same as primary care was that the “PHC movement” has steered the focus away from clinical medicine, leading to assumptions that PHC is not applicable to developed areas and does not include “high tech medicine”. Misperceptions among staff and health professionals can also then filter down to students, breeding more misunderstanding.

“...the PHC movement, I think has erred in that they have deemphasised clinical medicine. And I think that was a mistake, because if you deemphasise clinical medicine then people think, well then it's barefoot doctors...” (Prof. J. Volmink)

With regards to the students' understanding of the PHC approach, the BHP course convenor, one of the key informants, felt relatively confident in the students' understanding of the PHC approach, and stressed the importance of a good understanding of the PHC approach at the end of the students' first year in order to provide them with something that they can then critically evaluate as their degree progresses. However, along with this was also the acknowledgement that an understanding of the PHC approach requires skills that students do not necessarily

obtain through their secondary education and therefore find it difficult to come to grips with learning about the approach.

“...they’re students who have achieved at school by swotting hard and those who can learn things off by heart and regurgitate stuff, I mean our education system embraces that...but there is so much about primary health care that students need to grapple with that it’s not good enough to just say ‘that’s or this is the right answer’...” (Mrs. L. Olckers)

Theme 4 - PHC: for and against

Key informants also commented on the students’ attitudes towards the PHC approach, with one comment addressing the belief that a curriculum focussed on the PHC approach would be of inferior quality and stating that this belief is based on a misunderstanding of the PHC approach. Related to this, it was also mentioned that in terms of international reform in medical education and the inclusion of the PHC approach, South Africa has not and probably should have been at the forefront of these changes.

“...this whole thing of revised curricula with the PHC approach and a different way of doing things started in the 1960’s already, and we’re coming in at the tail end so to speak in a country that really should have been leading the way with our health needs.” (Prof. D. Hellenberg)

Regarding students’ attitudes towards the PHC approach, key informants had the most to say about what influences these attitudes. Influences mentioned were the negative attitudes of staff, students’ background, social class, life experiences and exposure to clinical settings. There was also an acknowledgement of the fact that teaching styles or methods may not be encouraging positive attitudes towards the PHC approach among the students, and that these need to be reflected on and improved if necessary.

“...I think your social class determines more the way that you think about the world than the colour of your skin.” (Prof. S. Reid)

However, there were a few influences that were picked up on that did not come up in students’ discussions and these were to do with the students’ age when they arrive at medical school (around seventeen or eighteen years old). Firstly, students are at an age where their parents’ attitudes and opinions are very influential, and students may not have formed their own opinions yet and are therefore vulnerable to this influence. Secondly, when students enter medical school, the majority of them have just finished

high school, and it was argued that their level of maturity is not at a stage where they are able to think independently and analytically, implying that they may be open to influence of their parents' and other students' attitudes and may not be able to critically evaluate those opinions that they come across and may also not be able to critically evaluate the PHC approach and understand its value.

"...I think a lot of what students come in with at the age of eighteen is really just paraphrasing what their parents say around the dinner table and what parents may be talking about..." (Mrs. L. Olckers)

One of the very significant contributions of the key informant interviews conducted with staff from other universities was the information they were able to give on how the PHC approach is being integrated into other medical curricula in South Africa, and this information highlighted the students' limited knowledge of what is actually being done at other universities as well as a possible reliance on the potentially biased opinions of students from other universities. All three of these key informants spoke of curriculum changes at their and other universities in South Africa, and although these changes were somewhat different to each other and to UCT, there seem to be a similar move towards integrating the PHC approach. This then refutes the notions that UCT is unique in incorporating the PHC approach, although there may be some truth in the belief that UCT is focussing particularly strongly on the PHC approach.

"I'm sure you can get hold of the end product statement. Everybody's got that, all of them say that, but the impression I get from having now been involved in medical education for the last ten years is that I don't think anybody is just paying lip service to that." (Prof. D. Prozesky)

Theme 5 - PHC: views of the approach

Idealism of PHC and Theory vs reality

The idealism of the PHC approach was raised with some of the key informants, and it was pointed out that a belief that the PHC approach is idealistic can become an excuse not to implement it and that students should be convinced that it is possible to implement it and make it work. Other key informants agreed that the PHC approach is idealistic but that this idealism provides a goal that can be worked towards and challenges students to be aware of and hopefully play a role in changing those social and environmental factors that impact on health.

"I think a lot about the PHC approach is very idealistic. There's nothing wrong with being idealistic. I think it sets a standard to which one can strive, and as such it's very useful to have that out there so that we challenge students, we challenge future doctors to think beyond just the pathological process, and to take into account the impact social and environmental factors. And I think in a country like South Africa, it's absolutely vital to do that. And it's true, they may not be able to do a lot to change those social factors. But I think that just by being aware of them, they'll be much better doctors." (Prof. J. Volmink)

In terms of the tension between the theory and the reality of the PHC approach, it was also pointed out that it is often the case in life that what is presented in theory does not necessarily work out in reality, and that the onus is on the students to measure up what is happening in reality with what the theory proposes.

"I think they are almost thinking that they are going to take what we are teaching them and it is all going to be neatly out there. But I think it is good that they go out and they see it's not all neatly packed, very few things in life ever are and actually what they have to do is take the theory and see to what extent does it match." (Mrs. L. Olckers)

PHC principles and comprehensive care

The two PHC principles that came up in discussions with key informants were intersectoral collaboration and multidisciplinary teams. Comments around these principles all seemed to emphasise the important role that other sectors and other health professionals play in health and the fact that the PHC approach does challenge the notion of the doctor as all important and all knowing, even proposing that in some situations the doctor may not be the most appropriate professional to lead a multidisciplinary team. The significance of intersectoral collaboration was particularly highlighted in one case where it was pointed out that students and doctors might find it difficult to accept that if issues like living conditions and sanitation are properly addressed, the need for doctors in their curative role may fall away or become less significant, and this could explain some of the resistance to the PHC approach.

"...the real change in health status came in England when the Industrial Revolution came. So it wasn't the health services that improved, but better housing, running water...and that made the difference to the health status of people, and not increased or improved health services. It's difficult for students to get their minds around that issue, because you're really tacitly admitting to yourself that you are superfluous in the system, that do you really need doctors then, if those things are more important than me. And that's hard for anyone to actually admit to." (Prof. D. Hellenberg)

Comprehensive care was also mentioned by some of the key informants, the main point being the importance of prevention and that preventing disease will help reduce the burden of the curative. The heavy burden of curative care in South Africa and the demands this places on health professionals were however acknowledged.

“...the reality is that if you go out into the community or in your surgery, is that patients are there...you don't have time to go out there to speak to the community and see what's going on, that's the perception. Once you realise that actually by going the other way around you can actually reduce the curative care.” (Prof. M. de Villiers)

“...they may even go into practice and practice curative medicine, but it's pretty pointless after a while if you don't tackle things in a more holistic way...” (Prof. S. Reid)

The role of doctors in the PHC approach

There did seem to be an acknowledgement that the role of doctors is broadened within the PHC approach, and that in the past, doctors have taken on a role that has been more disease focussed but now need to focus more on health. The PHC approach was also said to require a greater range of skills in doctors, especially in South Africa, as it requires generalist doctors that are capable at all levels of health care once they graduate. The point was also made that a very small percentage of people actually need tertiary level care, but that there are more in need at the primary level, which then emphasises that doctors should be able to function effectively within a community setting and this includes having an understanding of the community they are placed in. Due to the political dynamics surrounding health, the role and responsibility of doctors as advocates for change was also stressed, and this advocacy role is something that comes with the “powerful” and “privileged” position that students' will be in as a result of their education at UCT and the fact that they will be seen as leaders by communities they will work in as well as by those at higher political levels.

“I definitely think doctors need to take on an advocacy role. I think that by virtue of the education they've received they are in such a privileged position...they are seen as leaders not only by the communities that they work with but also by people in senior, high positions in politics, and they'll be taken seriously. So they need to understand that with the piece of paper that says that they are a graduate comes with a real responsibility...” (Mrs. L. Olckers)

Theme 6 - Medicine and PHC in the South African context

Regarding the issue of health and health care in South Africa, the bleak view of working conditions in the public sector was recognised, and some did comment on the uncertainty, frustration, anger stress felt by health professionals working in this sector, and that frequent changes made by the government seem to be exacerbating the already difficult situation.

“Well, I think even doctors who work in the system now, and all the other nurses especially, they feel uncertain about their future...In terms of ‘can I live on this salary?’...government is making a lot of changes, on a regular basis, which affects the working conditions of people...” (Prof. D. Hellenberg)

An interesting point was made about the treatment of doctors by government, and could help to explain this seemingly poor treatment. Relating to the traditional view of the doctor at the top of the hierarchy of health professionals and the arrogance that could go with this position, it was argued that because the power is now shifting, doctors are now being ‘put in their place’, particularly by those on a political management level. It would seem that there has almost been a build-up of resentment around the high position of doctors and that it is with a certain measure of satisfaction that doctors can now be put on an equal level.

“The medical practitioner has become marginalised because they’ve all the years been arrogant, ‘I’m the doctor, I know best, the politicians say ‘no, man, you’re a doctor, I don’t want to listen to you’...it is being felt that medicine must be put in its place...you are part of the team and finish and klaar...”
(Prof. M. de Villiers)

Concerns about working in a health system that has not yet fully adopted the PHC approach relate to the issue of staff and other health professionals’ awareness, understanding and acceptance of the approach. This lack of awareness as well as misunderstandings of the PHC approach were also mentioned by some key informants, and mention was also made of the fact that there may be multiple understandings of the PHC approach, which could lead to confusion.

“Even within the School of Public Health and Family Medicine, if you ask ten different people what PHC means, you’d probably get ten different answers. And then you have to try and define it, because it’s a whole lot of things together.” (Dr. E. de Vries)

Concerns were also raised about the government, particularly with regards to poor management of funds, their desire to maintain control, and changes made in haste without adequate consultation with or support for the involved parties. It was noted that students may not always be well informed about the government's decisions and actions or aware of the governments' intentions to improve health care, and that their views may be shaped by what is fed to them by the media and disgruntled doctors. It was also mentioned that younger students may not appreciate the complexity of this issue because of their tendency to criticise and view things as "black or white."

"...for young students things are black or white, right or wrong. Whereas as you get older you realise that there's a lot of grey, there's not just good guys or bad guys, there'll be some good things and some bad things...when young people are developing mentally, you have to criticise society and establishment and everything. And then later when you're part of it, you have to help to make it better." (Dr. E. de Vries)

There was a general acknowledgement that a gap does exist between the public and private sector and a few comments were made regarding the students' reasons for choosing to work in either of these sectors. These comments included the financial benefit of working in the private sector and the poor working conditions in the public sector that cause doctors to feel that they cannot provide good care. What was then stressed was the importance of allowing students to have positive experiences of the public sector in which they are able to observe quality, integrated care.

"Well, it's all about money isn't it? I'm not even saying that critically, I think the reality is that a) there's a very expectation of high earnings when you register to become a doctor, and the private sector is where you maximise your earnings. So I think students, understandably, need to earn because of debts that they have incurred. And then a third factor is...the conditions in the public sector are so abysmal that if you're a good doctor, you actually don't want to work there because you have to compromise so much on what you do and how you do it, and you feel that you can't give your patients your best care..."

(Prof. J. Volmink)

Theme 7 - PHC and the learning environment

New curriculum

Due to the fact that all key informants had some role to play in the reform of medical education, their views of these changes are unsurprisingly positive, but some reservations were expressed. These related to the fact that reforms in medical

education are demanding on human and financial resources and that these are not in abundance in South Africa at the moment. In addition to this, there are some aspects of the old paradigm of teaching that can still be valuable in certain cases and should therefore not be completely disregarded for the sake of reform. The point was also made that students should receive more information before they register for the course so that they can have a better idea of what their degree will entail and adjust their expectations accordingly.

“...uncritical embracing of the new paradigm of medical education, which has been tried and fully verified in rich, first world countries with many resources...it’s really human resource intensive and therefore has large cost implications. A country such as ours that is not rich...resources are shrinking in terms of human resources...the challenge is to come up with a paradigm that fits South African and is educationally good.”
(Prof. D. Prozesky)

There were a number of positive comments about the group-based teaching style of UCT’s new curriculum, some relating to problem-based learning which was said to encourage students to be more proactive and responsible in the learning process. With regards to the BP and BHP groups, the diversity of these groups and the “richness” this diversity can bring to the group experience were also mentioned. It was also acknowledged that the teaching style of the new curriculum goes against much of what students are used to from their schooling where they were used to passively receiving information and not participating in the learning process.

“...how we teach them, in terms of learning things yourself and finding things out for yourself is very important and not feeding with a spoon. And also the way that we teach them if you don’t know go and have a look.” (Prof. M. de Villiers)

“I think that what they would like is for us to give them a book that has the answers in it...I think it comes out of I think a school system that encourages that, that...sees them as empty vessels that we’re going to fill...” (Mrs. L. Olckers)

Regarding the content of the curriculum, one key informant raised the point that students’ concerns that there is not enough basic science in their curriculum should not be disregarded, but that curricula should be examined to see if this is in fact not true and also for any repetition in content which will ultimately bore and antagonise students.

“...we should also listen to the student’s because perhaps why they feel there is not enough of the basic sciences is because there isn’t...In our curriculum when we looked at the biopsychosocial input...students

have always said it's terribly repetitious, and it is...We say the same thing to them over and over again in six different ways...after the first 3 times they really understand this thing, that it's even sunk into them that they even believe it. Then after that we just bore them and antagonise them.” (Prof. D. Prozesky)

How PHC is taught

With regards to how PHC is or should be taught, it was reiterated that students' points of view need to be taken into account, and this was with reference to the students' feelings that there is too much PHC in the early years and that there was also repetition of concepts. The issue of who is teaching the students was also picked up on, and this was a concern for a few students who felt quite strongly that their facilitators should be able to answer all their questions. This particular point was raised by another key informant who stated that the role of facilitators (for BP and BHP) is *not* to provide answers but rather to guide students in the right direction.

The students' concerns around not learning about other approaches besides PHC was addressed with one key informant, the BHP course convenor, and she maintained that students are being helped to make the link between poverty and health, which should hopefully get students to see the value of an approach such as PHC, and she also proposed that students may be feeling a need to know about other approaches so that they are better able to justify to others why the PHC approach has been adopted. This then relates back to their feelings of disempowerment around their perceived lack of choice in the matter.

“But it is more about their role of helping students to find answers, and to accept and allow the challenges that are coming through and then to open it up for discussion...I think sometimes what happens is the facilitator who brings expertise wants to answer the questions and I think the students are very good at getting people to answer questions who are experts in an area...primary healthcare is so complex that I think students really need to grapple with it much more than just having like, ‘okay, so this is primary healthcare.’” (Mrs. L. Olckers)

Clinical exposure

The value of clinical exposure was highlighted by some key informants, and it was argued that it could help students to understand the PHC approach, and that helping with simple tasks could help familiarise students with patient interaction. It was

however stressed that this kind of exposure needs to be more than just “student health tourism” that often has little benefit for the people working at these facilities, but should involve students in tasks that are at their level of skill and that help to ease the work load of staff, making them more willing to accommodate the students.

“It’s very difficult to teach primary health care in isolation or in theory, it remains just the theory until you’ve actually experienced it in some way or another.” (Prof. S. Reid)

One informant proposed a different approach to clinical exposure that allows students to “construct the meaning out of consecutive experiences” rather than having to fit their experiences to the set of truths that they have been presented with. This ‘constructivist’ approach leaves space for students to have possibly difficult or confusing experiences and then aims to answer the questions that are thrown up by these experiences. It does provide students with some framework to work within, but puts a fair amount of faith in the students’ own abilities and initiative. There was however a concern expressed about this kind of approach as it could result in unpleasant experiences which may then “immunize” students against working in that type of environment again.

“...they need a framework to work from, but they need surprisingly little. We assume that they need much more, and they don’t, because if you trust learners enough to find their own path they will do it, we’re not talking about stupid people here, we’re talking about intelligent individuals on the whole, who’ve managed to make it through into varsity and into medical school, most of them are self-starters, are initiators, so I trust them that they will discover it.” (Prof. S. Reid)

Conclusion

This section has presented the views of key informants from both UCT and other universities, and topics included some of the common perceptions of medicine, the importance of role models, and opinions of what makes a good doctor. Some of the students’ expectations about studying medicine were picked up on as well as factors that might lead to these perceptions. Students’ reasons for studying medicine were also discussed along with future plans, and working in rural areas in particular. Some of the common misperceptions of the PHC approach were mentioned in relation to students’ understanding of the approach.

Also covered were students' attitudes towards the PHC approach and what influences these attitudes, as well as some of their views of the PHC approach and the role of doctors in the approach. In relation to the PHC approach in the South African context, the poor working conditions for health professionals were brought up, along with staff and health professionals' views and understanding of the PHC approach, the government's involvement in the implementation of the PHC approach and reasons for doctors to choose to work in the public or private sector. Lastly, regarding PHC in the learning environment, topics that were addressed include the applicability of curriculum reform to South Africa, the teaching style and content of the new UCT curriculum, how the PHC approach is taught and exposure of students to clinical settings.

Regarding the key informant interviews with UCT staff, it is clear that besides the expected differences, there is a measure of congruency between staff and students in the areas that were discussed and that staff at least have a grasp of students' views of the PHC approach and their experiences of the curriculum. This is encouraging in the sense that there is not a wide gulf between these sets of views or that staff are completely out of touch with students as either of these scenarios could surely not promote positive attitudes towards the PHC approach or the curriculum. The key informant interviews with staff from other universities helps to confirm that there is a general effort in South African universities to train doctors to be effective in the South African context through emphasising a holistic approach to health and the importance of community-based education.

Introduction

This chapter will begin by summarising the main findings that have emerged in this research, and this summary draws on what was depicted in Figure 2 (p.43) - 'Into and through the journey of medicine.' What follows this summary is a progressive discussion of these findings and related issues, which will link to relevant literature and theoretical perspectives. Since there is a lack of research in many of the areas under discussion, the majority of literature that will be mentioned will serve to merely affirm and validate the students' views rather than provide points of direct comparison.

Summary of main findings

The findings of this research suggest that students are entering their medical training with quite a traditional view of medicine that is curative and biomedical, and that focuses on the clinical more than the interpersonal, not really involving community interaction. Alongside this traditional view of medicine is a view of teaching and learning that is largely didactic and that entails more 'teacher' than 'learner' responsibility. These views of medicine, teaching and learning form part of the students' greater world view that is influenced by their background and life experiences, and is also significantly affected by the views of their parents or primary care givers.

Students then arrive at UCT to study medicine, in a sense 'armed' with their world views as they are potentially a source of stability and security for them because of their familiarity. These world views however, are seriously challenged by the content and teaching methods of the MBChB curriculum. In terms of the teaching methods, students realise that they need to be both independent *and* interdependent learners and have to take on a fair amount of responsibility for their learning, particularly regarding their participation in the learning process. With regards to content, the psychosocial component of the curriculum along with the PHC approach essentially compel students

to broaden their world view - to look at 'the bigger picture' of the medical profession and health in general.

On the whole, students seem to have a good understanding of the PHC approach, and although there are some misperceptions of this approach, students' perceptions of the PHC approach are for the most part accurate. Students' attitudes towards the PHC approach are generally good, but they seem to find it problematic that the theory of this approach does not match the reality of its implementation in South Africa, as students are mostly aware of the realities of health care in South Africa, either through their personal experience outside of the curriculum or through exposure to clinical settings as part of their training. Hence the concepts that students are learning are inevitably compared with what they have seen or heard, and this seems to give rise to or cultivate the notion of PHC as idealistic, setting up the struggle between theory and reality.

In terms of the students' world views, the findings of this research suggest that the students' world views are open to change and changes do seem to occur. One of the changes taking place is the increased acceptance of the political dynamics involved in health care, and students seem quite aware of the impact of these dynamics on their future as doctors. Attitudes towards the PHC approach, although generally positive regarding its theory, do change somewhat as students progress to include increased acceptance and appreciation of the PHC approach.

This summary of findings shows that although this research set out to investigate students' attitudes towards and perceptions of the PHC approach, these attitudes and perceptions are embedded in and surrounded by an extensive range of other issues. From these issues, discourses of power and responsibility have emerged, and these will be explained and picked up at various points through the rest of this chapter.

Perceptions of medicine and doctors

Previous research on students' perceptions of medicine and doctors is limited, but what has been done provides a less than clear picture, but bears similarity to the findings of this research that show that perceptions of medicine and doctors are multifaceted. A study with first year medical students in Sweden⁹⁷ reported a range of perceptions of medical practice that included curative, biomedical, interpersonal and altruistic

dimensions, and these results correspond with the findings of this research. A different picture emerged from a study with final year medical students in the United States of America (USA)⁹⁸ which found that they viewed the role of the doctor from a more vocational perspective that involves more alleviation of suffering than money, prestige and success. Results that were more dissimilar were from another report on students in the USA that found the altruistic dimension of being a doctor problematic in the sense that they did not feel that acting altruistically was an obligation, but rather something that they would engage in on their own terms.⁹⁹

Other literature affirmed the prestige of doctors mentioned by students, and stated that doctors have historically had a position of status in society and a dominance among health professionals, playing an influential role in health that casts them as central to the provision of health in society.¹⁰⁰ The prevailing clinical view of doctors in society was also mentioned, and this was said to be due to the fact that society is more familiar with the image of a doctor in a hospital than in the home,¹⁰¹ and this could help to explain biomedical and curative perceptions of doctors that were mentioned by students.

Regarding perceptions of doctors and what makes a good doctor, a range of opinions is given in the literature by students and staff, and this confirms the diversity of opinions put forward in this research, as well as the difficulty students had with isolating particular characteristics. Most mention a number of valued attributes,¹⁰²⁻¹⁰⁷ (see also Appendix G) but there were some characteristics that received frequent mention: cultural competence¹⁰⁸ which includes respect for patients' diversity⁵³ and the ability to function as part of a culturally diverse environment¹⁰⁹; lifelong learning,¹¹⁰⁻¹¹³ some highlighting the role of undergraduate medical education in instilling this characteristic in students^{114,115}; professionalism and professional development^{97,99,116-121}; team or group work skills,^{11,122} some specifically emphasising the importance of these skills for doctors working within the PHC approach^{123,124}; and communication skills.^{50,120,125-128} Within the literature there does seem to be an acceptance that personality plays a role in shaping doctors,^{98,102,103,107,126,129-133} although in these studies, no clear explanations are given of a particular personality type that is specifically suited for a career in medicine, which is consistent with the findings of this research.

The role of personality in shaping doctors has implications for student selection - something which did not emerge as a very pertinent issue in this research, but is nevertheless important to address as it relates to other relevant issues. In terms of what makes a good doctor, the question is raised of whether it is possible to select those who will make good doctors. Some accept that medical schools have a responsibility to do so,^{102,103,120,134,135} but there is also acknowledgement of the complexity of this task.¹³⁵⁻¹³⁷ The issue of student selection for medicine is essentially a debate about nature versus nurture¹²⁰: Do students learn to be good doctors (nurture), highlighting the impact of educational factors, or are there certain personal attributes that predispose students to being good doctors (nature)? This debate extends to attitudes - are they inherent and inflexible or open to influence? - as well as students' choice of career - will students' future aspirations become their future actions? The fact that there are selection procedures reported to select students according to abilities that extend beyond the academic¹⁰³ such as attitudes,¹²¹ moral orientation,¹³⁸ an interest in primary care,¹³⁹⁻¹⁴¹ or a generalist orientation¹⁴²⁻¹⁴⁴ suggests that the argument for nature has weight, and there are admissions policies that have proven to be successful in this regard.^{145,146}

The importance of role models, which emerged more clearly in discussions with key informants, is acknowledged in the literature,^{108,121,139,147,148} particularly with regard to professional values,^{120,149,150} and the need for generalists was also noted.¹⁵¹ The role of culture was also acknowledged in the selection of role models, and this was said to become increasingly significant as students progress.¹⁰⁹ It was also maintained that older students will be more likely to choose medically qualified individuals¹⁴⁹ and this highlights the need for good PHC role models as students enter their clinical years.

Motivations and future aspirations

Little research has been done on students' motivations for entering the medical profession, and although these are addressed in some instances they are not expanded on.^{99,152} The research that does explain these in more detail bears some similarities to what was found in this research. In a study with first year students, altruistic motivations were overshadowed by a desire for prestige, money and success,⁹⁸ and this is not similar to my findings. This could be because the research was conducted in the United Kingdom, a developed country with a different economic climate. Research conducted in the USA that was more in line with my findings reported a greater range of

career related values which could be strong indicators of motivations to study medicine.¹⁵³

With regards to students' future aspirations, the literature looks mainly at what impacts on career choice, particularly in terms of specialty choice. This seems to be acknowledged as a complex issue as there are a range of factors influencing these types of decisions.^{139,152,154-156} Some accept that pre-medical school factors such as students' characteristics, social and cultural background, medical school factors such as their educational experiences and role models, and post-medical school factors such as financial responsibilities and job market conditions, are all at play.^{139,154,155} This conclusion would be in line with the findings of this research as there seemed to be no apparent dominance of any particular type of factors, but rather an acknowledgement of the wide range of factors. However, in other research only one or two of these factors were emphasised, or the impact of one or more factors was discounted.^{52,133,152,157-169} Existing literature therefore does not do much to clarify this issue, but does confirm that all these types of factors do need to be taken into consideration. In terms of where students would like to work, a similar selection of factors are also responsible for influencing these choices.¹⁷⁰⁻¹⁷³

The issue of doctors working in rural areas is also a pertinent one and was mentioned frequently in the literature. The poor state of rural health services in South Africa,¹⁷⁴ the unequal distribution of health professionals between urban and rural areas due to the migration of professions to urban areas,¹⁷⁵ and a lack of experienced health professionals in rural areas¹⁷³ seem to be pressing concerns in this regard, and all these issues emerged to some extent in this research. Again, a number of factors are said to be responsible for students' choosing to work in these areas,^{170,176} although emphasis was placed on certain factors, with other factors being disregarded by some.¹⁷⁷⁻¹⁸⁰ This relates to the issue of financial incentives offered to health professionals to encourage them to work in rural areas, but some do question the weight that is put on these incentives.^{173,174} Clear consensus is lacking on this issue, although there does seem some agreement around the factors of rural upbringing and an initial interest in primary care or rural medicine, and the presence of these is believed to positively impact students' choices regarding working in a rural area.^{141,181-183}

The findings of this research do not completely tie in with previous research on working in rural areas, particularly in terms of the belief that students from a rural background will be motivated to return to such an environment. This highlights the need to explore this issue further in order to get a better understanding of the factors impacting on these decisions. Students' feelings about going overseas that emerged in this research also do not match up to the widespread concern about the migration of health professionals to wealthier countries.^{173,175,184-193}

Making sense of perceptions, expectations, motivations and aspirations

It is necessary to consider how students' perceptions of medicine and doctors, expectations of being a doctor, reasons for studying medicine and future plans relate to their attitudes and perceptions of PHC approach. Firstly, these are important to understand, because the way in which students characterise medicine will influence how they learn,⁹⁷ and secondly they contribute to a mental image of what their career will entail, and will therefore have an impact on their expectations about their academic training for this career. This mental image becomes internalised as students picture themselves in the role of doctor, and will see in themselves some of the personality traits, skills and abilities that they believe are necessary to fulfil this role. At the foundation of this image are certain values, beliefs, and priorities associated with a doctor, and which are shaped by the students' perceptions.

Students then enter medical school with these values, beliefs and priorities, and are exposed to the PHC approach, which has its own set of values, beliefs and priorities. The question then is whether or not there is congruence between the values, beliefs and priorities that the students came in with and those of the PHC approach. Resistance will most probably develop if there is incongruence between these sets of values, beliefs and priorities and a negative attitude towards the PHC approach could then develop. There may initially be congruence but students may still develop a negative attitude due to other factors such as how the PHC approach is taught. Values, beliefs and priorities may be challenged and changed as time progresses, particularly as students are exposed to clinical settings, and may become more in line with those of the PHC approach, leading to the acceptance and appreciation of the approach that was reported on.

One inconsistency that does emerge in this section is between students' acknowledgement that medicine does not and should not have a purely biomedical focus, and their expectation that their medical degree would be biomedical in its content. This raises the question that if students are expecting doctors, and hence one day themselves, to be caring, helpful, compassionate and socially adept, where are they expecting to learn and hone these characteristics and skills if not at medical school? Even though many students recognised the role that personality can play in influencing the type of doctor that one will be, there was no resounding agreement that all these desirable characteristics mentioned above are embedded in the personalities of those who come to study medicine.

A more likely reason for this inconsistency is that students may assume that these characteristics are merely acquired through the course of one's academic career and do not need to be explicitly taught. Another likely reason is that expectations of studying medicine may be more strongly influenced by secondary schooling as was mentioned by some key informants, as subjects such as mathematics, science and biology are all emphasised as important for medicine, and this can then lead students to believe that it is these types of subjects that will dominate their curriculum. As for learning about psychosocial issues, it is possible that students entering their first year of studies have little or no previous exposure to subjects such as psychology and sociology, and therefore may not make any link between psychosocial issues and the interpersonal dimension of being a doctor, or they might presume that this type of knowledge is largely common sense and hence does not need to be taught and assessed.

In terms of how students' future aspirations relate to their attitudes towards and perceptions of the PHC approach, these future aspirations and particularly those at early stages of a student's academic career, are merely an expression of the mental image of their medical career that was mentioned earlier and the associated values, beliefs and priorities. The term 'future aspirations' is used instead of 'future plans' in order to highlight the fact that this image may change and students admit that it is open to a variety of influences. The PHC approach in many ways requires that doctors are well positioned to assist in the implementation of the approach, and it has been mentioned that this is perceived to be a fault of the PHC approach as it presumes that doctors will choose to place themselves in positions that are most beneficial to this process of implementation.

Although it would be unwise to draw too many conclusions from the future aspirations that students have mentioned thus far, the aspirations mentioned seem to indicate that there are students who would be willing to work in areas that are in the most need of the PHC approach and at this stage there does not seem to be a strong desire to leave South Africa once qualified. However, the concern about working in rural areas and the students' willingness to work in such areas is a concern as these are potentially the areas that are most in need of the PHC approach.

The nobility and power of the medical profession

It is within the first two themes that it has been necessary to evaluate the reasons for the nobility of the medical profession and why doctors are placed in high esteem in spite of the clear difficulties that are associated with working in this field. There are two reasons that seem apparent and these were suggested rather circuitously by students. The first reason is that doctors are involved in life and death - they help to bring people into this world, help to alleviate pain and suffering, often preventing death, and are ultimately involved in the departure of people from this world. The second related reason is that doctors possess the knowledge and skills to make and act on decisions that can have life changing and life saving consequences, and one student alluded to this by labelling medicine as the "height of human expertise". What helps to confirm these reasons is that the specialties that students seem to mention the most are all specialties that relate to these two reasons mentioned above. Surgery, cardiology and neurology are particularly good examples of this, cardiology and neurology specifically as they involve the two major organs that give us life: the heart and the brain.

These two reasons are also corroborated in students' motivations for studying medicine, and interviews, focus groups and the questionnaire results all suggest that the most common motivations for studying medicine are altruistic (helping people and serving their community) and an interest in biology and the human body. Without questioning the validity of these altruistic reasons, it should be noted that implicit in this motivation is an assumption that doctors have the ability - and thus the power - to help people and make a difference in their lives. An interest in biology and the human body is suggestive of a desire to attain the knowledge that will ultimately enable one to make those life and death decisions as a doctor. The reason "I have always wanted to be a doctor" does not actually qualify as a motivation as students that make this assertion are in effect

admitting that they cannot remember the original reason for deciding to become a doctor one day, but it would be reasonable to believe that the nobility of the medical profession had something to do with it.

Within the first two themes there also seems to be an association between knowledge and power, drawing on the commonly held belief that '*knowledge is power*', and this is a discourse that can be picked up at numerous points. In this case the knowledge and skills mentioned above give doctors the power over life and death, and it is possible that this power, along with the nobility of the medical profession can then make it easier for students to disregard the difficulties of being a doctor. The fact that students do seem so aware of these difficulties is rather puzzling, and it is hard to make sense of the fact that in light of all the difficulties mentioned, there are still those who willingly decide to take on these burdens and stresses.

Perceptions of the PHC approach

In terms of how students referred to and described the PHC approach, their perceptions were generally accurate, particularly in the sense that they refer to PHC as an approach, and there were also occasions where it was clear that PHC was a philosophy. However, misperceptions and misunderstandings of the PHC approach did emerge in students' criticisms of the approach as well as their views on its applicability for South Africa in general and for the public and private sector. These views could possibly give rise to a negative attitude towards the PHC approach, and the possibility of this highlights the importance of gaining insight into students' perceptions and understanding of the PHC approach as these can play a crucial role in influencing their attitudes.

Attitudes towards the PHC approach

One of the key findings in this research is that students have a generally positive attitude towards the PHC approach in terms of being in favour of what it stands for, i.e. its values, beliefs and priorities. Research done on medical students' views and understanding of the PHC approach has not clearly shown the existence of either positive or negative attitudes towards the PHC approach among medical students,^{14,25,34,38,39} so it is therefore difficult to compare findings. The crucial question

still remains about whether students have internalised these values, beliefs and priorities, and it seems possible that some students would be able to think and feel positively about the PHC approach but not actually allow their own values, beliefs and priorities to be altered. This points to the complex nature of attitudes and the difficulty of isolating and measuring them specifically, and ambiguities in previous research may be because of this.

Others have also acknowledged the difficulty of understanding the development of professional attitudes¹⁹⁴ and the fact that traditional methods of teaching are not that effective in altering these attitudes,¹²¹ largely due to their psychosocial nature and their dependency on both psychological and social factors.¹⁹⁴ Howe¹²¹ does well to capture this complexity: "Attitudes are at the interface between the personal and public psyche, relying more on individual experience and the accumulated impact of social and cultural interpretations than on propositional knowledge..." (p.353). The understanding of attitudes may not be obtained also partly due to the assumption that attitudes predispose behaviours, and while this is true to some extent, the link between attitudes and behaviours is not unchallenged and needs to be more closely examined.¹⁹⁴

Regarding UCT's promotion of the PHC approach, it is encouraging that some students did recognise the importance of promoting an approach such as PHC in order to prepare them for work in South Africa, and this has been stated as a priority by the South African government² as well as others.¹⁹⁵ The concerns expressed by students about this seemed to relate to insecurities about their level of knowledge and skill, asking questions like 'will I have enough knowledge?' and 'will I be able to do what I am supposed to do?' These concerns seemed to be heightened by the perception that other universities are not placing the same emphasis on the PHC approach and might therefore be offering a superior degree. Information from key informants however refutes this presumption, but even just the belief that UCT is on its own track appears to be enough to unnerve students and cause concern about the quality of their own degree. It should also be noted that students' insecurities about their level of knowledge may be related to the teaching methods in the new curriculum as well as the proportion of psychosocial knowledge included in the curriculum and not only the fact that the curriculum is PHC-driven.

The impact of socioeconomic status and background on attitudes

In terms of the influences of students' attitudes towards the PHC approach, there was one ambiguity, and this was to do with the role of SES and background. Students had a range of opinions on this role, not always clarifying the way in which factors such as race, SES, background and experiences of health services are intertwined. This ambiguity does cause me to question the extent of students' knowledge of and insight into the history of apartheid in South Africa, and this was mentioned in the 'Introduction and Literature review'. Their limited knowledge of and insight into the history of apartheid may be due mostly to their age and their exposure to a more racially integrated environment in terms of their schooling and society in general. These students therefore may not be used to thinking in terms of race and SES and so when questioned about the influence of these factors, they are unsure of the role that they play. This unfamiliarity with issues around race and SES, juxtaposed with the persistent impact of the legacy of apartheid on the lives of those who were previously and are still currently disadvantaged, seems to be the root of this ambiguity.

Understanding changes in attitudes

With regards to the change in attitudes reported in this research, these can only be compared to attitude changes in general, and other research has found that as students progress through their academic career they become more cynical,^{56,194} there is a loss of idealism, they are more concerned with making money, but are also more concerned for patients and more helpful.⁵⁶ The increased cynicism reported is not very well defined or clarified, but this attitude and a positive attitude towards helping patients are apparently not mutually exclusive.⁵⁶ Attitudes towards the psychosocial content of the curriculum may change because of the philosophy of the new curriculum which supports students' autonomy, and if their autonomy is supported, students are said to become more psychosocial in their orientation.¹⁹⁶ This could then validate what students said about realising the value of the psychosocial component of their curriculum as time progresses.

These attitude changes reported in previous research do little to help understand the appreciation and acceptance of the PHC approach that occurs with older students, and

this change of attitude may be better explained by the influence of the 'hidden curriculum', which is defined as "...a set of influences that function at the level of organisational structure and culture...commonly held 'understandings', customs, rituals and taken for granted aspects..." (p.404),¹⁹⁷ and is widely acknowledged in literature on medical education.^{41,108,120,121,150,173,197-203} While the promotion of the PHC approach is clearly taking place within the formal MBChB curriculum, this promotion may also be occurring at a less obvious level that is impacting positively on the students' attitudes, for example through the positive attitudes of group facilitators (for BP, BHP or BaDr - see Appendix A) and their belief in the value of the PHC approach.

Students' attitude changes could also be partly explained by considering the theory of 'deep' and 'surface' learning. Ramsden²⁰⁴ defines deep learning as that which emphasises the meaning of a task and aims to understand, whereas surface learning emphasises the 'signs' - the words and sentences, and the aim is to accomplish what is required. Younger students may focus more on the wording and terminology of the PHC approach, and this could be weighing them down and hindering a deeper understanding of the approach. A more shallow understanding may then downplay the value of the approach and fail to stimulate an appreciation of it, and a focus on the terminology of the approach may also confuse students, delaying their acceptance of the PHC approach. Older students on the other hand may be more able to look at the broader and deeper meaning of the PHC approach, possibly because they will have grappled with the surface aspects of the approach, and their exposure to the reality of the PHC approach through their clinical exposure may also have stimulated a motivation to understand it.

The reason this theory of learning only partly explains attitude changes is because students do more than just learn the PHC approach. Because it is a philosophy it needs to be embraced at an ideological level and the values it upholds need to ultimately be internalised. In addition, there were some younger students that showed more insight than some of their peers and who appeared to have progressed already to deep learning in spite of their academic level, so this also makes the application of this theory debatable. Students' attitude change seems to be most likely due to their increasing exposure to clinical settings, which will be discussed further at a later stage, as well as to a broadening perspective that comes with increased contact with a wider range of people and life experiences.

Views of the PHC approach

With regards to how students' views of the PHC approach reflect their attitudes towards this approach, it should be acknowledged again that attitudes are complex phenomena to measure, and it is not always possible to get a clear indication of these attitudes from one specific measure. Asking students about their views of the approach often helped to start off the discussion of the PHC approach in interviews and focus groups, and the discussion that followed usually gave a broader depiction of these views, including the strengths and weaknesses of the approach and their opinions on its various aspects. It was surmised that students who stressed the weaknesses of the approach and were critical of various aspects of the approach would have a negative attitude towards it, whereas those who stressed the strengths of the approach and who spoke positively about the various aspects of the approach would have a positive attitude. Students could also be said to have a positive attitude towards the PHC approach if their comments indicated an embracing of the philosophy of PHC, for example the importance of providing health care for underprivileged communities and looking at health from a holistic point of view.

Students' views of the strengths and weaknesses of the PHC approach could also give some indication of their perceptions of the approach as well. Of the strengths and weaknesses mentioned, there were some that focussed more on specific aspects of the PHC approach which could indicate a perception of PHC as more of a strategy, whereas some strengths and weaknesses related to the PHC approach in general and these could signify a perception of PHC as a philosophy. Since the PHC approach is both a strategy and a philosophy, either of these perceptions would indicate an understanding of the approach. There were however some weaknesses pointed out that were based on misperceptions of the PHC approach and that revealed a limited understanding.

Students' attitudes towards the PHC approach could also be reflected in their views on comprehensive care and the importance of prevention and promotion, and it could be argued that those students who stressed the importance of prevention and promotion would have a better understanding of the philosophy of the PHC approach as well as a more positive attitude towards the approach. However, this might not necessarily be the case as those students who emphasised the importance of cure did cite practical and relevant reasons to support their contention and it is therefore not possible to simply

claim that their attitude to the PHC approach would be negative. These positive views of prevention and promotion are consistent with other research in this area that found generally positive attitudes towards promotion and prevention among students.²⁰⁵⁻²⁰⁸ The importance of the community in the PHC approach was also stressed, and some students specifically highlighted this importance. Others mentioned the difficulty of working with communities and this also indirectly affirms this importance because if community participation was not important then lack of cooperation would not be a concern.

Hierarchy and the role of doctors in the PHC approach

Under the students' discussion of multidisciplinary teams, particularly with regards to the way in which the hierarchy of health professionals is challenged by the PHC approach, the association between knowledge and power re-emerges. Students speak of how doctors have traditionally been placed in more senior positions or positions of authority, not only because of the volume but also the value of their knowledge. This vital knowledge seems to be mostly to do with diagnoses and treatment, and is portrayed as more complex than the knowledge of nurses, who are depicted as more practical and better suited to deal with common illnesses. This feeds into the image of doctors as omniscient, God-like characters that are consulted for major decisions, for which nurses would feel too afraid to take responsibility but are comforted by the assurance that the doctor is there to shoulder the weight of that burden.

The fact that students are affirming this shift in power could be indicative of a more positive attitude towards the PHC approach, and could also mean that this knowledge-power link is becoming less sacrosanct, with things like practical skills and experience increasing in value. However, it should be noted that students find it easy to talk about this shift in power in theory, but may not necessarily be willing to surrender their authority in a practical situation, particularly in a situation where a doctor is not taking the leadership role, and the possibility of this was mentioned by some key informants.

Regarding the role of doctors in the community, there was no consensus amongst the students. Although lack of time was given as a reason for doctors not being able to engage on a community level, the implication was often that doctors had better and more important things to do, thus drawing again on the discourse of knowledge and power. Embedded in students' justifications for doctors not being able to engage on the

community level may be the belief that because of the perceived nobility of their profession and the power associated with their knowledge and skills, doctors should not have to involve themselves with less important community matters. This then can potentially devalue the role of the community thereby creating an inconsistency between these views and the general view of the community's importance, the outcome being the belief that the community is important, but not as important as the doctor.

The whole issue of the role of doctors in the PHC approach is quite a telling aspect of students' views as it can potentially indicate the level at which the PHC philosophy has been embraced and internalised by medical students. It is a good example of how the values, beliefs and priorities that students have as part of their image of a doctor that they begin with can be rather resistant to change, and students' discomfort with the broadening of the doctors' role could be due to a feeling that this image is being contested. It may not always be that explicit to students how these values, beliefs and priorities need to be altered, and this could lead to the students' uncertainty, confusion and insecurity, and these feelings, along with an unwillingness to change could lead to a resentment of the PHC approach or to the notion that the PHC approach is something that 'others do'. The role of doctors in the PHC approach is not sufficiently addressed in the literature, with only one source emphasising the community, social and leadership role of doctors.²⁶ This could compound the ambiguity and uncertainty around this role as the traditional role of doctor remains unchallenged in the academic sphere, making it more difficult for students to adopt or accept their new role as it is not being taught strongly or prominently role modelled within medical curricula.

Theory versus reality

The issue of the gap between theory and reality was a significant one for students, and the tension between the two came up in their discussion of other aspects of the PHC approach as well. For example, students who were in favour of selective PHC felt that a selective approach is less idealistic and theoretical and more realistic. Other students expressed the view that certain PHC principles such as multidisciplinary teams were good in theory but are not happening in reality.

Talking around this issue of theory versus reality with both students and staff, there seemed to be an underlying discourse of the students' responsibility. Students'

discontent around this gap between theory and reality comes with an uncertainty of whose responsibility it is to bridge this gap. That students should take the responsibility of matching what they are learning in theory to what they are exposed to in reality was mentioned by one key informant and only a few students, which does suggest that students generally do not feel this responsibility as their own and find it easier to put it into the hands of those teaching and training them. It is possible that the school environment could play a considerable role in downplaying the students' responsibility in the learning process and that as a result, they have become accustomed to being passive through this process which remains to be far more didactic in nature.

Students' difficulty with information of a theoretical nature should also be noted when considering this issue of theory versus reality, and the school environment could again be a factor to take into account as there are few subjects at a secondary education level that encourage students to think conceptually and theoretically. Because of this lack of experience in dealing with theories, students may be under the impression that theories are a statement of how things *are*, and battle to understand that the theoretical is more often a statement about how things *should* or *could be* and hence will generally not mirror reality because of this. Instances where students are able to observe aspects of the PHC approach in practice are therefore crucial as the theory that they have been exposed to then becomes a reality and be stored in the mind as an experience or an observation rather than an abstract concept or idea.

PHC in the South African context

As the majority of students at UCT come from South Africa, the context of this country will have influenced them before even arriving at UCT. Throughout their academic career they will be in contact with the South African context, be it through interaction with communities, clinical exposure or exposure to the various South African cultures at UCT. Once they are qualified doctors, they will also have to work within a South African context, at least for their internship and community service years. Students are therefore faced with the issues of this country all through their journey into the medical profession, and whatever they have had exposure to in terms of the South African context before they come to UCT is going to shape the image they have of medicine and doctors and hence their values, beliefs and priorities regarding these.

In terms of students' awareness of the state of health care in South Africa, I again wonder about the extent of students' knowledge and understanding of apartheid, and it may be the case that there are many students that have a limited understanding of the impact of apartheid on the accessibility of health care. This knowledge and understanding could also depend on the students' race and the advantage or disadvantage that has historically been associated with different race groups in South Africa, and hence the exposure they may have had to either the public or private sector. This exposure could then impact on students' perceptions of the need for the PHC approach and the applicability of this approach for South Africa. It should also be pointed out that arguments against the applicability of this approach for South Africa are based on misperceptions and misunderstandings of the approach.

Claims that the PHC approach needs to be adapted for and refined within the South African context are not necessarily faulty and are not unique to students, as Chen et al²⁰⁹ argue that all countries should have a human resource structure that is appropriate for its circumstances and health needs, and this applies also to the PHC approach since human resources are an integral part of its philosophy. Calls for adaptability could therefore actually indicate a better understanding of the South African context and the factors within this context that could hinder the implementation and success of the PHC approach, and could also be an effort to help bridge the gap between the theory and reality of the approach by adjusting the theory of the PHC approach to match reality.

Working conditions and human resources for health

Within this South African context, students' feelings about working conditions for health professionals in the public sector and the way in which doctors are seen to be treated are valid and the impact of poor working conditions on health professionals is recognised.^{100,209-212} Some doctors have also expressed their feelings about the way in which doctors are portrayed and treated.¹⁹¹ Although finances are a relevant feature of these issues, raising salaries is not seen to be the answer to these problems^{173,211} as the solution needs to be broader than this. Chen et al²⁰⁹ maintains that "for workers to be effective they must have drugs and supplies, and for them to use these inputs efficiently they must be motivated, skilled and supported" (p.1986), and this echoes a number of the students' comments and highlights the pivotal role of the government in workforce development,²⁰⁹ another point raised by students. Another prominent issue in the

literature is the reality of the deteriorating state of tertiary academic hospitals,^{195,212-215} which has an impact on students' training and could limit their career choices, which could then increase the chance of them migrating to countries with more favourable options.²¹²

Literature contends that South Africa is experiencing difficulties with human resources in health,^{175,212} but is not alone in this struggle as there is a global crisis in human resources for health,^{191,214} and one of the problems, professional migration has already been mentioned. This crisis is calling for the acknowledgement of the crucial role that human resources play in the quality and efficiency of health care,^{100,173,175,189,210,211,216,217} and more specifically, strong human resources have been identified as an essential feature of the achievement of the United Nations' Millennium Development Goals^{209,211,216,218} and the state of health in South Africa will most definitely benefit from the achievement of these. In addition, human resources also need to be mobilised, empowered and strengthened in developing countries such as South Africa in order to make PHC a reality.²¹⁷

Students' strong feelings around issues of working conditions in the public sector and the treatment of doctors could indicate their comprehension of the significance of human resources in health and in the PHC approach, and a realisation of the conditions that could undermine the effectiveness of these human resources. The sense of discontent, unfairness and indignation that some students expressed could also be related to issues of power as there may be a feeling that given doctors' position of power and nobility, they deserve better treatment than what they are currently perceived to be receiving, suggesting a sense of entitlement to treatment that is befitting to this position.

The depiction of the working conditions in the public sector as difficult may also serve to justify or rationalise students' decisions to work in the private sector where things are seen to be easier, more comfortable and less stressful, and could help to shift blame onto the South African government as they are seen to be largely responsible for the state of working conditions in the public sector. The discourse of responsibility therefore reappears as students, by placing the responsibility on government, are able to decrease their burden of responsibility. This responsibility pertains not only to advocating for and bringing about change in the public sector, but could also include a responsibility to endure difficult working conditions that could demand more effort and sacrifice. Some

of the students' remarks about wanting to make a difference and help people may seem to contradict this inference, but these are easy remarks to make when one has not been fully exposed to the reality of working conditions such as those in the public sector, and people's 'capitalist motivations' that were mentioned, although somewhat cynical, may in fact come more to the fore when reality is faced.

The implementation of PHC in South Africa - a success?

Students' views that the PHC approach is not working or that it has not been fully or properly implemented in South Africa are not necessarily inaccurate, as Ntuli and Day²¹⁰ maintain that South Africa has struggled to put an "impressive array of legislation, policies and guidelines to direct the provision of services" (p.9) into practice, and others have acknowledged the problems and difficulties regarding the implementation and success of the PHC approach in South Africa.^{8,212} However, students' views are still a concern as it is these types of views that are likely to make students lose confidence in the PHC approach and will most likely widen the disjuncture between theory and reality, because although the theory may be seen as good, the reality of it is not visible. On the other end of the spectrum, the fact that some students did point out some of PHC's successes is also a true reflection of many of the positive changes that have taken place in South Africa with regards to health care. Van Rensburg⁸ backs this up by claiming that despite the difficulties that have been encountered, progress has been made in implementing the PHC approach with respect to equity, accessibility, the reprioritisation of funding, building of health facilities, training of staff and future health professionals and the referral system, and a few of these points were mentioned by students.

The implementation of the PHC approach in South Africa relates to the meeting of the new and old paradigm of health and health care, and when students who have been trained under a new paradigm then enter settings that are functioning within an old paradigm, their confidence in the PHC approach could be further diminished, and their attitude towards this approach may become negative. Adding to these negative views are the negative views of staff and health professionals that students have contact with. Many of these views seem to be founded on misperceptions and misunderstandings of the PHC approach along with insecurity about change. For doctors, an acceptance of the PHC approach may signify a lack of control and therefore a loss of power, as it "rattles at the foundation of deeply entrenched notions of how a health care system should be

structured and who should be at the top and who at the bottom of this structure” (p.8).⁵⁹

In addition to this loss of control and power, a key aspect of the PHC approach is acknowledging the contexts of people’s lives, and traditionally doctors have ignored these in order to uphold objectivity.³⁰ Therefore, any threat to this objectivity may then be avoided, and this would include the PHC approach. It is also true, as students pointed out, that within the PHC approach, health professionals may not easily make the link between their efforts and their patients’ health.³⁰ Those health professionals providing clinical care may also feel that working with others in a team may be slower and more difficult than working alone.³⁰ The views of staff, and particularly those that are professors and doctors, are significant for students as many of these individuals may serve as role models for the students, and the importance of these has already been discussed, as they are seen to be the ones with knowledge and therefore the power and influence.

Still on the issue of the implementation of the PHC approach, obstacles to the implementation and success of the PHC approach that students mentioned are similar to those proposed by Cueto²¹⁷: misconceptions of PHC as ‘second class care’ or ‘poor’ medicine that have weakened it as a health paradigm; insufficient and inconsistent funding; resistance from health professionals; and in developing countries, inadequate PHC interventions that have preserved a culture of survival in which the political elite control limited resources, maintaining their power in a resource scarce environment. This culture of survival could help to explain some of the community perceptions that students raised, particularly with regards to the importance of fast, curative treatment and misconceptions about health promotion. A culture of survival also has connotations of disempowerment, and this then links to the history of disempowerment that was mentioned by one student.

The issue of responsibility emerged again in students’ discussions of obstacles to and requirements of the success and implementation of the PHC approach as the majority of these factors mentioned are not under the control of doctors, thereby decreasing the burden of responsibility on students to ensure the successful implementation of the PHC approach. By decreasing their own responsibility, the responsibility of others is accentuated, particularly the responsibility of the government, who seem to be seen as

a major factor to be considered in the implementation and success of the PHC approach. Students either stated this explicitly or it was implicit in their comments about what the government is or is not doing. Placing responsibility on an individual or on an entity also fulfils the human need to assign blame when something has gone wrong or is not working, assuring us that we are not responsible and therefore not to blame. There were however a few students who realised the problem with placing the responsibility on government and blaming them for the current state of health and health care. There were also some students who admitted their relative ignorance about the government, and this was also mentioned by some key informants, thus making these students less qualified to pass judgement on what the government should and should not be doing.

Political dynamics of the PHC approach

In terms of the political dimension of the PHC approach, it would seem that many students have found it difficult to come to terms with the political dynamics of their career, as these dynamics most probably did not feature in their image of the medical profession. Nevertheless, it has been argued that students do need to have a greater awareness of the political factors that impact on the success of the PHC approach.²¹⁷ Even if students are not as aware as they could be about the workings of the South African government, their criticisms are not completely unfounded as they appear elsewhere in the literature. Others have pointed out that issues of poverty and HIV/AIDS need to be addressed,²¹⁴ and the government's approach to HIV/AIDS has been criticised, both in South Africa and internationally.²¹² The government has also been criticised for their prioritisation of resources, particularly with regards to the allocation of resources to military equipment, and a massive figure of \$5.73 billion was mentioned in this regard.²¹²

Underlying the students' complaints about the government seems to be a feeling of unfairness around the way in which the government is prioritising their funds and energies, as it is probable that a number of the government's decisions are strongly impacting the health sector. The feeling that 'doctors do not deserve this kind of treatment' may be relevant here as well, linking to issues of power, but considering the comment by one key informant about this issue, it would appear that those in political positions may have become tired of having to affirm the position of power and esteem that doctors have historically held.

Regarding the political dynamics surrounding the PHC approach, it is necessary to consider whether or not these political dynamics will ultimately prevent the full implementation of the PHC approach. Students identified government support and commitment to the PHC approach as requirements for its success, and the approach is completely in line with the South African government's aims as it espouses principles such as democracy and equity. The question however, is whether political expediency and the government's private and public agenda will stand in the way of making the PHC approach a reality in South Africa. It is possible that there will always be other issues, such as the acquisition of arms, that will take priority over health, and as long as this is the case, the PHC approach will only be evident in bits and pieces throughout the health system, thereby pushing the ideals and theory of the PHC approach further away from the reality of their implementation in South Africa.

The public / private divide

The vast difference between the public and private sector in South Africa was something that came up often with students, and it has been claimed that one of the South African health system's greatest ongoing challenges is to address the inequity between those who have access to private medical care and those who rely on public services.²¹⁰ The "yawning divide" (p.10)²¹⁰ between these two sectors, which is not a new challenge,²¹³ seems to be widening,²¹⁹ and this widening is fuelled by increased private sector expenditure.²¹² A continuation of this could bring about "economic apartheid" to replace the racial apartheid of the past.²¹⁵ The fact that students have picked up on this divide between private and public could be indicative of their awareness of this as a major issue needing to be addressed, but it is also possible that it was mentioned so frequently by students in order to help them make sense of the huge disparity that exists, which some regarded as unfair and even embarrassing. Students did mention that government should obtain more support from the private sector, and collaboration between sectors has been mentioned in the literature as a possible solution to the divide that exists.^{100,213,215}

Students' descriptions of the public sector may again be justifying or rationalising a choice to work in the private sector. However, what seems to contradict this is that working in the public sector is depicted as more satisfying, fulfilling, inspiring, brave, and sacrificial. Students did not expound on these feelings, but it is possible that they

have something to do with the fact that because of the tough conditions in the public sector, doctors need to be brave and have a willingness to sacrifice many of their own needs, particularly with regards to their own quality of life in order to meet the needs of others. If the patients' needs are met then doctors will feel that they have made a difference and truly helped these people in spite of the odds stacked against them, and it is this accomplishment that most probably brings satisfaction, fulfilment, inspiration and a sense of being valued. The nobility of the medical profession is also derived in part from a doctors' willingness to put patients' needs above their own and hence the ability to transcend the selfish ambitions that seem to pervade our society.

Students' reasons for choosing to work in the public or private sector also link back to their motivations for studying medicine and the value judgements some students placed on these motivations by labelling some reasons as 'right'. Based on what has been discussed above, 'right' may be referring to a willingness for self-sacrifice, and the fact that students were far more able to ascribe 'wrong' motivations, such as status and wealth to others helps to confirm this and highlights the possibility that students would rather be seen as sacrificial than selfish. The fact that such a high percentage of questionnaire respondents indicated that they are expecting to make sacrifices as a doctor could be seen to confirm this, but it is important to point out that *expecting* to make sacrifices and being *willing* to make sacrifices are very different as willingness implies a decision and a desire to make these sacrifices. Bearing in mind that the PHC approach does ask more of doctors and in many ways requires doctors to be willing to make sacrifices, some students might feel that they should demonstrate a positive attitude towards the PHC approach in order to be recognised as self-sacrificing and unselfish.

Willingness for self-sacrifice could in fact signify recognition of the philosophy of PHC and an accurate perception of the PHC approach. However, what indicated a limited understanding of PHC and misperceptions around this approach were some students' views about the applicability of the PHC approach to the public and private sector. The fact that very few students picked up on the absence of affordability and equity, two key principles of PHC, in the private sector shows an incomplete understanding of the values, beliefs and priorities of the PHC approach, and indicates that these values, beliefs and priorities have not yet been internalised by these students. Another associated misperception is that receiving good service at a health facility equals the

implementation of the PHC approach. This raises questions of ‘what is good service?’ and as was the case with ‘what is a good doctor?’ one has to ask from whose perspective are these questions being asked? It is quite possible that good service according to a patient may also be very different to good service according to a doctor or a medical student, and good service according to the PHC approach may differ from good service within a biomedical and curative paradigm.

PHC in the context of curriculum reform

Unmet expectations regarding their curriculum seem to be a very significant issue for students, and it seems to take them about the whole of first-year to acclimatise to their new and unanticipated environment. The PHC-driven new curriculum seems to challenge students’ expectations on all fronts as it views health from more than a biomedical perspective and requires an awareness of the psychosocial, it exposes them to different teaching methods in terms of group work instead of lectures, it emphasises and teaches intra- and interpersonal skills, and it promotes the PHC approach which for many may be an approach to health care that is foreign to them, either because they have only been exposed to poor quality health services or because they have only had exposure to the private sector and may not have identified the need beyond their own experiences.

It is therefore very difficult to isolate students’ attitudes towards and views of the PHC approach as they seem to be tangled up with views about the new curriculum, feelings about their expectations not being met, apprehension and insecurity about all the new ground they are covering, and the feeling that the values, beliefs and priorities they associated with a career in medicine may not be matching up completely with those of the curriculum they are in. The fact that students seemed generally positive about the theory of PHC and what it proposes suggests that much of their antipathy is directed at things other than the approach itself. In addition, many expectations have not been met, and this could mean that students may not know what to expect further on in their academic and professional career which could leave them feeling that the future is unpredictable and out of their control, triggering an increased stress response in them that could spill over into their attitudes towards the PHC approach.

This type of unexpected change can be disempowering for students who do not feel that they understand the reason for change and the impact that it is going to have on them.

This then links again to the discourse of responsibility and the initiative students could have taken to find out information about their curriculum before arriving at UCT, and it seems that students placed the responsibility on UCT to inform them about the new curriculum, therefore making it easier to blame UCT for their feelings of shock, apprehension, confusion and scepticism regarding the new curriculum. This also underscores the strength of their image of the medical professional and the assumption that this image could be carried through unchanged into the academic career.

Views on curriculum content and teaching methods

A review of the literature does reveal that psychosocial aspects have become an accepted part of medical education,^{9,11,97,108,109,120,220-228} although from the students comments in this research, this acceptance is not well known to them. Regarding the students' views on the content of the new curriculum, their concern about their lack of knowledge, especially scientific knowledge, highlights once more the discourse of power and the association between knowledge and power. In terms of this association and its relevance for the content of the curriculum, one would think that increased knowledge of psychosocial issues might make up for less knowledge of the 'hard' sciences. However, if this psychosocial knowledge does not fit into students' images of medicine then this knowledge may be disregarded as unimportant. Students may also feel that because psychosocial knowledge is theory-based, it is less factual and undisputed, and that because they cannot trust this type of knowledge not to change, it is not within their control and hence does not give the same sense of power and mastery that come with scientific facts.

Students' views of the teaching methods in the new curriculum are somewhat contradictory in that they generally expected lectures to be the dominant method of teaching, but did not exactly ring the praises of this style of teaching. However, returning to the discourse of responsibility, lectures do decrease the students' responsibility in the learning process and generally ensure that one is filled with knowledge from someone with a lot of knowledge and is therefore perceived to be powerful. Some students did specifically mention that the new curriculum's emphasis on self-directed learning and the increased responsibility that students need to take for their learning is daunting and can lead to uncertainty about whether or not they will have enough knowledge. In the literature, the use of small groups is advocated as a

teaching method,²²⁹⁻²³² and the students' positive views about group work in the new curriculum reflect their awareness of many of these advantages mentioned and show that students are realising that knowledge can also be gained from group settings. They may also be realising that this knowledge is often richer as it is imparted through a variety of sources, and that exposure to this range of sources can also help to refine students' knowledge.

Teaching the PHC approach

There is little literature on how the PHC approach should be taught to students, but the use of groups as a teaching method is valued within the PHC philosophy,²²⁹ and it is maintained that within their curricula students need to be trained to function interdependently within the PHC approach.¹²⁴ Ritchie³⁰ argues that the teaching of the PHC approach should reflect the foundational aspects of the approach: self-reliance, equity, community participation and intersectoral collaboration. She makes further suggestions on this topic, and these have been included as 'Recommendations' in the following chapter.

The way in which the PHC approach is taught in the new curriculum seems to be a strong influence of students' feelings about the PHC approach, which may not necessarily amount to a negative attitude towards the approach but does seem to decrease students' receptiveness to learning about it. If these feelings combined with feelings about the new curriculum do lead to a negative attitude towards the PHC approach, there is a possibility that this might change and that students begin to see the benefits of the approach, but surely there must be a risk of permanently inoculating students against the PHC approach or even casting a long lasting pall over their view of the approach? Some students alluded to this possibility and felt that the outcome of negative feelings about how PHC is taught may ultimately deter doctors from playing an active role in the implementation of the PHC approach.

Most of students' dissatisfaction with the way in which PHC was taught links to issues already raised around knowledge, power and responsibility. Students' feelings that what they were given on the PHC approach was too theoretical and not applied enough, points again to their discomfort with the theoretical and their need for more concrete, scientific knowledge. Related to this, the portrayal of the PHC approach as glorified,

according to students, serves to further widen the gap between theory and reality, thereby decreasing their own confidence in the approach. The 'force' with which the PHC approach was presented to students also seems to have left them feeling disempowered, particularly as many of them are under the impression that they were not able to choose the PHC approach because *they* felt it was the best option. Although there were some students who did not feel this was the case, they were in the minority, and this could once again highlight within the majority of students a lack of knowledge or awareness of the history of apartheid and where South Africa's health system has come from and hence the appropriateness of an approach such as PHC for South Africa.

Linked to feelings of disempowerment, students' resistance to how PHC is taught may also be due to the fact that students feel their position as adult learners is threatened, although there are certain educational strategies that are being employed in their curriculum that do affirm this role, such as self-directed learning, problem-based learning, integrated learning and multiprofessional learning.²³³ The relevant principles of effective practice in facilitating adult learning are: 1) Participation is voluntary and learners should not be coerced or intimidated; 2) there is collaboration between facilitators and learners; 3) there should be a nurturing of self-directed, empowered adults who view themselves as proactive learners who are able to take initiative.²³⁴ If students are feeling forced, possibly because of the hidden curriculum, to accept the PHC approach, and if they feel as if they did not choose the PHC approach, the first two principles mentioned above would definitely be compromised. This may then decrease the chance of students being self-directed in their learning, leaving them disempowered and possibly unprepared to be proactive and take initiative, which are exactly *not* the kind of learners the PHC approach requires.

With regards to when students are introduced to the PHC approach, some of the comments in favour of an early introduction to the approach were based on the acquisition of knowledge, but the majority of comments relate to my argument that the PHC approach challenges students' values, beliefs and priorities around the medical profession. There were students who were aware of this and accepted the fact that the PHC approach offers a different world view and that there are critical periods in which this world view would be more easily accepted and adopted. This does indicate that these students have a correct perception of PHC as a philosophy and not just something that needs to be done.

The value of clinical exposure

The significance of clinical exposure seems to be undisputed by students and staff, and even if these experiences are negative, they still provide an opportunity to observe and experience reality and therefore decrease the reliance on the theoretical. There are strong arguments in the literature for early clinical exposure, and those relevant for the development of positive attitudes towards the PHC approach include: the affirmation of the student's role of health care providers,^{44,54} relating to students' feelings of their curriculum as not being 'medical' enough; the increasing of students' self awareness and their awareness of others and social contexts, an essential part of the PHC philosophy that requires an understanding of the social determinants of health; the addition of depth and context to their theoretical knowledge, helping to address students' concerns about the presentation of the PHC approach being too theoretical; and the education of students on the role of health professionals, potentially giving clarity to the role of doctors within the PHC approach.⁵⁴

Those students who were negative about an aspect of their clinical exposure, the BHP visits, may have had an expectation that the PHC approach would be working or be successful, and this could be based on what they have been exposed to regarding the theoretical. This is more evidence of the students' difficulty with the theoretical, and it was pointed out by one key informant that these visits were not necessarily supposed to show that the approach was working or successful, but that students need to take responsibility for matching theory and reality, raising the issue of responsibility again. The fact that clinical exposure can be difficult, especially with staff and sometimes with patients also highlights the meeting of a new and old paradigm and that the difference between the two can be particularly evident in the way that staff interact with each other and with their patients.

With regards to the nature of this clinical exposure, literature supports the notion that mere observation of clinical settings on the part of students will soon lead to boredom and a loss of enthusiasm. Not ignoring the logistical challenges associated with arranging clinical exposure for large groups of students, there are ways to maintain students' focus and involvement, such as using the skills they already possess,²³⁵ which was mentioned by one key informant, and students' accountability for activities should be stressed.²³⁵

Recalling Howe's¹²¹ description of attitudes and their reliance on individual experience, it makes sense that experiences of clinical exposure could strongly impact on attitudes. These experiences may also provide an opportunity for the challenging of social and cultural interpretations that she mentions, thus strengthening the impact of these experiences. This then supports my belief that the most important contribution of clinical exposure is that it provides experience, and the students' valuing of experience over facts and knowledge is potentially the greatest evidence of the changing of their mindsets about knowledge and power. Experience also requires involvement from the students and therefore increased responsibility in and ownership of the process, and can therefore also help to prevent the avoidance of responsibility in the learning process. As these mindsets are changed, there is a greater chance that their values, beliefs and priorities regarding the medical profession will also be changed, making room for the values, beliefs and priorities that underpin the philosophy of PHC. If students were able to reach this point, their perceptions and understanding of the PHC approach would be accurate and their attitude towards and views of the approach might be more positive, making them more likely to play an effective part in the implementation and success of the PHC approach.

The perspective of situated learning

Considering the perceived value of clinical exposure, it would be useful to look more closely at *why* this exposure is valuable, and the theory of situated learning is helpful in this regard. Situation learning draws on the notion of 'learning by doing'²³⁶ and is classified as a social theory of learning^{236,237} as it challenges the idea of learning as an individual process,²³⁷ maintaining that "learning is an integral and inseparable aspect of social practice" (p.31).²³⁶ Within the theory of situated learning, Lave and Wenger^{236,238} refer to 'communities of practice', and a community of practice can be defined as "a set of relations among persons, activity, and world, over time and in relation with other tangential and overlapping communities of practice" (p.98).²³⁶ Those who are learning will be a part of various communities of practice,²³⁸ and their increasing participation in these communities of practice is what constitutes learning. Learning, within this approach, cannot be limited to the transfer or assimilation of knowledge, and can occur even in the absence of formal teaching or organised apprenticeship, although apprenticeship is a significant component of learning in communities of practice such as medicine, where a high level of skill is required.²³⁶

Learners enter communities of practice as 'new comers', and as their knowledge and skills are developed and they acquire a new discourse, their identity becomes that of an 'old-timer' and a member of that community of practice. The concept of identity is fundamental to the theory of situated learning as it maintains that learning involves the whole person and that through learning our identities are constructed and altered.^{236,237} Lave and Wenger go so far as to say that our sense of identity cannot be separated from our learning.²³⁶

This theory then helps to understand the value of clinical exposure as within clinical settings, students are going to find themselves in a number of communities of practice, and depending on their academic level, will be placed somewhere between being 'newcomers' and 'old-timers'. Through increased clinical exposure, students will build on their knowledge and skills, and will also become more familiar with the discourse of medical practice. Therefore, according to the theory of situated learning, the students' identities will be undergoing a process of change through their learning process.

This development of identity is significant to this research for two reasons: firstly, a change in identity may account for the change in attitudes towards the PHC approach that were discussed earlier and an increased acceptance and appreciation of the approach. Secondly, it addresses the reality that attitudes towards the PHC approach are only a part of a greater mindset or world view that needs to be altered. It has already been mentioned that implying causality is very difficult when it comes to attitudes, so simply increasing knowledge or influencing emotions is not going to be the answer to shifting students' attitudes in a more positive direction and will certainly not go very far in changing their mindsets. However, if students' identities are altered through their learning process within clinical settings - 'communities of practice' - there is more hope of changing students' mindsets, and the values, beliefs and priorities that form these mindsets.

Conclusion

This chapter has evaluated the main findings of this research, illuminating many of the complexities of the issues involved in students' attitudes towards and perceptions of the PHC approach. Comparisons with previous research and literature have been limited due to the scarcity of literature on these topics, highlighting the need for further

research. This will be addressed in the concluding chapter, which will go on to discuss the significance and implications of these findings along with the strengths of weaknesses of this research and my involvement in the research.

University of Cape Town

Introduction

This concluding chapter will address the significance and implications of the research findings, and recommendations will be made in accordance with these findings along with suggestions for future research. This chapter will also point out the limitations and strengths of this research and will explore issues of reflexivity.

Significance and implications of findings

Owing to the fact that these students are going to be the doctors of the future and will be involved in the implementation of the PHC approach and helping to ensure that it is working, it is vital that there is some examination of their perceptions, understanding, attitudes and views of the PHC approach, considering the fact that these impact on one another. It has already been mentioned that those with a negative attitude towards and negative views of the PHC approach are unlikely to adopt the philosophy of PHC and play an active role in its implementation and the ensuring of its success. Without having an idea of these perceptions, understanding, attitudes and views, it would not be possible to know if these views need to be changed.

Students' confidence in the implementation and success of the PHC approach is low, and this, along with the fact that so many students view the PHC as idealistic is troubling, as this can further diminish confidence in the PHC approach and therefore decrease the chances of it being implemented or successful if there is a belief that it is not going to work. Although older students seem to have a greater appreciation and acceptance of the PHC approach, their confidence in the implementation and success of the approach does not necessarily grow to the same extent. What could exacerbate this lack of confidence is the gap between the theory and reality, and if students do not have the opportunity to observe the theory in practice, their confidence in the approach will continue to decline, decreasing the probability of the approach being implemented, which then further reduces the chance of the PHC approach becoming a reality. This then creates a vicious cycle that is depicted in the following diagram:

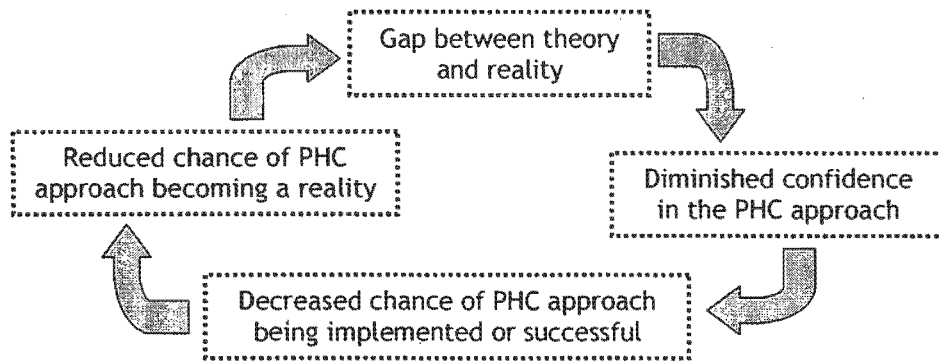


Figure 15: Theory vs reality, confidence in the PHC approach and implementation and success of PHC approach

The findings of this research highlight the impact of curriculum reform on the students involved and signal the need to make the transition from an outgoing, traditional curriculum to an incoming, problem-based, PHC driven curriculum a smooth process in which students can feel empowered. The need for curriculum reform is not disputed, but as one key informant suggested, the nature of this reform needs to be appropriate to the setting, and care should be taken to ensure that changes suit the environment in which they are taking place.

It should be clear from these findings that students are not unaffected by curriculum changes and that the feelings associated with unmet expectations along with uncertainty about their academic future are not easily dispelled and can easily permeate their entire academic experiences, including their willingness to alter their mindsets or world view. Linked to this is a need for more consideration of the way in which students are used to being taught. The point is not that the way in which they have been taught through their schooling is necessarily flawless, but that the university needs to be aware that if the difference between how students learn at school and how they learn at university is too great, it is possible that the shock of this may be incredibly overwhelming and unnerving, making students far less receptive within the learning process.

The importance of clarifying the role of doctors within the PHC approach is also highlighted by these findings, because as much as there is an understanding that the PHC approach calls for a widening of this role, there do not seem to be clear parameters that outline what is expected of doctors. This lack of clear boundaries seems to be causing confusion among students and an uncertainty about what their future as a

doctor will hold. Without clarification of this role, it is possible that the perception of PHC as something that is the responsibility of nurses may persist and the notion that doctors do not have time to be involved in activities other than their clinical responsibilities may remain unchallenged.

Students' perceptions of medicine as a profession and of doctors raise the issue of how the career of medicine is marketed as well as the role of society in the construction of these perceptions. When considering students' attitudes towards their curriculum and the PHC approach, their image of the medical profession and its associated values, beliefs and priorities seem to be a key issue, as it is ultimately these values, beliefs and priorities that need to be in line with those of the curriculum and the PHC approach. One of the many factors that influence these perceptions of medicine and doctors are role models within the medical profession, and as was pointed out by some of the key informants, there need to be more role models who epitomise the philosophy of PHC and a culture needs to be created in which there is value placed on all who contribute to health, not just those that appear to be the most glamorous, noble or powerful.

The issue of student selection was not a major topic of discussion, but is prominent in the literature on medical education and is something worth considering in light of the fact that there are factors outside of the university environment that have been said to have an impact on students' attitudes and perceptions. These factors include SES, background, upbringing, experiences of health services and students' personalities, and this is quite relevant when it comes to the issue of rural areas. Selection policies need to be continually evaluated in light of research evidence in order to ensure that universities are fulfilling their responsibility of selecting those students who are likely to become good doctors. In my opinion, this would be doctors that will embrace and internalise the philosophy of PHC and will be willing to work in those areas in South Africa in which the health situation is most dire and health care is especially needed.

One of the major implications of the findings of this research is that there are flaws in the manner in which students are taught about the PHC approach and how it is portrayed in the curriculum, and there seems to be a call from students to take more into account *who* is being taught, in terms of the developmental stage of students and the way in which they are used to learning and being taught. Although some students admitted feeling confused about the PHC approach, the general understanding of the

students was satisfactory, and this shows that the way in which the PHC approach is being taught is enabling students to understand the approach, but is not necessarily encouraging them to 'buy into' it and hence internalise the values, beliefs and priorities of the approach, which is what is really crucial.

Lastly, the implications of this research regarding the South African government are significant, and it seems impossible to ignore the political dynamics that suffuse the issue of health in this country. The first implication is the need for better collaboration between government and tertiary institutions as these bodies seem to be functioning independently, although they are all supposed to be pursuing the same goals in terms of the PHC approach. PHC is mentioned by the government in their documentation,² by the Health Professions Council of South Africa (see Appendix G), and by UCT (see Appendix A), yet there does not seem to be evidence of collaboration that has resulted in a unified effort to implement the PHC approach successfully.

Secondly, despite the fact that students may be relatively ignorant about the government's actual activities and decisions, their opinions of the government, which are backed up by views of other health professionals, and most certainly their disillusionment with the government, cannot be put aside as these feelings of disillusionment will undoubtedly impact many students' aspirations about working in South Africa in the future. This could have a direct bearing on the implementation and success of the PHC approach, particularly in the public sector.

Recommendations

On a political level, I believe it is essential that the South African government takes stock of their stance and commitment to health and health care in this country. One does not need to know exactly what the government is doing or not doing to be able to say that faith in the government is an issue that needs to be urgently addressed. The government's commitment to the PHC approach² could also be made more evident and students' concerns about the implementation need to be addressed otherwise South Africa may end up with a generation of disenchanted and frustrated doctors. Attention also needs to be given to promoting the PHC approach to the general public, and students highlighted the government's capacity to do this. This would not only have a positive impact on communities who would be better informed about their health

system, but would also ultimately help to promote the values, beliefs and priorities of the PHC approach, and therefore helping to better pave the way for students who will be studying medicine in years to come.

Issues around human resources and health also need to be urgently addressed, and the government's role in this has already been stressed. Should political commitment to the PHC approach continue at its current level, it seems unlikely that the problems faced in human resources will be adequately addressed, thus making the reality of the PHC approach seem an even harder goal to reach. An increased focus on the human resources in health should also include properly educating existing health professionals about the PHC approach, and this would help to facilitate a smoother transition between an old and new paradigm. This transition could also be better assisted by working on the links between medical education and health services, and the importance of these links has been widely acknowledged.²³⁹⁻²⁴³ Ritchie argues that is there is collaboration between those developing health professionals and the systems in which they will work, students can be afforded more opportunities to apply new knowledge, attitudes and approaches, which will hopefully hinder them from reverting to old practices,³⁰ a concern raised by one student.

In light of the substantial disparity between students' expectations and the reality of the curriculum, I would recommend that more consideration be given to the way in which students are informed about changes to the MBChB curriculum. Information about these curriculum changes is available on the Health Sciences Faculty website and in the Faculty Handbook (see Appendix A), and one would hope that prospective students would consult these sources of information and that these would adjust their expectations. However, none of these sources of information were mentioned at all by the students in interviews or focus groups, and the main sources of information about the new curriculum seemed to be older students. This suggests that perhaps more needs to be done to disseminate information about the MBChB curriculum, and this could involve the Health Sciences Faculty taking more proactive steps to advertise these changes and their benefits, particularly at a school level where impressions are so strongly shaped.

This links to the need to influence the culture of the medical profession in such a way that the philosophy of the PHC approach becomes more valued, and in many ways this

would be a marketing endeavour. Thought needs to be given to information about the medical profession that the general public receives, particularly those who are considering tertiary education. This includes the way in which certain specialties are held in high esteem or given more weight because they fit in with the traditional idea of a doctor, as well as research conducted in areas that may not necessarily endorse the PHC philosophy. An example that comes to mind of what would be more newsworthy - the availability of a new antiretroviral treatment for those infected with HIV, or a school programme encouraging responsible sexual behaviour among adolescents? In an age where time is such a precious commodity, society craves quick results rather than long term solutions. It is easy to pay lip service to community upliftment, education and empowerment, but it has become increasingly difficult to uphold these ideals in the face of so many urgent and pressing issues, and AIDS is an obvious example of this.

Regarding the students' expectations, I believe that the process of handling unmet expectations could be managed more effectively, and students' feelings around these unmet expectations emphasise the need for this. More information could be given to the students that explains the need for curriculum change and a focus on the PHC approach, but this may not be as effective as arranging older students who have experienced these changes to speak to new students. This is apparently already being done, according to one key informant, although it was not mentioned by the students. What students did appear to value highly was input from doctors and staff that are in favour of the new curriculum and the PHC approach, and these individuals could become role models of a new paradigm for the students to look up to. It would also be helpful to place UCT's curriculum changes in the context of extensive reform in medical education both in South Africa and globally, as this would not only help to normalise these changes, but would also alert students to the fact that there is a widespread paradigm shift in the field of medicine that has been taking place for a long time.

In terms of how PHC is taught, students did make some suggestions, and other suggestions were implicit in their discussions. It should be noted though that the use of group work to teach students about the PHC approach was not contested, but the areas for improvement seem more to do with the content of the group sessions and the methods used. Firstly, it has been mentioned on more than one occasion that students' understanding of the history of apartheid in South Africa may be limited, and that a greater understanding of this history and the impact of apartheid on the disadvantaged

sector of the population might give students a deeper insight into the need for an approach such as PHC. Giving the students a clear outline of the approach taken to health care during the era of apartheid might highlight this need, and related to this, it might also be useful for students to hear about approaches to health care in other developing countries and whether or not these approaches have been successful.

Secondly, considering that the majority of medical students are strong in subjects such as mathematics and have mentioned their craving for 'scientific' facts, an effort should be made to give them such facts that pertain to the PHC approach in order to help them understand the need for this approach. In light of their professed affinity for these type of facts, giving them these facts may also possibly pique their interest in the PHC approach. On this point, it is important to recognise that the discourse that surrounds the PHC approach and other political and systemic issues is completely unfamiliar to students as it speaks in "broad concept terms", in the words of one student. The scientific discourse of facts and figures is far more familiar to students, and some attempt needs to be made to help bridge the gap between these two discourses.

Regarding the students' unfamiliarity with certain discourses, Ritchie,³⁰ speaking about teaching PHC argues for a gradual transition from the familiar to the new, with the starting point being students' examination of their own experiences, incorporating discovery and reflection. An introduction to theories and concepts should take place further on, and students should ultimately be given the chance to transform their learning into action. The rationale for this gradual transition is the clear distinction between principles of traditional clinical care and those of the PHC approach, and that a fast transition could be perceived as threatening and ruthless. This in no way plays down the teaching of the PHC approach, but emphasises the need to consider the way in which unfamiliar information will be received by those being taught.

More consideration could also be given to the fact that students are developmentally in a transitional phase where many of them have not yet lost their "cocky" adolescent attitude that one student mentioned, but are also developing their independence as young adults and need to feel that they are exercising their autonomy and decision making power as adult learners. This need came out strongly in terms of the decision to *choose* the PHC approach as opposed to being told that this is what they are going to learn, and this also relates to what was mentioned about exposure to other approaches

besides PHC. Students' adolescent inclination to question and criticise can often drive those teaching them to take the stance that students do not have a full understanding of what they need to know and therefore are not responsible for making the decision about what they will be taught. While there is an element of truth in this and while it may be an appropriate response to adolescents, it is not necessarily effective with young adults trying to assert their independence, as it places them in a rather powerless position. These feelings of disempowerment may then drive students to reclaim their power and control in other more destructive ways, such as resistance towards the new curriculum or the PHC approach.

Students' comments about repetition in the teaching of the PHC approach also need to be taken into consideration, and this was mentioned by one key informant. The goal of the curriculum should be to revisit concepts and issues at a deeper level at various points through the curriculum, but if these concepts and issues are revisited at the same level of depth, then repetition is taking place and what should be a spiral towards an increasing depth of knowledge and understanding is merely a continuous circle that repeatedly covers issues at the same level of depth, not unlike a 'stuck record'. Collaboration between those responsible for teaching the PHC approach is essential in this regard, and students did pick up on disorganisation and a lack of communication among those teaching the PHC approach.

Lastly, regarding students' complaints that the teaching around the PHC was too theoretical, more opportunities should be created where students are able to be in settings where the PHC approach is being implemented, or if not being implemented then students should be challenged to look at why this is the case. Although first year students do go on visits to communities and health facilities, and these undoubtedly have an impression on students, ways should be found to maximise on the students' eagerness to be involved in 'medical' activities, particularly as their curriculum is not as 'medical' as they expected it to be. As was suggested by one key informant and was affirmed in the literature, basic medical tasks such as taking temperature and blood pressure readings could be completed by young students, and this would satisfy their own need to do something practical, would give them a realistic and close-up view of a health facility, would benefit the staff at these facilities, and would help to turn knowledge into experience thereby encouraging the students' responsibility in their learning process. Linking back to the theory of situated learning, this would introduce

students to a community of practice as newcomers, thus setting off the process of identity development that becomes essential for the change of students' mindsets.

The possibility of requiring students to do some kind of elective in their early years should also be explored, and such a programme seems to be running effectively at the University of KwaZulu-Natal where first-year students are required to spend time in a health related setting (not a health facility) and are encouraged to take initiative and responsibility for these experiences. Other ideas for early clinical exposure could be carrying out health promotion projects in first year, or making more formal links with the Rural Support Network that seems to have facilitated a number of valuable experiences for students. All these suggestions could provide opportunities for situated learning which could lead to identity development. Obviously the logistics of such endeavours cannot be overlooked, but within reason, the benefits of these activities may eventually cancel out the costs. The main aim of these efforts should be to provide students with exposure to reality that they are able to compare with the theoretical input they receive, and to encourage students to take responsibility for their learning. Students' thoughts and feelings about their learning environment, the content of what they are learning and the manner in which they learn always need to be taken into consideration, and it is vital that the collaboration between staff and students regarding their curriculum continues.

Suggestions for future research

Due to the paucity of literature on medical students' attitudes towards and perceptions of the PHC approach, there is definitely a need for more research in this field, as well as research into issues related to the main research questions, such as reasons for studying medicine, perceptions of medicine and of doctors and the origins of these perceptions, students' expectations of studying medicine and their future plans, particularly in the context of a problem-based curriculum. Research that is done in these areas within the South African context is especially necessary, as the majority of existing research has been conducted in developed countries and the results may not be directly transferable a setting such as South Africa, a developing country. Regarding perceptions of medicine and doctors, students' perceptions need to be looked at more closely, but it would also be helpful to gain a better understanding of the perceptions of the general public, and to look at those factors that influence the public's perceptions and particularly those

wanting to enter the medical profession. There is also a need for more clarity on what influences students' attitudes towards the PHC approach, especially since there was a noticeable lack of consensus regarding the influence of SES. Understanding these influences may ultimately help to identify areas in which negative attitudes can be diffused and positive attitudes promoted.

Although research has been done on other attitudes of medical students, there is a great deal more that can be done to uncover their thoughts, feelings, perceptions and attitudes on a wide range of issues. The traditional and often paternalistic approach to medical education needs to give way to a greater appreciation of students' perspectives, a respect for their points of view and an acknowledgement of their concerns and fears. None of this appreciation, respect or acknowledgement can take place without giving the students a voice that extends beyond course evaluations and brief conversations, but can be given through in-depth, qualitative research, and particularly through the use of methods such as interviews and focus groups. The rise of qualitative research in the health sciences and medical education is incredibly encouraging, but there is a long way to go still before the value of such research is fully realised.

Apart from looking at medical students, there is also enormous scope for research into health professionals' and especially doctors' attitudes towards and perceptions of the PHC approach, possibly examining their own feelings about the change in paradigm that is taking place in medicinal education, the state of health and health care in South Africa, their reasons for entering their profession, and their future plans regarding their career. By having a firmer grasp of these attitudes, it would then be possible to compare these attitudes and perceptions with those of the students and be able to identify areas of weakness that require intervention and areas of strength that can be maximised.

Limitations of research

The limitations of this research relate both to methods used as well as the topic under investigation. Regarding the methods used, the first limitation would be the reliance on self-report data within the questionnaire, and although it was anonymous it is possible that students were not completely honest in their responses. This limitation was however compensated for by using interviews and focus groups, but these methods also have their own limitations such as the power dynamics within interviews and focus

groups, and these have already been mentioned. It is possible that students felt pressured to present more favourable responses, for example that they are positive about PHC and that they chose to do medicine to help people. However, the fact that there were negative responses given on a number of issues suggests that students did feel comfortable to share their honest opinions. Within the focus groups, there may also have been pressure to agree with views of the group rather than present individual views, and at times there were strong views that seemed to dominate certain groups, but within these groups there were also students who were willing to present their own contrasting views.

Related to the concern about self-report data is the fact that students were asked to answer questions that they know have 'right' answers, such as their reasons for studying medicine and their views of the PHC approach. The presence of negative responses, as explained earlier, does address this concern to some extent, but the question still remains whether or not students' responses can be taken at face value or should they be automatically doubted because of the chance that students want to be cast in a favourable light?

Exploring reasons is not an easy task, especially when it comes to students' reasons for studying medicine. Asking students for these reasons at the beginning of their first year seems like the most logical point to obtain this information, but it is also a time when students generally do not have that much insight and understanding into what has influenced these reasons, but they do know the 'right' reasons to give. However, when students are older and probably have more insight and understanding, they are not as likely to remember their original motivations or cannot remember enough to be able to critically analyse these motivations. The complexity of this limitation should not be reason enough to not ask students these kinds of questions, but their responses to these questions should be weighed up against the context in which these responses are given and their responses on other issues.

Lastly, my involvement with the MBChB curriculum and familiarity with many of the students as well as the environment at UCT medical school could be regarded as a weakness of this research, as some may argue that this involvement and familiarity may have hampered my ability to remain objective. However, this criticism would be invalid considering the qualitative framework of this research and the role of the researcher

within this type of framework. This issue will be discussed in more detail under 'Reflexivity'.

Strengths of research

Regarding the last point about my involvement in this research, I would regard this involvement as a definite strength of this research. Through being involved I was familiar with the type of students that would be involved in the research as well as many of the social dynamics that exist in this environment. The MBChB curriculum is also very familiar to me in terms of the teaching methods and content through my experience of teaching students and being part of curriculum design. Because of this, I am aware of many of the strengths and the difficulties experienced with the new curriculum, and the recommendations I have made have been informed by these insights. Despite my involvement, I was however able to maintain boundaries in terms of my emotional involvement in the sense that I am not a medical student nor a medical professional, and this helped me to maintain an appropriate emotional distance from many of the issues that stirred up strong emotions in the students.

Another strength of this research was the fact I have a humanities background (particularly psychology and sociology), giving me a better understanding of the multiple factors that come into play when trying to assess attitudes and perceptions, as well as an awareness that it is very difficult to establish causality when looking at what influences attitudes. This background is also reflected in my inclusion of context and the acknowledgement that an awareness of context aids in the understanding of students' views. The consultation of key informants was an additional attempt at placing this research within the context of UCT as well as medical education in South Africa.

Possibly the greatest strength of this research in my opinion, was the use of qualitative methods. Focus groups and interviews gave students a voice that they would not have had through a questionnaire or attitude scale. This seemed to be empowering for students because besides course evaluations and informal discussions between classmates, there have been no official opportunities for students to vocalise their thoughts and feelings about the PHC approach specifically, which can leave students feeling as if their opinions do not matter or are inconsequential. On more than one occasion I was asked what was going to be done with these results, and this indicates

that the opportunity was important for students as they were keen for their input to be fed through to the right channels.

Reflexivity

The issue of reflexivity has already been raised in the role of the researcher in qualitative research and has also been mentioned under the strengths and limitations of this research. Having established that it is unlikely for me to attain neutrality and objectivity in this research process, it is important to acknowledge the influence I have had on this process, and this extends from the initiation of this research, to the sample selection, gathering, analysis and reporting of data.

This research was initiated partly out of my own desire for students to be positive and passionate about the PHC approach, and was fuelled by my involvement with the new curriculum and the amount of time and energy I had expended in helping to making the curriculum a success. My involvement with the outgoing, traditional MBChB curriculum also helped to highlight the need for an investigation into the students' attitudes towards the PHC approach. The use of a purposive sampling strategy allowed me to select participants that I felt would benefit the aims of this research, and the decision on the number of focus groups and interviews conducted was ultimately based on what I believed would best serve these aims.

The gathering of data through focus groups and interviews was probably the area in which I was most influential. To start with, the interview and focus group guides are basically a reflection of the issues that I felt needed to be explored, and to varying degrees, I was able to guide the interview and focus group discussion in the direction that I felt best served the purposes of this research. My personality and style of interviewing and focus group moderation would definitely have had an impact on these encounters, and I generally adopt a rather relaxed approach to interviews and focus groups as I believe that students are more likely to participate and contribute in a relaxed environment. Students may have been positively impacted by my age as I am still young enough to recall my experiences of being a student and can therefore better identify with their own experiences. The fact that my research was being conducted for my own studies, and therefore placed me in the role of student could also have been

reassuring to students and could have helped diffuse some of the power dynamics between researcher and participants.

My own views about the PHC approach may also have had an impact on these interview and focus group encounters, as admittedly I started off with a rather idealistic and optimistic view about the implementation of the PHC approach, and found it difficult to understand why students would not be positive about such an approach. However, as a result of being exposed to the students' views through the interviews and focus groups, my own views changed as I was able to see things more from the students' perspective. I was also able to gain a deeper understanding of the numerous factors that impact on students' attitudes, and this emphasised the difficulty of isolating and accurately measuring attitudes when there are so many issues surrounding these attitudes.

The data analysis phase of the research process merged and overlapped with other phases of the research process, as is often the case with qualitative research. Right from the start of this project I have been engaging in analysis by reflecting on the issues involved in this research and drawing conclusions about the findings that have emerged. What is eventually being reported is a culmination of this extended analysis, and my findings reflect many of my own insights and perspectives on the issues investigated. This report also is a reflection of my growing understanding of the process by which students' mindsets around health care and the profession of medicine have been influenced and changed.

Conclusion

Having started this thesis with an emphasis on the primacy of health, it makes sense to return to this point and evaluate it in light of what has been presented. This research has emphasised that the issue of health is multidimensional and one cannot merely focus on the status of people's health and wellness. 'Health' in its broadest sense is a social, political and economic issue that includes both lay, professional and academic perceptions of and approaches to health, and requires human resources that serve to maintain health and provide health care. This broad scope of dimensions can seem rather overwhelming and complex, but it is vital that these dimensions are acknowledged in order for South Africa and indeed the world to have any hope of improving the state of health and health care in this country.

However doctors are viewed - self-serving or sacrificial, noble or arrogant, prestigious or humble, they have an inimitable responsibility in this broad issue of health. The extent of this responsibility may change according to the paradigm in which they operate, and it would seem that this responsibility is at its greatest with the PHC approach. This approach incorporates the traditional curative role, but goes further to include health promotion, disease prevention, advocacy and community involvement, and calls for the embracing of values such as social justice, human rights, equity and team work. It also requires an understanding of the social and economic determinants of health, the psychosocial dimensions of health and the context of the community in which an individual and family is located.

As medical students are prepared for their career as doctors in South Africa, they are introduced to the PHC approach, and these responsibilities outlined above are conveyed to students through both the formal and 'hidden' aspects of their curriculum. How these students understand, accept and appreciate this approach then becomes a crucial aspect of the issue of health as it would only seem reasonable to assume that if this approach is not understood, accepted and appreciated by medical students who go on to become doctors, then PHC will remain a theory in academic circles and an ideal that survives only on the paper of political manifestos.

Examining medical students' attitudes towards and perceptions of the PHC approach therefore becomes an important step in the process of determining whether there is an understanding, acceptance and appreciation of this approach as it highlights areas of success as well as weaknesses. If these attitudes and perceptions can be understood then successes can be capitalised on, weaknesses can become areas for improvement, and valuable lessons can be passed on. Failing to investigate and appropriately address these attitudes and perceptions could ultimately lead to a situation where medical students not only become doctors that are unprepared for the realities of South Africa's health system, but also possess a set of values in opposition to those of PHC and that are incredibly resistant to change.

In a country that is fraught with disease and that is bearing the load of social, economic and political baggage from an era of inequity, this research has hopefully played a small part by contributing new insight and understanding into the issue of health in South

Africa by looking into medical students' attitudes towards and perceptions of the approach that the South African government has committed to. These findings will hopefully be fed into channels that can institute change where it is needed in order to better equip our country's doctors for the situations they will face as health professionals and agents of change. It is also my hope that these findings will serve as an affirmation of the progress that has been made in this regard and the potential that these students have shown in terms of fulfilling their role in the PHC approach and bringing the ideals of this approach to fruition in South Africa.

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Appendix A - Details of MBChB curriculum

New MBChB (Bachelor of Medicine and Bachelor of Surgery Degree): 2002*

The Faculty of Health Sciences at UCT is in the process of transforming its undergraduate educational curricula. Until this process of curriculum change began to spread through medical schools the world over in the 1990's, little change or modernization of medical education had occurred since the 1920's. UCT's medical curriculum was last revised in the early '70's. It is highly likely that the international recognition which UCT's medical school and its graduates currently enjoy would be lost if we were not to follow the global trend towards student centred, group based learning that other other leading institutions have adopted.

UCT's process of curriculum reform began in 1998. All our undergraduate degree programmes have been under review, but the most profound educational changes are occurring in the MBChB curriculum, which has been introduced in 2002. These changes incorporate both the Faculty's 1994 decision to undertake a comprehensive curriculum review and reform with the Primary Health Care (PHC) philosophy as its basic tenant and to implement the kinds of changes to medical curricula recommended by a number of international bodies. These include the World Federation for Medical Education and national bodies such as the General Medical Council of the United Kingdom which controls medical education in British medical schools and which presently recognizes the UCT MBChB. Members of our curriculum reform team have visited medical schools in Britain and Canada which have already adapted their curricula in line with new international trends, thus enabling us to draw on their expertise and experience.

In our own context, the Health Professions Council of South Africa (HPCSA) published guidelines to assist the eight SA medical schools in their medical curricular reform. We believe that our new MBChB curriculum will satisfy the HPCSA. This is important because future accreditation by the HPCSA of UCT's Faculty of Health Sciences as a training institution depends upon successful curriculum transformation and the introduction of teaching methods that reflect a modern understanding of how adults learn.

Through curriculum transformation, and in keeping with the PHC approach, UCT's Faculty of Health Sciences aims to produce health professionals whose training, whilst continuing to enjoy international recognition, will be both excellent and relevant for service to the whole South African community.

Two leading themes characterise our curriculum change:

Firstly, there will be a shift in emphasis from the purely biological and scientific model of illness to the one in which the individual is viewed within their biological, emotional and sociological context (the bio-psycho-social model). An appreciation of the impact of the illness upon the patient's life and that of his/her family will be regarded as important as a scientific understanding of a patient's disease. It will no longer be sufficient for the doctor to diagnose and treat illness, but also to prevent illness, to promote health and to participate in the rehabilitation of people with chronic disease and disability.

Secondly, community-based learning opportunities will increase. This is aimed at complementing academic hospital-based learning so that students develop competency to practice at primary, as well as secondary and tertiary levels of health care. In fact, modern health care the world over is no longer based mainly in hospitals but is much more likely to occur closer to peoples' homes in community clinics and in general practitioners' offices.

Other educational principles that will underpin the new curriculum are:

- It will be OUTCOMES-ORIENTED.

* 2002 was the first year in which the new MBChB curriculum was implemented. Some changes have been made since then, for example problem oriented learning is now referred to as problem-based learning.

- The attached Profile of the Graduate was drawn up in 1999 to reflect the knowledge, skills and professional values required of the UCT MBChB graduate. We have a description of what is expected of a doctor at the end of undergraduate medical education and training !
- It will ensure student-centred learning, the key to which will be the development of SUPPORTED PROBLEM ORIENTED LEARNING (POL) STRATEGIES. These acknowledge that the adult learner prefers to select their own learning objectives, will typically apply knowledge that s/he already possesses in order to understand and acquire new information, and will gain a deeper understanding if the learning has an authentic professional context, that is based upon actual real life problems.
- It will employ ACADEMIC SUPPORT STRATEGIES, where necessary. Students who struggle will receive additional tuition, provided they continue to meet certain minimum performance criteria. Academically strong students will receive additional opportunities to pursue new interests and develop new skills.
- It will exploit MULTI-DISCIPLINARY AND MULTI-PROFESSIONAL LEARNING OPPORTUNITIES, whenever educationally feasible and appropriate. Modern medical practice and health care delivery requires teamwork, so this approach encourages that co-operation from early.
- It will employ an INTEGRATED, SYSTEMS-BASED APPROACH TO THE STUDY OF THE SCIENCES basic to medicine, the key to which is early clinical contact in the form of clinical scenarios with the patients as the focus of learning (see above). This has the beneficial effect of eliminating the pre-clinical / clinical divide which characterizes traditional curricula. Currently many students find it difficult to apply the principles that they have learnt in the first three years of pure scientific theory to their last three years of clinical practice. An integrated approach from the first year will allow students to assess a health problem much earlier on, and draw on the full range of both scientific and clinical knowledge and skills in developing a management plan for the patient's condition. Students will be able to see the clinical utility of the scientific concepts that have to be learned and understood at a much earlier stage.
- It will require students to have CORE KNOWLEDGE AND CORE SKILLS whilst also offering SPECIAL STUDY MODULES AND ELECTIVES/SELECTIVES to facilitate learning in depth. This will enable students to develop special interests, higher level competences and research expertise. Both the integrated systems-based approach and identification of a core of learning, deemed essential to medical practice, benefits the student in reducing the factual overload that has crept into traditional curricula with the burgeoning of scientific knowledge. The ability of the student to choose from a menu of special study modules allows for learning in depth and, if desired, for the student to develop a certain level of expertise in a particular subject such as Women's Health or Sports Medicine, albeit at a graduate, and not postgraduate level.
- It will make use of COMPUTER-BASED TECHNOLOGIES where appropriate, whilst ensuring continuation of the close tutor/student interaction that is our Faculty's strength.
- It will include teaching of CLINICAL SKILLS, CLINICAL REASONING AND DIAGNOSTIC AND MANAGEMENT SKILLS to ensure development of clinical competence. UCT has always prided itself on the strong clinical skills acquired by its students, culminating in strong diagnostic and patient-management abilities. This will continue and, if anything be reinforced, through the teaching of clinical skills in the early semesters of the curriculum and the application of these skills laboratory environments.
- It will facilitate the acquisition of GENERIC COMPETENCES such as study skills, IT skills, communication and second language (Xhosa and Afrikaans) skills, interpersonal skills, problem-solving ability and decision-making ability. No professional in this new century can risk being computer illiterate and incapable of exploiting information technology. Computer laboratories are being set up to enable all students to acquire IT skills. Successful and healing doctor-patient relationships (whether the patient be an individual, a family or a community) also demands acquisition of a broad range of communication skills, which will be taught and encouraged.
- It will have a strong commitment to HIGH ETHICAL STANDARDS AND PROFESSIONAL VALUES. The Faculty is fortunate in having a well-established Bioethics Centre whose staff will continue, to teach students the moral and ethical responsibilities that a fundamental to being a member of the Health Care professions.

THE "SEMESTER APPROACH"

A number of curriculum design teams are responsible for developing the educational content of each of the 12 semesters in what is presently anticipated to be a 6-year, post-high-school-entry, curriculum. The design and implementation process, infrastructural changes necessary to increase small group learning and community-based learning, as well as the re-orientation and development of teaching staff, are taking

place under the direction of a new Educational Development Unit, staffed by a Director of Medical Education, other medical education experts and an IT expert.

Semesters 1 and 2 have been designed around two themes, and we are at the stage of training teaching staff in problem-oriented teaching methods. The first semester serves to introduce "Basic Health Sciences" in relation to the human life cycle; the second focuses on "Becoming a Health Professional" which, importantly, will promote our ambition for multi-professional learning at the critical entry phase of our students' learning. Semesters 3-5 will be an integrated, systems-based approach to the study of the vocation-specific sciences (Anatomy, Physiology, Medical Biochemistry, Anatomical Pathology, Chemical Pathology, Medical Microbiology) and will include Primary Health Care and Public Health and develop integrated clinical skills. The focus of learning at core and special study levels are patient-cases selected for their relevance to the South African environment. This will ensure early clinical contact.

The clinical clerkships, which will comprise semesters 7-12, will encompass the clinical disciplines of Medicine, Public Health, Primary Health Care and Family Practice, Pharmacology and Therapeutics, Surgery (incorporating the surgical sub-specialities such as Orthopaedics), Paediatrics, Obstetrics and Gynaecology, Psychiatry, and Anaesthetics.

It is envisaged that Semester 6, which will serve as the "bridge" between semesters 5 and 7 will be Primary Care- and community-based.

Community-based education is not new to UCT. Much of the clinical experience offered to our current traditional curriculum students is already community-based and has been for many years. Examples are Obstetrics, Primary Health Care and Family Practice. However, in line with our ambition to graduate doctors capable of mature and effective clinical practice in tertiary, secondary and primary hospital settings, the Faculty is forging additional partnerships with provincial health authorities, non-governmental organizations and other agencies to secure primary care teaching/training sites, and to expand our existing teaching platform still further.

UCT has a long and respected tradition of community service. The Health Sector clinics of The Students' Health and Welfare Centres Organization (SHAWCO) have been run by medical and other health professions students, under supervision of clinical staff who operate at our teaching hospitals, since the 1930's. In addition a number of medical students have formed the Rural Support Network and volunteer to serve rural communities during university vacations.

As is presently the case, students will be able - and in fact encouraged - to pursue an intercalated degree. This is not necessarily health sciences oriented, and will be completed over one year between semesters 5 and 6. The purpose is to broaden the individuals education and permit development of their expertise within a specialized clinical or research area. Students who successfully pass course work assessments during this year will obtain an additional, BSc(Med) degree, before continuing their clinical studies.

Graduate profile for the new MB ChB curriculum

Curriculum Goal - To produce a basic undifferentiated doctor with the requisite attitudes, knowledge and skills to enter the pre-registration period with confidence.

The Context

The Faculty of Health Sciences will continue to strive to be an outstanding faculty within the University of Cape Town. It will offer educational programmes to a diverse and talented student-body, equipping students with the attitudes, knowledge and skills required for life-long learning and competent clinical practice. The educational principles laid out in the University's Academic Planning Framework (APF), against which our programmes have been measured, will be integrated into the educational process.

The change of name from Faculty of Medicine to Faculty of Health Sciences indicates a substantial shift in the Faculty's understanding of its role in the training of health professionals. The emphasis on health rather than disease requires a comprehensive educational approach. This approach would have to create a balance between preventive, promotive, curative, protective and rehabilitative health care in order to meet the health needs of the country.

This comprehensive approach is encapsulated in the principles of Primary Health Care (PHC). The PHC philosophy incorporates:

1. Integration of basic sciences with clinical practice and population health
2. A team approach to health care involving the various health disciplines
3. Interfaculty and intersectoral collaboration
4. Application of individual and population perspectives in teaching, research and health care delivery.
5. A comprehensive approach at all levels of health care namely: quaternary, tertiary, secondary and primary.
6. An awareness of complementary and informal health systems in South Africa.

Due regard will be afforded to the cultural, economic, political, social and scientific context within which our graduates will work. The University of Cape Town and the Faculty of Health Sciences have clearly defined their role in participating in the reconstruction of the country. There is a stated commitment to contribute to redressing past imbalances of race, gender and class and to developing a culture of human rights.

THE GRADUATE

The MB ChB graduate should acquire and must be able to demonstrate the following characteristics:

Attitudes

Attitudes necessary for the achievement of high standards of medical practice, both in relation to the provision of care to individuals and to the wider South African community. These should include:

1. Intellectual curiosity, initiative and a willingness to assume responsibility for the acquisition of knowledge, the development of skills for self-education, and the continued development of clinical skills and critical analysis of information for the life-long learning demanded by a career in the health field;
2. Willingness to work effectively as a member of a multidisciplinary health care team to ensure the highest possible quality of patient care at all times;
3. The awareness of one's own limitations and the need to seek help where necessary;
4. Willingness to be self-critical and to develop the capacity for self-audit and participation in the peer review process;
5. Traits that all clinicians dealing with patients, their families and professional colleagues should possess. These must include empathy; caring; compassion; patience; gentleness; cultural and gender sensitivity; acceptance of diversity; respect for patients' dignity, privacy and confidentiality; personal honesty; open communication with and responsiveness to patients of all ages;
6. The need to develop a professional and respectful patient-doctor relationship based on mutual understanding and trust, which includes the recognition of the patient's right to take part in management decisions;
7. Appreciation of ethical principles in the provision of health care to individual patients, families and communities;
8. Willingness to adapt to change and tolerate uncertainty;
9. A holistic approach to individual patients and their health problem within the context of family and community;
10. An understanding of the total spectrum of health needs of the country and a recognition of their duty to commit themselves to the service of society.

Knowledge

The following core knowledge:

1. Normal and abnormal human growth and development, the structure and function of the human body and mind, in health and disease;
2. The principles of health promotion, disease prevention and management of illness in the context of the individual, the family and society;

3. The pattern, aetiology and natural history of common diseases and disabilities in rural and urban South Africa. The influence of environmental, socio-economic, political and class determinants on health and disease and their particular effect on women and children;
4. The structure, organisation and function of the healthcare system in South Africa, including the medico-legal context. In addition each student will be required to participate in special study modules.

Skills

Competence in the ability to:

- Communicate effectively, clearly and courteously, both verbally and in writing, with patients and their families and with other health professionals;
- Conduct a complete examination of a patient appropriate for age, gender and clinical presentation, which will include physical, mental and psychological status;
- Make a reasoned diagnosis or differential diagnosis;
- Develop a management plan;
- Compile a structured medical record;
- Recognise acute life-threatening emergencies and initiate appropriate management;
- Carry out basic clinical procedures and side-room investigations;

To continue developing intellectually, into clear and independent thinkers who can make informed decisions and provide leadership. These would encompass the following:

Analytical and critical thinking skills.

Problem-solving

Numeracy

Computer literacy

Appropriate language proficiency

Versatility and the ability to adapt

Love of learning and search for new knowledge

Basic understanding of research methods.

This document was obtained directly from:

<http://www.health.uct.ac.za/Degrees/mbchb.htm>

Outline of MBChB Curriculum

Semesters 1 and 2

PPH101F	Becoming a Professional
HUB106F	Introduction to Integrated Health Sciences: Part I
HUB107S	Introduction to Integrated Health Sciences: Part II
PPH102S	Becoming a Health Professional
PHY125S	Physics 125
CEM111F	Chemistry 111

Semesters 3, 4 and 5

HUB 217E	Integrated Health Systems: Part IA
LAB200S	Integrated Health Systems: Part IB
HUB308F	Integrated Health Systems: Part II
PPH200W	Becoming a Doctor: Part IA
SLL202H	Becoming a Doctor: Part IB
PPH300F	Becoming a Doctor: Part IIA
SLL302F	Becoming a Doctor: Part IIB

Plus, in semester 4, one of the following Research Modules:

PPH201F/HUB 218F/LAB201F/OBS200F/MDN200F/PRY200F/AAE200F/
PED200F/CHM200F/RAY203F/AHS249F

Semester 6

MDN301S	Introduction to Clinical Practice
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Semester 7 and 8

(Fourth academic year and first clinical year of MBChB)

PPH413W	Public Health
MDN411W	Medicine (including Therapeutics)
OBS402W	Obstetrics and Gynaecology (including Neonatology)
PPH414W	Primary Health Care
PRY400W	Psychiatry

In addition, the teaching in Anaesthesia will commence in fourth year and continued and examined in fifth year.

Semester 9 to 12

To be advised.

(In addition to these courses there is an intervention programme that spans semester two and three which aims to assist students who are struggling to cope academically with first year.)

This information is available from the Faculty of Health Sciences Student Handbook.

HUB106F INTRODUCTION TO INTEGRATED HEALTH SCIENCES PART I

Course co-ordinators: Mr G Weir, Dr G Gunston

Course outline: Integrated Health Sciences Part One is a first semester course that introduces students to the whole person via the bio-psycho-social model. Using the human life cycle as the theme of the course, students will be introduced to the key physical, psychological, social and developmental factors and issues that shape the human life cycle from conception to death. At the conclusion of this course it is anticipated that students will have gained an introductory overview of the human life span as well as the necessary core knowledge and skills from a range of disciplinary domains [e.g. Anatomy and Physiology, Psychology and Sociology].

Problem-based learning [PBL] is the central learning activity of this course, and each student will be allocated to a PBL group that meets twice a week. In these groups students will discuss and analyse a number of carefully designed cases that will illustrate the key issues that the students are required to learn. In addition to these PBL sessions student will be provided with a range of other resources [e.g. lectures and practical sessions] to help them learn.

Apart from providing students with the means to develop content knowledge, a key curriculum aim of PBL is to allow students the structured opportunity to begin to develop some key professional life skills [e.g. work effectively in teams, learn independently, problem-solve and think critically].

This course is also a key diagnostic course of Year One of the MBChB Programme. Its aim is to provide students with as clear picture as possible of their academic performance. For this reason there is regular assessment to help determine whether students have the requisite foundational knowledge and skills to successfully participate and learn in the subsequent semesters of the MBChB Programme.

In cases where it is established that students don't have this requisite foundational knowledge and skills, the Faculty may require students to enter the Faculty's Intervention Programme.

At the commencement of the course students will be provided with a handbook and other relevant course information [e.g. the timetable of scheduled activities].

Assessment: Students will be required to write a number of 'in-course' assessments and an 'end-of-course' assessment. The written assessments will use a case-based format with in-course associated questions. In addition students will have to complete two Basic Health Sciences [BHS] Practical Assessments, a test and an examination. The in-course assessments and the practical test and examination will contribute 60 % of students' overall course mark. The end-of-course assessment will contribute 40% of students' overall course mark. In order to pass Integrated Health Sciences Part One a student must obtain an overall assessment mark of 50%.

DP requirements: To qualify to sit the end-of-course written assessment and the BHP Practical Examination students will have to meet the following DP requirements. Attend all:

- weekly problem-based learning sessions
- scheduled tutorials
- scheduled BHS practical sessions

and complete:

- all set written activities
- all scheduled 'in course' assessment activities

In cases where students are unable to sit a written in-course assessment or complete the BHS Practical Test for legitimate reasons, the percentage value of the missed assessment activity will be added to the next assessment. In instances where students fail to provide legitimate reasons for being unable to complete an assessment activity, the percentage value of the assessment activity will not be transferred.

Students may not miss any problem-based learning sessions, tutorials or BHS practical sessions without the written permission of the academic staff responsible for these activities, as attendance of these activities is compulsory. A medical certificate or an explanatory letter from a parent, relative or guardian must support absence on the ground of illness or personal/ family difficulties.

HUB107S INTRODUCTION TO INTEGRATED HEALTH SCIENCES PART II

Course co-ordinators: Mr G Weir, Dr MA Davies

Course outline: The theme of the course is 'Transitions in Health', and it has been chosen because the country is in the midst of change of its disease profile - diseases due to infection as well as diseases of lifestyle are common. In essence the health status and health care needs of the South African are in transition.

Students will be introduced to key principles, concepts and areas of knowledge of the Basic Health Sciences [Anatomy, Biochemistry and Physiology], as well as Public Health and Family Medicine. The expectation is that students will acquire an integrated understanding of the key structural and functional elements of the human body within a public health and family medicine context. The means of achieving this integrated and contextually embedded understanding will be via supported, case-based PBL.

The aims of this course are to help students understand the:

- key South African health challenges within a broader social and environmental context
- epidemiology of the major causes of disease in South Africa
- basic structure and function of all organ systems of the human body
- basic structure and function of the biochemical components of the human body.

At the commencement of the course students will be provided with a handbook and other relevant course information [e.g. the timetable of scheduled activities].

Assessment: Students will be required to write a number of in-course assessments and an end-of-course assessment. The written assessments will use a case-based format with associated questions. In addition, students will have to complete two Basic Health Sciences [BHS] Practical Assessments, a test and an examination. The in-course assessments and the practical test and examination will contribute 60 % of students' overall course mark. The end-of-course assessment will contribute 40% of students' overall course mark. In order to pass Integrated Health Sciences Part One a student must obtain an overall assessment mark of 50%.

DP requirements: To qualify to sit the end-of-course written assessment and the BHS Practical Examination students will have to meet the following DP requirements. Attend all:

- problem-based learning sessions
- scheduled tutorials
- scheduled BHS practical sessions

and complete:

- all set written activities
- all scheduled 'in course' assessment activities.

In cases where students are unable to sit a written in course assessment or complete the BHS Practical Test for legitimate reasons, the percentage value of the missed assessment activity will be added to the next assessment. In instances where students fail to provide legitimate reasons for being unable to complete an assessment activity, the percentage value of the assessment activity will not be transferred.

Students may not miss any problem-based learning sessions, tutorials or BHS practical sessions without the permission of the academic staff responsible for these activities, as attendance of these activities is compulsory. A medical certificate or an explanatory letter from a parent, relative or guardian must support absence on the ground of illness or personal/ family difficulties.

HUB217E AND LAB200S INTEGRATED HEALTH SYSTEMS - PART I (SEMESTERS 3 AND 4)

HUB308F INTEGRATED HEALTH SYSTEMS - PART II (SEMESTER 5)

Course co-ordinators: Assoc Prof G J Louw, Dr L Weight and Dr J Ramesar

Course outline: This course, over three semesters, provides the student with a detailed understanding of the normal structure and function of the human body, and how these are affected when the body suffers from disease. Twenty cases, all of which have relevance in the greater Cape Town area, in the Western Cape, or in South Africa as a whole, have been selected to provide vehicles for the study of each of the systems of the body, fully integrated with anatomical and chemical pathology and medical microbiology, as follows:

Semester 3: Furuncle ("boil"), contracting scar tissue after a burn, lower backache, cardiac failure, cardiac ischaemia, asthma, acute glomerulonephritis;

Semester 4: Diarrhoea, jaundice, anaemia, insulin dependent diabetes mellitus, non-insulin dependent diabetes mellitus with vaginal candidiasis (peri-menopausal).

Semester 5: Benign prostatic hyperplasia, chronic obstructive lung disease, leukaemia, neural tube defect, tuberculous meningitis, stroke, maternal alcohol abuse and foetal alcohol syndrome, and human immunodeficiency virus / autoimmune deficiency syndrome (HIV/AIDS). Integrated Health Systems Part 1 includes all cases covered in semesters 3 and 4, and Integrated Health Systems Part 2 includes all cases covered in Semester 5.

In a completely integrated way, students learn core material in the Basic Health Sciences (Gross Anatomy, Embryology, Histology, Cell Biology, Medical Biochemistry, Molecular Biology and Physiology), core material of infectious diseases (Medical Microbiology and Immunology), changes that occur from the normal structure and function (Anatomical Pathology, Chemical Pathology and Haematology), and the principles of Pharmacology and early management. Emphasis will be placed on psychosocial matters relating to each case, drawing in all relevant aspects of Family Medicine, Primary Health Care, Public Health, and mental well-being. Concurrently, students will learn clinical skills, interpretation of data, professional values and ethics, and certain procedural skills directly related to the cases studied. Whilst initially the emphasis will be on normal structure and function, the student will also learn what results when the normal structure and function change during illness and disease, the impact on the well-being of the individual, family and society, and the role of the health care services in alleviating illness.

The approach of this course remains that of supported Problem-Based Learning, as begun in earlier semesters. This entails case-based, group learning supported by lectures, practicals and stand-alone modules. Students will develop the key life skills that are the central requirements of an effective health care professional, including that of a multidisciplinary team approach.

At the start of the course students will be provided with details outlining the weekly timetable and scheduled learning activities. At the conclusion of the Semester 3 course, which is 22 weeks in duration, students will have undertaken:

- Ninety-six hours of full-body dissection in anatomy
- Eighty four hours of Pathology practical
- Eighty four hours of practicals related to other basic health sciences disciplines
- Ninety nine hours of Problem-Based Learning
- One hundred and thirteen hours of self-directed learning
- One hundred and thirty two hours of lectures
- Two hundred and twenty hours of self-learning, outside of standard working day.

At the conclusion of the Semester 4 course (which is ten weeks in duration) students will have undertaken:

- Sixty hours of practicals related to Health Sciences disciplines
- Forty-five hours of Problem-Based Learning.
- Fifty-five hours of self-directed learning time.
- Fifty hours of lectures
- One hundred hours of self-learning, outside of standard working day.

At the conclusion of the Semester 5 course (which is eighteen weeks in duration) students will have undertaken:

- Ninety-six hours of practicals related to Health Sciences disciplines
- Eighty eight hours of Problem-Based Learning
- Eighty-eight hours of self-directed learning time (plus twenty-five hours in assessment preparation week)
- Ninety-six hours of lectures
- One hundred and sixty hours of self-learning, outside standard working day.

Assessment: Students will be required to complete a series of in-course assessments, based upon learning objectives and practicals, which will contribute 60% to the final assessment at the end of Semester 4. A summative assessment will be held at the end of Semester 4, contributing to 40% of the total marks. Assessment tasks will include written papers, assignments that form part of a portfolio and practical examinations. Regular self-assessment activities will provide feedback to students on their progress.

Students must achieve an overall pass in the in-course assessments, failing no more than one of these assessments, and an overall pass in the end-of-semester 4 assessment to progress to Semester 5. The result of the assessments in Semester 3 & 4 will be carried forward, as in-course marks, to contribute to the final end of Semester 5 assessment, the Second Professional Examination. The in-course assessments will comprise 60% of the total mark. The final examination will be in June at the end of semester 5, and will constitute 40% of the total mark.

An Assessment Board will meet at the end of Semester 4 in order to examine students' academic performance during semesters 3 and 4, based on in-course, performance-based assessments, and a summative assessment taken at the end of Semester 4, to determine whether they may progress to Semester 5. Students have to obtain an overall pass mark for all in-course assessments, as well as a pass mark in the summative assessment. If students fail to pass these assessments, they will be required to repeat all courses in semesters 3 and 4, including the Research Modules, if students passed such modules with less than 60% or failed them.

DP requirements: To qualify for the final assessment (final examination) in the course, students have to meet the DP (duly performed) requirements:

- Attending problem-based learning sessions
- Attending tutorials, "stand-alone" units and practicals
- Completing set assignments
- Sitting assessment activities

In cases where students fail to complete a particular in-course assessment, the percentage value of that assessment will be added to the next assessment.

Students may not miss problem-based learning sessions without a valid reason, and absenteeism will be reported to the Head of Department. Problem-Based Learning sessions, tutorials, "stand-alone" units and practicals are compulsory. Absence on the grounds of illness requires a medical certificate. Validity of absence on the grounds of personal or other problems will be considered on an individual basis.

PPH101F BECOMING A PROFESSIONAL (including developing awareness of HIV/Aids) (MEDB14)

Course co-ordinator: Ms L Olckers

Course outline: Becoming a Professional is a first semester course. This course introduces all first year students registered in the Faculty of Health Sciences to the process of developing professional conduct. As the first building block in this process, the course aims to promote the conduct, attitudes and values associated with being a professional, as well as being a member of a professional team. In addition, it will assist students to understand and respect the knowledge, skills and roles of all colleagues who make up a professional team, as well as the role, knowledge and skills of the person, group or community being served.

The course focuses on the knowledge, experience and basic skills of being an effective team member, leader and professional, which includes being non-judgemental, sensitive and ethical when working with colleagues, clients, patients and community members who may have different values and traditions. In order to achieve this knowledge, experience and the basic skills, students' use:

- Theory on the stages of interviewing which is applied in simulated and real interviews;
- group theory applied in simulated experiences to build skills in managing team membership and leadership roles;
- critical analysis and reflection on professional conduct, including principles of non-judgementalism, empathy, Human and Health Rights.

The educational approach is participatory and experiential; therefore all students are required to engage actively in the small learning groups.

Information Literacy and Computer Skills are systematically integrated from the outset in this curriculum component to assist students in the range of learning, teaching and assessment activities elsewhere in the curriculum.

Assessment: Continuous performance-based assessment is used to provide students with regular feedback. Students are required to complete a number of in-course assignments, which comprise 60% of the total mark. The summative assessment makes up 40% of the total mark.

DP requirements: To qualify for the summative assessment (final examination) in the course, students have to meet the DP (duly performed) requirement, which entails:

- Attending all small group learning sessions
- Completing set assignments
- Sitting assessment activities

In cases where students fail to complete or are unable to complete a particular in-course assessment, the percentage value of that assessment will be added to the next assessment.

Small group learning sessions are compulsory. Absence on the grounds of illness requires a medical certificate. Validity of absence on the grounds of personal or other problems will be considered on an individual basis by the Head of Department.

Developing awareness of HIV/Aids:

Outline: Developing awareness of HIV/AIDS is an extra component of PPH101F Becoming a Professional. It is taught in the form of a workshop, designed specifically to introduce first year Health Sciences students to the basic relevancy of HIV/AIDS issues, in their private and professional lives.

The course constitutes a platform upon which future HIV/AIDS learning will be based.

Contact time in small group tutorials is 12 hours.

DP requirements: Attendance is compulsory.

PPH102S BECOMING A HEALTH PROFESSIONAL (MEDB14)

Course co-ordinator: Ms L Olckers

Course outline: Becoming a Health Professional is a second semester course, using some of the knowledge and skills developed in PPH101F Becoming a Professional.

The course equips students to work collaboratively on a community-oriented project based on the principles and approach to Primary Health Care, which include comprehensive health care (promotive, preventive, curative and rehabilitative care within the primary, secondary and tertiary levels of care); intersectoral collaboration; community involvement; and accessibility and equity of health care. Students are required to apply the knowledge, skills and values from Becoming a Professional to the community-oriented project to develop an appreciation of the contribution of all health professionals in the promotion, maintenance and support of health and health care of individuals, families and communities. The educational approach is participatory and project-based; therefore all students are required to engage actively in the project and in small learning groups.

Information Literacy and Computer Skills are systematically integrated from the outset in this curriculum component to assist students in the range of learning, teaching and assessment activities elsewhere in the curriculum.

At the start of the course students will be provided with details outlining the weekly timetable and scheduled learning activities.

Assessment: Continuous performance-based assessment is used to provide students with regular feedback. Students are required to complete a number of assignments, which comprise 60% of the total mark. The summative assessment makes up 40% of the total mark

DP requirements: To qualify for the summative assessment (final examination) in the course, students have to meet the DP (duly performed) requirement, which entails:

- Attending group sessions

- Completing set assignments
- Attending community visits
- Sitting assessment activities.

In cases where students fail to complete or are unable to complete a particular in-course assessment, the percentage value of that assessment will be added to the next assessment.

Group learning sessions and community visits are compulsory. Absence on the grounds of illness requires a medical certificate. Validity of absence on the grounds of personal or other problems will be considered on an individual basis by the Head of Department.

PPH200W BECOMING A DOCTOR (PART 1A)

PPH300F BECOMING A DOCTOR (PART IIA) (MEDB14)

Course co-ordinator: Assoc Prof D Hellenberg and Sr R Nash

Course outline: The course will run over semesters 3 to 5 and will occupy 30% of students' total study time in semesters 3 to 5. It will consist of and integrate three main sections:

1. Clinical methods
2. Language and communication
3. Health Care Practice.

This course will consolidate the knowledge, skills and attitudes learned in the Becoming a Professional and Becoming a Health Professional courses and students will be given the opportunity to apply them in the clinical environment. They will learn and practise the skills required for working with patients, including the essential elements of interviewing skills, history-taking and physical examination and concepts of professionalism and human rights. Students will be guided through the clinical, individual and contextual components in the assessment of a patient. This assessment enables the doctor to recognise the patient as an individual with fears, anxieties and concerns within a specific context. Students will learn how to use diagnostic equipment and apply other basic skills essential for diagnosis.

This course will build on the concept of the reflective, empathic and knowledgeable practitioner and students will be required to continue their reflective journals, commenced in previous courses, recording their personal development as professionals.

All students will be exposed to a diversity of health care settings in primary, secondary and tertiary care in both the public and private sectors.

Clinical skills: A structured approach to the development of clinical skills will produce the confidence and the competence required of students when dealing with patients. An integrated and contextual approach to learning, based upon the Problem-Based Learning scenarios used in Integrated Health Systems, will allow the students to learn the appropriate clinical skills, initially on simulated models and peers and eventually on patients selected as illustrative of the clinical cases.

Language and communication Students will learn how to communicate with patients whose language (English, Afrikaans or Xhosa) and culture is different from their own. This includes not only linguistic skills, but also an awareness of the contribution of cultural background to the doctor's and patient's concept of health and illness and to the doctor-patient relationship. By the end of the course students will be able to establish a relationship with a patient and obtain the main points of history in English, Xhosa and Afrikaans.

The focus will be on oral communicative competence rather than written skills.

Health care practice: This aspect of the course will offer students an opportunity to develop an understanding of delivery of health care, its management and organization; aspects of health promotion and disease prevention when applied to medical consultations; and to gain practical experience of the doctor-patient relationship and the consultation process.

Learning method: Student learning will take place in a variety of settings. The Clinical Skills Centre will provide a practical setting for students to develop their history taking and clinical skills. Students are expected to prepare for practicals and tutorials using reading and computerised material provided. They will have the opportunity to practise all the skills of this component of the course until their confidence and technique are perfected. Simulated models, diagnostic materials and learning resources will be readily available.

Tutorials, using case scenarios and case illustrations, will integrate the learning of clinical skills with language acquisition and understanding of cultural aspects of patient interaction. Students will explore two languages, other than their own, through group tutorials, peer learning and self-directed learning. Language learning will also make use of group work, the language laboratory, peer learning and multimedia sessions.

A small group tutorial environment will permit students' discussion of the doctor-patient relationship and the consultation prior to working with patients.

Later, learning will take place in community practices, clinics and other centres when students will be given opportunities to interact with patients and to observe and practice skills learned in the Clinical Skills Centre, applying language acquisition and participating in health promotion.

At the start of the course students will be provided with details outlining the weekly timetable and scheduled learning activities.

At the conclusion of the Semester 3 course, which is 22 weeks in duration, students will have undertaken:

- Sixty six hours of small group learning in Language and Communication
- Sixty six hours of Clinical Skills Practical
- Sixty-six hours of tutorials, including Health Promotion
- Six hours of field work
- Thirty-nine hours of dedicated self directed learning
- One hundred and ten hours of self-learning, outside standard working day.

At the conclusion of the Semester 4 course, which is 10 weeks in duration, students will have undertaken.

- Thirty hours of small group learning in Language and Communication
- Thirty hours of Clinical Skills Practical
- Thirty hours of tutorials, including Health Promotion
- Six hours of field work
- Thirty hours of dedicated self directed learning
- Fifty hours of self-learning, outside standard working day.

At the conclusion of the Semester 5 course, which is 18 weeks in duration, students will have undertaken:

- Fifty four hours of small group learning in Language and Communication
- Fifty four hours of Clinical Skills Practical

- Thirty-nine hours of tutorials
- Fifteen hours of field work
- Fifty four hours of dedicated self directed learning, (plus fifteen hours in assessment preparation week)
- Ninety hours of self-learning, outside standard working day.

All sessions and practicals are compulsory. Absence on the grounds of illness requires a medical certificate. Validity of absence on the grounds of personal or other problems will be considered on an individual basis by the Head of Department.

Assessment: An Integrated Structured Clinical Examination (ISCE), used in an objective way to cover the three topics within the course, will form the basis of assessment in this programme. The abilities tested in the ISCE will include practical skills, the ability to conduct an appropriate consultation, the ability to communicate with patients and peers, and the ability to communicate (in English, Afrikaans and Xhosa) at a level sufficient for a basic sharing of health-related information.

Students will also complete a portfolio of learning that will translate group or individual activities into a structured approach to learning, using a reflective model. These portfolios will be assessed both in a formative way and as a DP requirement during the course of a semester and a summative way, contributing to the assessment mark.

The in-course assessments (ISCEs held in the end of Semester 3 and mid way through Semester 4) will constitute 50% of the final mark and the OSCE at the end of Semester 4 will constitute 50% but both are required to be passed independently.

Failure to pass the end of year assessment (end of Semester 4), and failure to pass a supplementary assessment will require a student to repeat all courses in Semesters 3 and 4, excluding the Research Modules provided they have previously been passed successfully.

Students who have successfully passed Semester 3 and 4 activities will carry these marks through to Semester 5. These marks, plus one in-course assessment in Semester 5, will constitute the in-course marks, contributing to 60% of the total mark at the end of Semester 5. A summative assessment at the end of Semester 5 will contribute 40% of the total marks.

In cases where students fail to complete or are unable to complete a particular in-course assessment, the percentage value of that assessment will be added to the next assessment.

DP requirements: To qualify for the summative assessment at the end of Semester 4, students have to meet the DP (duly performed) requirement, which entails:

- Attending clinical skills sessions
- Attending language and communication activities, tutorials, and practicals
- Completing the Portfolios of Learning
- Attending external visits to community organisations
- Sitting assessment activities

This information is available from the Faculty of Health Sciences Student Handbook.

Appendix B - Interview and focus group guides

Interview guide questions - Set 1

- Where are you from?
- What is your home language?
- Have you studied before (at tertiary level)?

- How did you come to decide to study medicine?
- Why did you choose to study medicine?
- How would you define medicine?
- *What* and *how* did you expect to learn?
- What are your expectations of studying medicine?
- Diversity - cultural / gender

- What is *community*? What is your community?
- What is 'community work'?
- Did you expect to do 'community work' while studying medicine?
- Should you be expected to do 'community work'?

- What comes to mind if you think of a 'doctor'?
- What are your expectations of being a doctor?
- What is your perception of doctors?

- Where do you see yourself in 10 years time (after internship and community service)?
- Public vs private, urban vs rural - what makes people choose one or the other? What would make *you* choose one or the other?
- What health services have you been exposed to?
- What specialisations are the *most* popular? (associated with 'being a doctor') Why?
- What specialisations are the *least* popular? Why?

Interview guide questions - Set 2

- What were your initial expectations of studying medicine? Have these expectations been met? (reality vs expectations) Have your expectations changed?
- What was your perception of medicine when you started? Has your perception changed?
- When you started this year, what would you have said made a good doctor? Has your opinion on this changed?
- How would you go about making a good doctor? Do you think that UCT's MBChB curriculum will make you into a good doctor?
- What do you think of the biopsychosocial approach? Is it necessary and relevant?
- Do you think it's valuable to have a holistic approach to health? Pros and cons?
- What are your impressions of health care in SA? (from your experience?)
- What is 'good' health care?
- What is a 'good' approach to health care?
- What are your initial impressions of the PHC approach?
- How would you like to be taught about the PHC approach?
- How do you feel about doing Public Health in the second semester? Is it relevant and important?
- What stands out as the most valuable thing you learnt in semester 1?
- What stands out as the least valuable thing you learnt in semester 1?
- What are your expectations of semester 2?

Focus Group Guide - Set 3 & 4a

- Consent forms
- Recorded
- Anonymity
- Time
- Purpose of research: find out about medical students' views on PHC
 - Attitudes towards and perceptions of PHC approach
 - Understanding of PHC approach, w.r.t. teaching and learning of PHC
 - PHC approach in relation to expectations and future plans
- Highlight importance of honesty
- This isn't a test of how much you remember about PHC
- Don't need to all agree - disagreement is good: shows the range

Views and opinions of the PHC approach

General

- *Personal* view of the PHC approach that you have been introduced to at UCT
- *General* view of medical students towards the PHC approach
- Influences on view of the PHC approach (personally and generally)
 - Background (ethnicity / race, socioeconomic status etc)
 - BHP visits
 - Other health professionals / academics; some quite negative
 - Would it help if doctors working in the field were more vocal in their support of PHC?
- Appropriateness of PHC for SA?
- Is PHC necessary?
- How do you feel about PHC being promoted and taught at UCT?
- Are the new curriculum and PHC the same thing?
- Do you think other universities teaching PHC, or just UCT?
- Do you feel like you are doing an inferior degree because it's focussed on PHC?

- *Strengths* of the PHC approach
- *Weaknesses* of the PHC approach
- PHC approach too idealistic?
- PHC approach too broad? If yes, how could you change this?
- Lack of working example - where has PHC been implemented successfully?

Specific

- Which would you rate as the most important: promotion, prevention cure or rehabilitation?
- Should doctors focus on cure?
- Opinion of multidisciplinary teams
 - Any examples?
 - A reality?
 - Should medical students learn to work in a team?
- Role and importance of community in PHC approach
 - Doctor's role in community: working *in* vs working *within*?
- Role of other sectors besides health sector?
- How would you describe effective and efficient health services?
 - Of the health facilities you saw on your BHP visits, which would you classify as being efficient and effective?

- Division between public and private health care provision
 - What stands out as the difference between them?
 - How do you feel about the gap?
 - Is PHC only for the public sector?
 - Should there be an emphasis on providing services for poor and disadvantaged communities
- What is the government's role in implementing all these aspects of PHC?

Understanding of the PHC approach

- How would you describe your understanding of PHC approach?
 - What has helped / hindered understanding; BHP visits?
- Opinion of the way in which you were introduced to and taught the PHC approach
 - Pressure to accept the PHC approach?
 - Would you have liked exposure to other approaches besides PHC?
- Role of learning in a multiracial / multicultural environment in assisting / enhancing your understanding of PHC
- How does what you've been taught about the PHC approach compare with what you think you need to know about it at this stage of your academic career? Do you feel like you know enough?

PHC approach, students' expectations and future plans

- Thinking back on how you would have defined health (beginning of 1st year), has learning about the PHC approach changed this?
- Thinking back on your reasons for studying medicine, how does the PHC approach fit in? Any reasons confirmed / changed?
 - I wanted to become a doctor in order to serve my community (69%)
 - I am interested in biology and how the human body works (69%)
 - I want to help other people (66%)
 - I have always wanted to be a doctor (55%)
 - I did well at school and felt medicine was a good academic choice of study (30%)
 - I felt a religious or spiritual calling to become a doctor (28%)
 - I believe that being a doctor will put me into a good financial position (22%)
- Thinking back on your initial expectations of studying medicine, how does the PHC approach fit in? New concerns / excitements / expectations?
 - Concerns about studying for a long time
 - Concerns about exposure to HIV/AIDS and other diseases
 - Concerns about the volume of work
 - Concerns about competition in the class
 - Expecting to grow emotionally
 - Expecting views to change
 - Expecting to face many emotional changes
 - Expecting lots of stress
- Were you expecting to learn about PHC?
- Thinking back on your initial expectations of being a doctor, how does the PHC approach fit in? New concerns / excitements / expectations? Any of these changed because of PHC?
 - Expecting to financially secure, successful, have good social standing, good chance of regular employment, good job satisfaction, fulfilled and intellectually stimulated
 - Expecting to make many sacrifices
 - Expecting frustration
 - Not concerned about communication with patients
 - Concerned about exposure to HIV/AIDS
- Concerns about burnout / being overworked in the health system?
- Where you would like to work in future
 - private vs public
 - urban vs rural
 - big hospital vs clinic
- Does working in the public sector = making a difference?
- What has influenced your decision?
 - Learning about PHC?
 - The way the government treats doctors?
- Most popular specialisations: cardiology, neurology, paediatrics and surgery. Do you think this is still the case? Has PHC changed anyone's mind?
- Role of doctors in the PHC approach
- How do you feel about being trained in a 'new' system, but having to ultimately work in the 'old' system?

Focus Group Guide - Set 4b & 4c

- Consent forms
- Recorded
- Anonymity
- Time
- Purpose of research: find out about medical students' views on PHC
 - Attitudes towards and perceptions of PHC approach
 - Understanding of PHC approach, w.r.t. teaching and learning of PHC
 - PHC approach in relation to expectations and future plans
- Highlight importance of honesty
- This isn't a test of how much you remember about PHC
- Don't need to all agree - disagreement is good: shows the range

Views and opinions of the PHC approach

General

- *Personal* view of the PHC approach that you have been introduced to at UCT
- *General* view of medical students towards the PHC approach
- Influences on view of the PHC approach (personally and generally)
 - Background (ethnicity / race, socioeconomic status etc)
 - BHP visits
 - Other health professionals / academics; some quite negative
 - Would it help if doctors working in the field were more vocal in their support of PHC?
- Can you remember your views towards PHC early on? (1st and 2nd year)
- Have your views changed? If so, why?
- Appropriateness of PHC for SA?
- Is PHC necessary?
- How do you feel about PHC being promoted and taught at UCT?
- Are the new curriculum and PHC the same thing?
- Do you think other universities teaching PHC, or just UCT?
- Do you feel like you are doing an inferior degree because it's focussed on PHC?

- *Strengths* of the PHC approach
- *Weaknesses* of the PHC approach
- PHC approach too idealistic?
- PHC approach too broad? If yes, how could you change this?
- Lack of working example - where has PHC been implemented successfully?

Specific

- Which would you rate as the most important: promotion, prevention cure or rehabilitation?
- Should doctors focus on cure?
- Opinion of multidisciplinary teams
 - Any examples?
 - A reality?
 - Should medical students learn to work in a team?
- Role and importance of community in PHC approach
 - Doctor's role in community: working *in* vs working *within*?
- Role of other sectors besides health sector?
- How would you describe effective and efficient health services?
 - Of the health facilities you saw on your BHP visits, which would you classify as being efficient and effective?

- Division between public and private health care provision
 - What stands out as the difference between them?
 - How do you feel about the gap?
 - Is PHC only for the public sector?
 - Should there be an emphasis on providing services for poor and disadvantaged communities
- What is the government's role in implementing all these aspects of PHC?

Understanding of the PHC approach

- How would you describe your understanding of PHC approach?
 - What has helped / hindered understanding?
- Opinion of the way in which you were introduced to and taught the PHC approach
 - Pressure to accept the PHC approach?
 - Would you have liked exposure to other approaches besides PHC?
- Should medical students learn about the PHC approach early on (i.e. first year) or later?
- How does what you've been taught about the PHC approach compare with what you think you need to know about it at this stage of your academic career? Do you feel like you know enough?

PHC approach, students' expectations and future plans

- Thinking back on how you would have defined health (beginning of 1st year), has learning about the PHC approach changed this?
- Thinking back on your reasons for studying medicine, how does the PHC approach fit in? Any reasons confirmed / changed?
 - I wanted to become a doctor in order to serve my community (69%)
 - I am interested in biology and how the human body works (69%)
 - I want to help other people (66%)
 - I have always wanted to be a doctor (55%)
 - I did well at school and felt medicine was a good academic choice of study (30%)
 - I felt a religious or spiritual calling to become a doctor (28%)
 - I believe that being a doctor will put me into a good financial position (22%)
- Thinking back on your initial expectations of studying medicine, how does the PHC approach fit in? New concerns / excitements / expectations?
 - Concerns about studying for a long time
 - Concerns about exposure to HIV/AIDS and other diseases
 - Concerns about the volume of work
 - Concerns about competition in the class
 - Expecting to grow emotionally
 - Expecting views to change
 - Expecting to face many emotional changes
 - Expecting lots of stress
- Were you expecting to learn about PHC?
- Thinking back on your initial expectations of being a doctor, how does the PHC approach fit in? New concerns / excitements / expectations? Any of these changed because of PHC?
 - Expecting to financially secure, successful, have good social standing, good chance of regular employment, good job satisfaction, fulfilled and intellectually stimulated
 - Expecting to make many sacrifices
 - Expecting frustration
 - Not concerned about communication with patients
 - Concerned about exposure to HIV/AIDS
- Concerns about burnout / being overworked in the health system?
- Where you would like to work in future
 - private vs public
 - urban vs rural
 - big hospital vs clinic
- Does working in the public sector = making a difference?
- What has influenced your decision?
 - Learning about PHC?
 - The way the government treats doctors?
- Most popular specialisations: cardiology, neurology, paediatrics and surgery. Do you think this is still the case? Has PHC changed anyone's mind?
- Role of doctors in the PHC approach
- How do you feel about being trained in a 'new' system, but having to ultimately work in the 'old' system?

Key informant interview guides

Mrs. Lorna Olckers, Prof. Derek Hellenberg, Dr. Elma de Vries

- Their impressions of what the students think and feel about PHC
- Reactions to how students think PHC is taught - e.g. dragged out, drummed into them, too much for first year
- Students think PHC is a good idea - how can you get them to buy into it?
- Students think PHC is idealistic (particularly younger students)
- Their view on what influences students' views on PHC
- Impact of teacher's attitudes towards and knowledge about PHC on students' views
- How can students' expectations about medicine be better managed (in light of the fact that there is a new curriculum)?
- Too much change too soon?
- Effect of changes in the health system on medical education and on students; role of government
- What do they see as a good doctor? Importance of clinical competence? What is the most important?

Prof. Jimmy Volmink & Mr. James Irlam

- Their impressions of how students are taught and introduced to the PHC approach
- Their views on the new curriculum
- Their experience of promoting PHC at UCT
- Students think PHC is idealistic (particularly younger students) - is it really?
- Students think PHC is a good idea - how can you get them to buy into it?
- Why is PHC seen by some students as 'out there' (i.e. rural)? How could one attract more students to community medicine?
- How can students' expectations about medicine be better managed (in light of the fact that there is a new curriculum)?
- Too much change too soon?
- Effect of changes in the health system on medical education and on students; role of government
- What do they see as a good doctor? Importance of clinical competence? What is the most important?

Prof. Marietjie de Villiers, Prof. Det Prozesky, Prof. Steve Reid

- Relevant issues in medical education in SA
- Relevant issues about medical students and PHC
- Where does PHC fit into MBChB curriculum
- Impression of students' views of PHC / students' receptiveness
- What influences students' views?
- Issues around student selection
- Students' personalities - suitability for medicine, effect on views towards PHC
- Students' expectations of and reasons for studying medicine
- Students' future plans (public vs private), and leaving SA
- Staff receptiveness to PHC
- What influences staff views?
- Rural medicine and community service - how does it fit into PHC approach?
- Does community service give students and doctors a more positive / negative view of PHC?
- Effect of changes in health system (e.g. community service) on medical education and on students
- Effect of changes in student profiles on views towards community service, PHC etc
- What makes a good doctor / what is most important for medical students to learn
- Experience of promoting / teaching PHC at their university
- Is PHC idealistic?

Appendix C - Questionnaire

University of Cape Town - Faculty of Health Sciences
Educational Development Unit &
School of Public Health & Family Medicine

Thank you for agreeing to fill in this questionnaire. There are 6 pages to this questionnaire, and it is important that you complete the entire questionnaire. You are not required to give your name on the questionnaire, so you will remain anonymous.

Section 1 - Personal Details

1. Age: _____
 2. Gender: M F
 3. School at which you matriculated: _____
 4. Home language/s: _____
 5. Home town / suburb and city: e.g. Gugulethu, Cape Town / Parktown, Johannesburg

 6. Ethnic group:
 White Black Coloured Indian
Other - please specify: _____
 7. How would you classify your background?
 Disadvantaged Advantaged
 8. What are your parents' occupations?

 9. As a student, do you need to do part-time work (e.g. waitering) to support yourself financially?
 Yes No
If yes, what work do you do? _____
 10. Living arrangements at the present time:
 UCT residence With parents In 'digs'
Other, please specify _____
 11. Since finishing school, have you worked or studied before registering for this degree?
Yes No
If yes, where did you work / what did you study?

-

Section 2 - Your reasons for studying medicine

12. Why did you decide to study medicine? (tick the appropriate boxes)

- There are other doctors in my family. (Please specify: _____)
- I was pressurised by my family to do medicine.
- I did well at school and felt medicine was a good academic choice of study.
- I felt a religious or spiritual calling to become a doctor.
- I wanted to become a doctor in order to serve my community.
- I believe that being a doctor will put me into a good financial position.
- I believe that being a doctor will improve my social standing.
- I am interested in biology and how the human body works.
- I have always wanted to be a doctor.
- I want to help other people.
- Someone I know strongly influenced my decision to study medicine.
(Please specify: _____)
- I have experienced serious illness / injury, and this motivated me to study medicine.
- Someone close to me experienced serious illness / injury, and this motivated me to study medicine.
- Other reasons (please specify): _____

Section 3 - Approaches to health

13. Which of the following words or phrases would you associate most strongly with health? Tick no more than two.

Health is

- | | |
|--|---|
| <input type="checkbox"/> an absence of sickness or disease | <input type="checkbox"/> a sound body |
| <input type="checkbox"/> a sound mind | <input type="checkbox"/> happiness |
| <input type="checkbox"/> holistic | <input type="checkbox"/> wellness |
| <input type="checkbox"/> spiritual well-being | <input type="checkbox"/> emotional well-being |

14. Define what you understand by the term 'community'.

15. Before you came to UCT, were you familiar with the Primary Health Care approach to health? Tick one.

- | | |
|---|--|
| <input type="checkbox"/> Yes, very familiar | <input type="checkbox"/> I know a bit about it |
| <input type="checkbox"/> I've heard of it | <input type="checkbox"/> Not at all familiar |

Section 4 - Expectations and fears about studying medicine

Please specify to what extent you agree or disagree with the following statements regarding your expectations and fears about studying medicine (tick the appropriate block):

16. I worry that I might fail or not cope academically.

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
-------------------	----------	---------	-------	----------------

17. I don't know if I will be able to study for such a long time.

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
-------------------	----------	---------	-------	----------------

18. I am worried about interacting with fellow students and patients who cannot speak my language.

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
-------------------	----------	---------	-------	----------------

19. I am looking forward to making friends with students from different cultural backgrounds.

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
-------------------	----------	---------	-------	----------------

20. I am comfortable about studying with both male and female students

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
-------------------	----------	---------	-------	----------------

21. I am expecting to grow emotionally as a result of my studies.

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
-------------------	----------	---------	-------	----------------

22. I am worried about being exposed to HIV/AIDS and other diseases.

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
-------------------	----------	---------	-------	----------------

23. I am expecting my views to change as a result of my studies.

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
-------------------	----------	---------	-------	----------------

24. I am worried about interacting socially with fellow students.

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
-------------------	----------	---------	-------	----------------

25. I anticipate a lot of competition between my MBChB classmates.

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
-------------------	----------	---------	-------	----------------

26. I am worried about the volume of work that we will have to get through.

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
-------------------	----------	---------	-------	----------------

27. I am expecting to face many emotional challenges during the course of my studies.

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
-------------------	----------	---------	-------	----------------

28. I am anticipating a lot of stress in the next 6 years.

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
-------------------	----------	---------	-------	----------------

Section 5 - Expectations and fears about being a doctor

Please specify to what extent you agree or disagree with the following statements about your expectations and fears of being a doctor one day (tick the appropriate block):

29. I am expecting to be financially secure.

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
-------------------	----------	---------	-------	----------------

30. I am anticipating an improvement in social standing.

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
-------------------	----------	---------	-------	----------------

31. I am concerned about where I might have to work one day.

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
-------------------	----------	---------	-------	----------------

32. I am anticipating that my chances of being regularly employed will be improved.

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
-------------------	----------	---------	-------	----------------

33. I expect to be successful in the future.

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
-------------------	----------	---------	-------	----------------

34. I am worried about any emotional difficulties that may be the result of being a doctor.

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
-------------------	----------	---------	-------	----------------

35. I am concerned about my exposure to AIDS / HIV.

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
-------------------	----------	---------	-------	----------------

36. I expect to find great job satisfaction as a doctor.

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
-------------------	----------	---------	-------	----------------

37. I anticipate that I will have to make many sacrifices in my life.

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
-------------------	----------	---------	-------	----------------

38. I am expecting that being a doctor will involve much frustration.

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
-------------------	----------	---------	-------	----------------

39. I am concerned that being a doctor will have a negative impact on my future family life.

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
-------------------	----------	---------	-------	----------------

40. I anticipate that I will be mentally and intellectually stimulated as a doctor.

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
-------------------	----------	---------	-------	----------------

41. I am concerned about being exposed to sickness and disease.

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
-------------------	----------	---------	-------	----------------

42. I anticipate that being a doctor will be a source of fulfilment for me.

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
-------------------	----------	---------	-------	----------------

43. I am worried that I won't be able to communicate effectively with my patients.

Strongly disagree	Disagree	Neutral	Agree	Strongly agree
-------------------	----------	---------	-------	----------------

Section 6 - Your perception of doctors

44. Do you have a positive or negative perception of doctors?

- Positive Negative

45. Would you describe the majority of doctors as:

- Caring and understanding, OR as
 Arrogant and insensitive
 Other _____

Section 7 - Future aspirations

46. After completing your internship and community service, would you like to work in:

- private sector
 public sector
 city / large town
 small town / rural village
 other _____

47. Are there any fields of medicine that particularly appeal to you and that you would consider specialising in? (please tick)

- | | | |
|---|--|--|
| <input type="checkbox"/> Anaesthetics | <input type="checkbox"/> Neurology | <input type="checkbox"/> Psychiatry |
| <input type="checkbox"/> Cardiology | <input type="checkbox"/> Obs / Gynae | <input type="checkbox"/> Public Health |
| <input type="checkbox"/> Chemical pathology | <input type="checkbox"/> Oncology | <input type="checkbox"/> Radiology |
| <input type="checkbox"/> Dermatology | <input type="checkbox"/> Ophthalmology | <input type="checkbox"/> Research |
| <input type="checkbox"/> ENT | <input type="checkbox"/> Orthopaedics | <input type="checkbox"/> Sports medicine |
| <input type="checkbox"/> Forensic medicine | <input type="checkbox"/> Paediatrics | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> General practice | <input type="checkbox"/> Palliative medicine | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Genetics | <input type="checkbox"/> Pathology | <input type="checkbox"/> Urology |
| <input type="checkbox"/> Microbiology | <input type="checkbox"/> Plastic surgery | |
| <input type="checkbox"/> Other _____ | | |

Thank you very much for your time

Appendix D - Interview and focus group details

Interviewees - Set 1

Female	6
Male	3
Total	9

Focus groups participants - Set 1

Coloured / Indian		Black		White	
Female	3	Female	1	Female	5
Male	1	Male	2	Male	4
Total	4	Total	3	Total	9

Interviewees - Set 2

Female	5
Male	5
Total	10

Interviewees - Set 3

Female	4
Male	4
Total	8

Focus group participants - Set 4a

Focus Group 1: 2 nd years		Focus Group 2: 2 nd years		Focus group 3: 2 nd years	
Female	7	Female	2	Female	3
Male	3	Male	3	Male	0
Total	10	Total	5	Total	3
Focus Group 4: 2 nd years		Focus Group 5: 2 nd years		Focus group 6: 2 nd years	
Female	4	Female	2	Female	5
Male	3	Male	2	Male	3
Total	7	Total	4	Total	8

Note: Sets 3 and 4a are drawn from the same cohort of students as Sets 1 and 2.

Focus group participants - Set 4b

Focus Group 7: 3 rd years		Focus Group 8: 3 rd years		Focus group 9: 3 rd years	
Female	1	Female	2	Female	3
Male	3	Male	2	Male	0
Total	4	Total	4	Total	3

Focus group participants - Set 4c

Focus Group 10: 4 th years		Focus Group 11: 4 th years		Focus group 12: 4 th years	
Female	3	Female	6	Female	4
Male	3	Male	2	Male	1
Total	6	Total	8	Total	5
Focus Group 13: 4 th years		Focus Group 14: 4 th years			
Female	4	Female	3		
Male	0	Male	0		
Total	4	Total	3		

Key informant interviewees

Name	Position
Mrs. Lorna Olckers	Course convenor, 'Becoming a Professional' & 'Becoming a Health Professional', Faculty of Health Sciences, UCT
Prof. Derek Hellenberg	Head of Division of Family Medicine, School of Public Health and Family Medicine, UCT
Dr. Elma de Vries	Lecturer, Division of Family Medicine, School of Public Health and Family Medicine, UCT Family Physician, Mitchell's Plain Community Health Centre
Prof. Jimmy Volmink	Chair of Primary Health Care, Primary Health Care Directorate, UCT
Mr. James Irlam	Senior Lecturer, Primary Health Care Directorate, UCT
Prof. Marietjie de Villiers	Professor in Family Medicine, Head of School of Public and Primary Health Sciences, Faculty of Health Sciences, University of Stellenbosch
Prof. Detlef Prozesky	Director, Centre for Health Science Education, Faculty of Health Sciences, University of the Witwatersrand
Prof. Steve Reid	Rural Health and Community-based education, Centre for Rural Health, Nelson R Mandela School of Medicine, University of Kwazulu-Natal

Appendix E - Consent forms

University of Cape Town - Faculty of Health Sciences
Educational Development Unit &
Department of Public Health and Primary Health Care
Consent Form - Questionnaire

This research study aims to find out more about first year Health Science students' attitudes towards, and their perceptions of the Primary Health Care approach. In order for this to be understood fully, you will be asked initially to answer questions on related issues, such as: why you chose to study your degree, and some of your fears and expectations regarding this choice. There are no right or wrong answers, and it is important for you to answer these questions as honestly as possible.

Since you are not required to fill in your name on the questionnaire, there is no way of linking you to your answers, and you will remain **anonymous**. This consent form will **not** be attached in any way to the questionnaire that you complete.

Participating in this study is voluntary, and your participation is greatly appreciated. If you choose not to be involved in this study, your future academic and/or medical career will not be affected in any way.

If you have any queries, please contact Cathi Draper at cathdraper@iafrica.com.

Signature of participant

Date

University of Cape Town - Faculty of Health Sciences

School of Public Health

Consent Form - Interviews and focus groups

This research study aims to find out more about medical students' attitudes towards, and their perceptions of the Primary Health Care approach. In order for this to be understood fully, you may be asked to answer questions on related issues, such as: why you chose to study your degree, some of your expectations regarding this choice, your perceptions of medicine, and your future plans. There are no right or wrong answers and your honesty will be valued and much appreciated.

You will remain **anonymous**, and only I, as your interviewer / focus group facilitator, along with the other participants of this focus group (not applicable for interviews), will have knowledge of your identities as research participants.

Participating in this study is voluntary, and your participation is greatly appreciated. If you choose not to be involved in this study, your future academic and/or professional career **will not** be affected in any way. You may withdraw from this study at any time, and withdrawal from this study will have **no** impact on your academic performance.

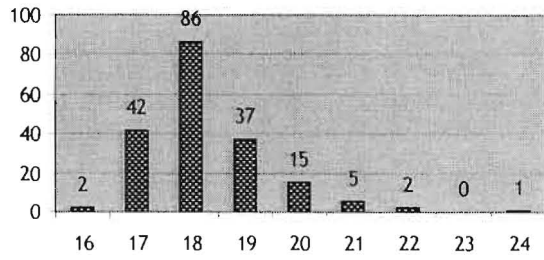
If you have any queries, please contact Cathi Draper at drpcat001@mail.uct.ac.za.

Signature of participant

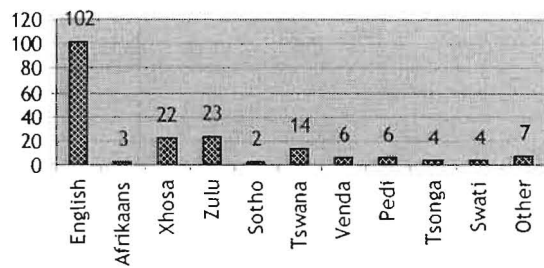
Date

Appendix F - Demographics of questionnaire respondents

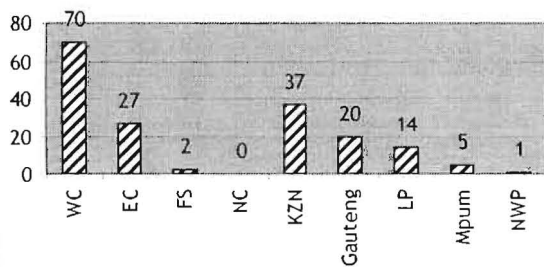
Age



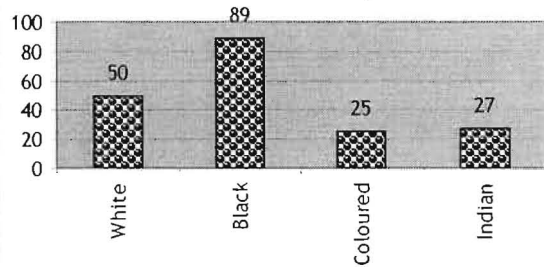
Home Language



Province



Ethnic Group



Profile of the doctor

- 2.1 *The undergraduate medical education of students embraces a period of learning (knowledge), training (skills) and moulding (attitudes and behaviour). On the successful completion of the undergraduate medical curriculum, the student should have developed into a basic doctor, fit to practise the profession over the broad spectrum of medicine or to undergo specialist education and training. Therefore, in creating a profile of the doctor we wish to educate and train, the following should be considered:*
- a. Knowledge, skills, attitudes and professional behaviour.
 - b. Promotion, prevention, treatment and rehabilitation.
 - c. Research, management, continuous professional development.
- 2.2 Attitudes, skills and knowledge are prerequisites for promotion of health and preventive, curative or rehabilitative activities which should be sustained and transferred to the next generation by appropriate management, professional development and research activities.
- 2.3 **To achieve the preceding, the basic doctor (i.e. a student who has completed the undergraduate curriculum successfully), needs to have the following core characteristics and qualities:**
- 2.3.1 The graduate student must have a sound knowledge and understanding of health care, the promotion thereof and of the prevention and management of disease. For this purpose, knowledge of the normal structure, functions and development of a person as a whole and as an individual within the context of the family and the community is required. The graduate student must also have a well-founded knowledge of diseases and pathological processes as the basis of clinical medicine. The doctor must have an understanding of medical scientific principles and be capable of medical problem-solving and decision-making. He or she must be able to use medical scientific terminology with confidence.
 - 2.3.2 The doctor must be proficient in basic clinical skills, including the ability to take a history, perform a physical examination and assess a patient's mental state, interpret the findings, diagnose and treat diseases, prevent disease and promote health. Professional reasoning and problem-solving should be an integral part of clinical practice.
 - 2.3.3 The doctor must be able to utilise diagnostic aids, as well as the services of professionals allied to medicine, and to work as a member of a team to the advantage of the patient in rendering health services.
 - 2.3.4 The doctor must have appropriate attitudes and behaviour patterns to ensure quality health care. Commitment to health care and a responsibility with regard to the physical, mental and social well-being of the community must be characteristic of the graduate student. He or she must recognise the importance of primary health care and of a community-orientated approach to health care. An attitude of lifelong learning must be established. The doctor must have the ability to take independent medical decisions with due consideration of ethical aspects.
 - 2.3.5 The doctor must be sensitive to and acquire the necessary knowledge and understanding to be aware of the health needs of the country. Doctors must be equipped through relevant education and training to serve communities optimally, but their education and training must also satisfy international standards of excellence.

- 2.4 In summary, doctors should thus promote health, prevent and treat illness and injury, and provide appropriate care. They should treat disease and palliate suffering with empathy and within ethical norms and guidelines. Doctors should also be effective managers of health, they must render a service as members of a health team, act as advocates for their patients and communities, be able to communicate well, be critical thinkers and practitioners who apply social and behavioural sciences and be well-motivated, lifelong learners.

University of Cape Town