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The Experience of Students in the South African-Cuban Medical
Training Program: An encounter with medical pluralism

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Abstract

The Cuban Medical Training program is an initiative that provides bursaries to international students from disadvantaged backgrounds. Understanding the experiences of South African participants, particularly those who complete their transitional component at University of Cape Town (UCT), and how they are prepared to meet the aims of the South African-Cuban Medical Training Program (SACMTP), the needs of their local communities, and ultimately, the needs of the South African health system, is the focus of my research. In this thesis, my aim is to describe their training experiences, which demonstrate that while biomedicine is often conceptualized in medical anthropology as a system dominating other medical traditions within medically plural societies, it is itself, a plural tradition. Doctors, who represent just one type of healer in the biomedical tradition, vary in the models they use to understand and manage illness. Therefore, medical professionalization processes which aim to introduce students to dominant practices within a given context also vary. Raising these issues, this paper will highlight the challenges and potential benefits that medical pluralism poses for the SACMTP, and expand current ideas around medical pluralism in medical anthropology.

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Chapter 1: Introduction

In 2002, several students from five South African provinces boarded a plane destined for Havana, Cuba. Upon arrival they boarded a bus, and traveled several more hours to Santa Clara in Villa Clara province. Nthando, one of the students, opened her eyes in the early hours of the morning as the bus slowed to a stop. Lifting her head slightly, she peered over the window sill. As her eyes adjusted to the dim light she saw a modest building and thought, “this can’t be the place.” “We’re probably just taking a break or something.” Nthando’s thoughts were interrupted by the jostling of students who had begun to exit the bus. Still tired from the long journey, Nthando sluggishly rose and went to join her mates. Stepping outside, she saw a number of Cuban officials, including doctors, a diplomat and medical school lecturers. At this point Nthando realized “this is it.” This is the place where she would begin her medical career, and be prepared to improve the health of her country, South Africa. The officials, she said, were “so welcoming,” and she was impressed that so many would rise at an early hour to greet her and the other students. This tone of acceptance continued throughout the duration of her medical training in Cuba.

Nthando is one of a group of students who formed the second cohort of South African students to attend a six year Cuban medical school program. The Cuban Medical Training program is an initiative that provides bursaries to international students from disadvantaged backgrounds. The aim of the program is to educate young people from under-served areas, to increase the representation of disadvantaged persons in medicine, and to improve health care access in their respective communities (Reed 2008). The aim of the South African component, in addition to the aforementioned objectives, is to contribute to the South African Department of Health’s efforts to shift from the curative approach of the biomedical model to the holistic primary health care (PHC) model (DOH 1999). Cuba cooperates with governments around the world including South Africa, the United States of America, and several African, Caribbean, and Latin American countries, to recruit students for this program.

My interest in this program stems from my personal background. Partly due to being an African-American woman from a US inner city, I am acutely aware of health disparities, the shortage of

African-American doctors, and the challenges that unequally educated and economically disadvantaged black students face in their efforts to gain admittance and pay fees to US medical schools. I was intrigued by Cuba's extension of the program to America and the ability for the two nations to cooperate to sustain US student participation in spite of the political tensions related to the US Blockade on Cuba, and the countries' different health care models. Doctors use the Primary Health Care model in Cuba, while most doctors in the United States draw on biomedical models that tend to exclude the social underpinning of illness. The program therefore is an exercise of non-traditional, sustainable health development, and international diplomacy. It is also an exercise of negotiating plural medical traditions.

When I discovered South Africa's involvement in the Cuban Training Program, I began to pursue the research topic to understand the intricacies of the South African experience, Understanding the experiences of South African participants, particularly those who complete their transitional component at University of Cape Town (UCT), and how they are prepared to meet the aims of the South African-Cuban Medical Training Program (SACMTP), the needs of their local communities, and ultimately, the needs of the South African health system, eventually became the focus of my research. In this thesis, my aim is to describe their training experiences, which demonstrate that while biomedicine is often conceptualized in medical anthropology as a system dominating other medical traditions within medically plural societies, it is itself, a plural tradition. Doctors, who represent just one type of healer in the biomedical tradition, vary in the models they use to understand and manage illness. Therefore, medical professionalization processes, which aim to introduce students to dominant practices within a given context, also vary. Raising these issues, this paper will highlight the challenges and potential benefits that medical pluralism poses for the SACMTP, and expand current ideas around medical pluralism in medical anthropology. The later aim of discussing the biomedical diversity as it relates to medical pluralism is important. Despite the discussion of biomedical diversity and the culture of biomedicine in anthropology generally, it is emphasized less in medical pluralism discussions particularly. Since medical pluralism addresses issues of conflict, inclusion and difference with regards to different health models, it is valuable to address internal biomedical diversity within a discussion about medical pluralism.

Background

South Africa's participation in the Cuban Medical Training Program began in 1997 through a bilateral government agreement, in which South Africa and Cuba formed an educational initiative that aimed to address the physician shortage in rural South Africa (Reed 2008:49). Cuban doctors would staff rural clinics while South African students would go to Cuba to receive medical education. The medical training component focused on "recruiting primarily black and disadvantaged high school graduates for medical training in Cuba," because they are underrepresented in medicine. There is also hope that they help alleviate doctor shortages by working in rural, sparsely staffed regions of South Africa. These students receive a bursary, which fully funds them to attend a medical school in Cuba. In return, the students must commit to serving in a disadvantaged community when they return to South Africa. The length of the service should at least be the equivalent of the time that the student spent training in Cuba, five to six years (Reed 2008:49). The agreement has existed for over ten years and there are over 400 students and 88 graduates (Reed 2008).

Despite its relatively short life span, the program is couched in a long history of political interactions between pre and post-apartheid South Africa and Cuba. Early interactions between the two countries began in the 1980's when the anti-apartheid struggle and other African resistance struggles were at their height. Along with Angolan and Namibian anti-colonial forces, Cuba aided the African National Congress (ANC) of South Africa. Assistance came in the form of medical aid, military training, and combat. The climax to Cuba's participation came in 1988 when the Cuban army, allied with the Angolan Army, successfully resisted apartheid South Africa's army in Cuito Cuanavale, Angola. This was a momentous point in Southern African resistance efforts that is still celebrated by the Cuban Diplomats in South Africa today.

These events established a strong political relationship between Cuba and the ANC members who would soon rise to government positions in post apartheid South Africa (De Vos, De Ceukelaire, Bonet, Van der Stuyft 2007:761). In the years following the end of National Party rule in the country, the opportunity for formal political cooperation and initiation of a bilateral agreement became possible.

At the time when the bilateral agreement was signed, the South African health system had a number of issues that needed to be addressed. First, the apartheid government had “prioritized resources” toward a medical approach that did not meet the needs of the non-white population (Blunden 2008:6). The ANC identified a consequent need for equality in both the distribution of health care resources and the provision of healthcare access (Gilbert, Selikow, Walker 1996: 101). Second, health care was mainly curative and did not place enough emphasis on preventive measures such as nutrition, housing and sanitation improvements (Blunden 2008:6). Yet these were significant factors contributing to healthcare issues in marginalized communities. Thus, a different approach to public health issues, one along the lines of a biopsychosocial approach which considers psychosocial, economic, and environmental determinants of health, needed to be adopted. To begin addressing the above issues, “the Government of National Unity adopted a primary health care (PHC) philosophy” (Blunden 2008:6). The primary health care (PHC) approach “looks beyond the curative biomedical framework,” (Hardon 2001:55) and aims to address all contributions to poor health including, social, environmental, and economic issues (Hardon 2001:55). The ANC particularly emphasized collaboration between and “commitment from communities, health and allied workers, health policy makers, health service managers and the broad range of health-related sectors (education, sanitation, water supply, electrification, finance, agriculture, small business, development, etc.) as a central component to successfully implementing PHC (Gilbert, Selikow & Walker 1996:181). This element of inter-sectoral cooperation and commitment is similar to Cuba’s approach to implementing PHC.

A third issue needing attention was the health provider shortage in the public sector. Many providers were working in the private sector. Another cause was the emigration of providers to other countries. One-third to one-half of medical graduates emigrate (Huish 2008:3). This combination led to a great shortage which has persisted. In 2005 there were almost 46,000 public sector vacancies (Reed, Torres 2008:49). In the particular provinces of Mpumalanga, the Northern Cape and the Eastern Cape, where many SACMTP students come from, there were doctor vacancies at rates of 38.5%, 53.4%, and 36.1% respectively. (Reed, Torres 2008:49).

Cuba was viewed as a viable partner to assist in addressing the three aforementioned issues for the following reasons. Cuba is a country that also adopted the primary health care approach during a political transition in order to improve health provision and health access; the system focuses on both “preventive and curative services” (Blunden 2008:6); Cuba has the capacity to assist with the doctor shortage, since, with one physician for every 120 persons, Cuba has more physicians per capita than many “developed” nations; many Cuban doctors have committed to providing medical assistance to the international community (Huish 2007); and finally, Cuba has the space to train South African students at its medical schools.

Today, seventeen years since the end of apartheid and adoption of policy provisions, some changes have been made to South Africa’s health system. However, it is still mainly curative based because the burden of disease necessitates devotion of resources to illness treatment. This presents a challenge for the Cuban students who were trained within a model that prioritizes prevention. However, as they meet these medical challenges, they do so with an intelligent understanding of the administrative challenges and social determinants of health in South Africa, a plan to address these determinants, and an active hope that they can still meet the goals of the program. Thus, they remain confident that they can fulfill what they have been taught is the role of the doctor and the goal of the program: to serve the disadvantaged, practice PHC, and improve health care in South Africa.

The use of Cuban doctors in South Africa is viewed as a temporary solution. The ultimate goal is to have a sufficient number of South African doctors. However, there is controversy over whether the use of Cuban doctors and the training of South Africans in Cuban medical schools is the appropriate way to address shortages. While debates ensue, the education program continues.

The educational component of the bilateral agreement allows for the allocation of sixty medical education bursaries to South Africa students each year (Reed, Torres 2008:49). These students begin their studies at Villa Clara, where they study Spanish and basic sciences (Reed 2008:49). The next three years are spent at one of Cuba’s medical schools. In their final year, they return to South Africa to reintegrate into the country’s health setting (Reed 2009). Reintegration

consists of a one to two year placement at one of four South African medical institutions. With the provision of this program, there is a professed hope that young South Africans will contribute to the alleviation of the doctor shortage and improvement of health care in South Africa.

Literature Review

Medical pluralism is a concept widely used in medical anthropology. It suggests that in certain contexts, there exist multiple modes of understanding and managing health and illness. The existence of these multiple perspectives can lead to collaboration, conflict, exclusion and competition amongst practitioners. Through explorations of medical pluralism, medical anthropology narrates and theorizes about these interactions. Therefore, exploring the SACMTP student experiences and the way in which they exemplify internal biomedical diversity within the medical pluralism framework, serves two purposes. One it is a helpful tool to understand SACMTP student experiences. Two, it is a way to contribute to a body of research, medical pluralism, that significantly impacts discussions about interactions between different medical models.

Cecil Helman is a preeminent anthropologist who writes about medical pluralism. Helman (1984/2007), following Arthur Kleinman (1980), outlines three sectors of healthcare in society as a way of conceptualizing medical pluralism. The sectors include the popular sector, the folk sector, and the professional sector. The popular sector is the “lay, non-professional, non-specialist domain of society where ill health is first recognized” (Helman 1984/2007:82). Within this sector, an ill person will either self treat or seek recommendations from family, friends or acquaintances.

The folk sector consists of healers. This sector according to Helman (1984/2007: 84), is quite heterogeneous and may include herbalists, spiritual healers, shaman other types of healers. Healers typically are not organized into formal associations. However, professionalization of healers is beginning to be considered in many countries such as India and China, and including South Africa (Freeman & Motsei, 1992).

The professional sector consists of “organized, legally sanctioned healing professions” (Helman 1984/2007:94). Helman (1984/2007) uses biomedicine as an example because in most countries it “forms the basis” of the professional sector (94). It is important to make a distinction between biomedicine as a system or tradition, and the biomedical model. In this thesis I discuss the biomedical tradition which consists of doctors, nurses and other allied health professionals. I also discuss the biomedical model, which is one of many medical models used in the biomedical tradition. The biomedical model “keeps health in the biological context (Gilbert, Selikow, & Walker 1996:5). The cause of illness is attributed to a specific biological etiology; the nature of intervention is curative medical treatment and “medical knowledge is sufficient” to address the illness; and the view of the patient emphasizes the patient’s body as “passive during treatment” (5).

Regarding the three health sectors, Helman contends that each has its own way of understanding and managing illness. He further suggests that within each sector, particular practitioners have different ways of approaching illness. Within the professional sector for example, doctors and paramedical professionals (nurses, physiotherapists, etc) have unique bodies of knowledge (Helman 1984/2007:98). He also recognizes that doctors alone, have various specialties and varying ideologies.

The health sector model has been applied extensively in medical anthropology and particularly in studies of medical pluralism. While Kleinman (1980) and Helman (1984/2007) suggested that there is variation between and within sectors, much of the work that has followed focuses more on pluralism between sectors, and the ways in which people navigate health seeking practices. Thus, while there is great diversity within sectors and specifically within professions, as my study of SACMTP will illuminate, it is explored less often. I argue that there is pluralism within the professional biomedical sector and that one way in which this plurality is demonstrated is by different models of understanding illness. The two models that I draw attention to in thesis are the biomedical model and the Primary Health Care model.

There has been a trend towards comparing and contrasting the professional sectors where biomedicine is dominant in relation to folk sectors (Baer 1997:214). Baer, Singer and Susser

(1997) for example, explore “biomedical hegemony in the context of medical pluralism.” They claim that “biomedicine attempts to control the production of health care specialists, define their knowledge base, dominate the medical division of labor, eliminate or narrowly restrict the practices of alternative practitioners, and deny lay people and alternative healers access to medical technology. They discuss biomedicine in contrast to other healing systems, and highlight resistance to biomedicine’s dominance (215). Particular attention is given to biomedical practice compared to shamanism and indigenous healing systems. Citing the work of Leslie (1978) who delineates the various systems in India, they demonstrate how these systems maintain significance in societies in spite of biomedicine’s dominant presence. This approach of discussing the hegemony of biomedicine relative to other traditions in a plural society is common.

For example, Judith Fadlon (2005) investigates the way in which alternative medicine is integrated into Israel’s medical context. She contends that in an effort to negotiate a place in the system, NCM ultimately is “incorporated, appropriated, and tamed (Fadlon 2005:117). This process according to Fadlon, illuminates the hegemony of biomedicine in this plural setting.

Steve Ferzacca (2001) compares biomedicine and traditional medicine on Java, an Indonesian Island. He reveals that in this context, biomedicine and traditional practices complement each other. His study provides an insight that deviates from the standard oppressive portrayal of biomedicine. However it still represents a body of research that does not explore diversity within biomedicine.

Biomedical critiques are valuable because they help us understand why medical models, particularly biomedicine, become dominant, and how dominance impacts alternative medical practices. This is particularly relevant in the South African and UCT contexts where there are attempts to introduce an alternative model, primary health care. However, while critiques of medical pluralism and biomedicine are accurate, they are incomplete because they tend to neglect the variation in practices and opinions within biomedicine itself. They also sometimes unjustly stigmatize biomedical practitioners. Finkler, based on ethnographic work in 1985 and 1991 with doctors and spiritualist healers in Mexico, found that doctors spend twice as much

time with patients, as compared to regional traditional healers (Finkler 1998:123). This is contrary to the common perception of doctors who are often characterized as spending little time with patients.

There are ethnographies that highlight pluralism within medical traditions. Kleinman (1989) for example, in *Illness Narratives*, illuminates the varying perspectives that doctors hold throughout the text. He then devotes an entire chapter to what he calls, “the varieties of experiences in doctoring” (Kleinman, 1989). The doctors in this chapter implement and appreciate preventive and traditional medical ideologies. This demonstrates that the narrow perception of doctors as being focused on the curative, biomedical model is inaccurate. Without consideration that pluralism exists both between and within healing traditions, these realities of biomedical practice will not be revealed. Davenport (2000) and Chin (2008), Kumpsalo (2009) are more recent examples of ethnographers that exemplify the diversity in ideologies and approaches that exist in biomedicine through their study of students and doctor respectively.

Oliver Human, (2009) in a paper presented at a Sawyer Seminar at University of Cape Town, depicts experiences of two South African doctors. He describes the way in which the two doctors deviate from or break medical protocols under certain conditions. This occurs when they felt that experience more than protocol, should inform their diagnosis. His discussion illuminates the varying ways in which biomedical doctors approach illness, and a blending with other types of healing. Explaining or understanding this overlap is challenging within medical pluralism discussion, in which there are strict divisions or boundaries between sectors.

Medical anthropology’s critique of medical pluralism is a useful framework to understand the program. It theorizes about dominance of biomedicine between sectors and can contribute to understanding of dominance of certain models within biomedicine. It is limiting in that the critiques usually emphasize pluralism between sectors rather than within. This trend is particularly poignant in discussions in which biomedical hegemony relative to other medical traditions is explored. Despite this trend, the medical pluralism framework remains useful. Therefore, I use current medical pluralism critiques to analyze the experiences of SACMTP

students, and likewise present these experiences as evidence that intra-sector pluralism exists and should be further explored in medical anthropology's discussions of medical pluralism.

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Chapter Two: Research Methodology

The SACMTP is an education program that is political and international. As such, my research process involved navigating political complexities of the program that shaped my access to the field, and engaging with students to understand their experiences in two international settings amidst plural medical perspectives. In this chapter I present the challenges to field access and implementation of my proposal, management of those challenges, and the methods that informed my understanding of student experiences in Cuba and South Africa. .

Initial Proposal

The initial proposal for this research in 2009 outlined a project for which the primary field site would be a Cuban medical school where South African students were in the midst of training. Background research for such a proposal involved contacting Cuban medical school administrators, contacting Cuban medical school students from South Africa and abroad, and seeking approval from the national governments of three countries that would have an interest in my travel to and research in Cuba. Those countries were Cuba, South Africa, and the United States, my country of citizenship. It was in my interactions with US and South African government officials that I first became aware of the difficult nature of this ethnographic study.

I found the Cuban government officials, foreign Cuban medical students, and Cuban doctors to be outstandingly responsive to and supportive of my research proposal. I began seeking contact with these persons by joining Facebook groups associated with Cuban medical schools. Through this process, I was able to identify students and administrators.

During this preliminary research period, I also met the Cuban Ambassador to South Africa. After a lecture given by the ambassador, at the University of the Western Cape, I spoke with him and got a very positive response. He took an interest in facilitating my introduction to authorities whose approval was crucial to my initiation of the project in Cuba. I remained in touch with the Cuban Ambassador and the Cuban embassy in South Africa, through email correspondence, and occasional meetings with diplomats that served to sustain our relationship. During this time, they assisted me with forwarding my proposal to the Cuban Ministry of Health. Following

deliberation, their final response was that if I could get the support of the South African government, they would be happy to assist me with my project. At this point considering the responsiveness and ease with which I was able to identify and engage with Cuban officials in various sectors of government and medical institutions, I realized that the greatest challenge to my travel would not come from Cuba but likely, from my countries of temporary and permanent residence, South Africa and America. By that time, my hunt for two elusive documents, a letter of support from the South African Department of Health (SADOH) and a travel license from the US Treasury Department, which would grant me access to Cuba, had already begun. I had not yet been able to converse with any officials from either government. The challenge with the SADOH was getting my proposal into the hands of the Human Resource Director. I emailed it to him and his personal assistant (PA), and sent a hard copy by post mail. Based on an update from his PA and another SADOH employee, the proposal remained on his desk for a number of weeks. Unfortunately, I never got a response. Without his approval, other SADOH personnel were not comfortable speaking with me. So I never got the support or perspective from the SADOH, both of which I felt were important whether I travelled to Cuba or not.

The challenge with the US Treasury Department stemmed from identity criteria and national and institutional affiliations. US citizens are not allowed to travel to Cuba unless they acquire a license. For purposes of research or professional obligations, a person affiliated with a US institution may obtain a travel license. As a degree seeking student at the University of Cape Town, I was ineligible to apply, and legally bound to the global space that surrounds Cuba. I felt stranded by my lack of freedom, and frustratingly aware of the irony that lied in the fact that citizenship of a 'free' country restricted my travel freedom.

A New Proposal

Since travel to Cuba was not feasible I had to adjust my project. Instead of conducting ethnography with students in Cuba, I considered working with recently returning Cuban trained students. Upon completion of studies in Cuba, South African students spend one to two years at one of six South African medical schools. University of Cape Town is one of those schools. I had already begun an initiative to identify South African program participants in Cuba, and those

who had returned to South Africa. At this juncture I began to increase my focus on identifying those who had returned and were then completing their undergraduate training at UCT.

Recruitment

I was introduced to two SACMTP students by a UCT administrator. One student in particular, organized a focus group, through which I met the remaining Cuban trained students. They also assisted me in identifying other key informants who included program participants who had graduated or were studying at other South African institutions. Additionally, they assisted me in identifying opportunities to conduct participant observation while they were in clinic or lectures. While these students were keen about participant observation, certain administrators were not. For that reason, obtaining field site access was challenging.

Field Site and Document Access

Field site access in Cuba was an issue of mainly politics. Field site access at UCT was an issue of biomedical ethics and likely politics as well. I had planned to employ participant observation, interviews and focus groups. What made field site access at UCT an issue is that Cuban trained students are in their final years of medical study. At this stage, medical students spend the majority of their time in clinical contexts in the presence of or engaging directly with patients. Therefore, my presence as a researcher elicited a reasonable concern about patient privacy, from medical school officials. However, I believe that interest in patient privacy was not the sole reason for disapproval of my proposal to conduct participant observation while students were in clinic.

UCT is a research institution where social science researchers frequently spend time in teaching hospitals and clinics, and even engage directly with patients. Furthermore, having completed a full UCT 6th year surgical block as an exchange “pre-medical” student and worked as a researcher at a UCT teaching hospital in 2005, I directly witnessed a host of researchers, social scientists, exchange students, medical students, non-medical students, and volunteers welcomed into the clinical setting for the purposes of research, training and patient assistance. Ethical guidelines have been designed for such occasions as those mentioned above. So unpreparedness for, unfamiliarity with or even disapproval of the presence of non-medical professionals and

students may not have been the only reason for rejecting participant observation. I would conjecture that another concern for administrators besides patient privacy, was the protection of the Cuban trained students.

A great deal of debate surrounds the SA-Cuba Medical Program, creating a stigma in South Africa about the student and Cuban doctor participants. The students are sometimes unable to escape this stigma even at their respective South African 'home' institution, UCT. While I was prepared through logistical planning and extensive experience in the UCT health sciences setting to discreetly navigate through ward rounds and other clinical activities, given the atmosphere surrounding the program, administrators' concern was understandable. Nevertheless, it illuminates one of two politically related challenges to accessing the field.

A second politically related challenge hindered my access to the field. That challenge stemmed from my own relationship with UCT health sciences and the SA-Cuba Training Program. I am a medical anthropologist, and anthropologists typically gain access to their site through relationship with key leaders of a certain site. As a student, without the support of Department of Health, and not commissioned by any group to conduct research, incentive to assist my efforts was minimal.

Overall, there seems to be a shroud of secrecy and protection that surrounds the SA-Cuba Training Program. Those who play a role in the program were hesitant to speak about it. I conjecture that this is a result of the political sensitivities that result from it being the product of a political agreement and from the fact that the many constituents of the South African medical fraternity seem to be dissatisfied with both aspects of the program. Those aspects are one, Cuban national doctor presence in South Africa and two, medical training of South Africans in Cuba. The consequence of such sensitivity and consequent secrecy has been a lack of transparency and monitoring. There is no public site to get information about the program or its administrators, and when I called to secure such information from the Department of Health, employees seemed hesitant and sometimes scared to respond. On one occasion I called a SADOH representative whose contact details had been provided on public statement regarding the Cuban Training Program. At the outset of our conversation he asked me if I was recording him and then accused

me of being dishonest. He repeatedly stated, “you are recording me, just admit it.” Needless to say, I never got the information that I was looking for. This inability to acquire information about exactly who is involved with the program, who administers it, and how it has progressed was a persistent trend throughout the duration of my research and fieldwork. Nevertheless, I managed to navigate the access issues that arose from many of these challenges.

Simulating the Field through Focus Groups, Interviews, and Participant Diaries

In the absence of the ability to be physically present in some aspects of the research field, I engaged methods to either simulate the field during times that I was with students, or to engage with the field vicariously through the students. The two fields that had to be simulated or experienced vicariously were Cuba and UCT clinical learning facilities. I found that overall, focus groups were the optimal way to simulate both the Cuban and UCT clinical fields. During focus groups the students would communicate with each other in Spanish and English, creating the sounds and language of the Cuban field. They would also recount a wide range of experiences eliciting memories of food, clothing, medical facilities, streets, and social arenas. During this time, fervour would fill the room as memorable experiences were recalled and re-lived through stories. After these initial casual discussions, our conversations typically transitioned to the academic aspects of their experiences in Cuba.

To simulate the UCT field, focus groups again were incredibly helpful. The telling of stories in a group setting where the students could reflect ideas and contribute various components of the UCT clinical experience to the discussion, seemed to create a composite sensation of what it is like to walk through the halls and engage with faculty and students in the examining and patient rooms of UCT teaching hospitals.

In addition to focus groups, when doing interviews, I would conduct them in a wide range of locations. They were often conducted in the students’ homes. However, on other occasions individual students and I would meet at UCT medical school, and in hospital break rooms and lunch facilities. In this way, the sights, sounds, and images of the hospital were present to elicit responses to stimuli, ideas and memories that are similar to clinical experiences.

On some occasions, we would simply walk together on the grounds of the hospital or medical school, allowing the students to acclimate me to their vision of UCT Health Science facilities.

Another method that I employed was the participant diary. I provided two participants with diaries in which they recorded their daily activities and experiences, as well as any other information that they wished to share. I provided no instructions other than a request for them to include thoughts and experiences that they found to be relevant. Of these two participants, one continued with diary writing. At our meetings, he would relay information that he had recorded in his diary.

Zimmerman and Weider (1977) recommend a similar method called the “diary-interview method,” for ethnographic situations where “problems of direct observation resist solution” (481). Access to their research field was challenging because their participants according to Zimmerman and Weider (1977), engaged in “diffusely organized activities, at different times and places throughout the day and into the night” (482). So they provided participants with diaries with the intention of it serving as “an observational log maintained by subjects which can then be used as a basis for intensive interviewing” (Zimmer & Weider 1977:481). In this way, observations of the field can be made and analyzed, even in the absence of the primary researcher.

Immersion in the Field

Since the students spent the majority of their time in clinic, I spent the greater portion of the day on my own. During this time, I tried to maximize my exposure to the facilities that they spent their time in. While at the medical school, I would study in the Health Sciences library and eat in the cafeteria. While at Red Cross and Groote Schuur Hospitals, I would use the hospital libraries, attend academic lectures with students or alone, meet with doctors and researchers, and have lunch with friends who were working as doctors or medical students at the hospitals. In engaging in these activities I hoped to immerse myself in the students’ environment and have opportunities to casually engage with them in the same way that their peers and supervisors do. This method proved effective, as there were ample occasions during which I engaged with both UCT and Cuban trained students.

Personal Reflections

As a researcher, it is important to remain cognisant of the way in which one's own experiences and characteristics influence one's engagement with the field. Four factors directly impacted my engagement with the field and the participants. These factors are my relationship to the field as a UCT student, my foreign status as an American, my race as a Black person, and previous experience as an exchange student at UCT medical school.

Traditionally, anthropologists have conducted ethnography away from home (Ferguson & Gupta 1997:24). There began a call which has continued, to recognize the value of alternative, local ethnographic fields (Ferguson 1997:25). As a resident of Cape Town and UCT student, I was indeed conducting ethnography at home. This challenges traditional notions of what a "proper" field site is (Ferguson & Gupta 1997:2). There are pros and cons to this type of research. It certainly required me to consciously engage my ethnographer status. For it was easy to move about UCT medical and main campuses as a simple UCT student. On the other hand, familiarity with and 'membership' in the environment gave me access that an average researcher may struggle to obtain. I have a UCT student card which allowed access to the medical school, medical library, and hospitals without question. Further, I am familiar with the landscape which allowed me to navigate the terrain without being questioned or even noticed.

As a foreign student, I could identify with many experiences that Cuban students have upon return from Cuba. Foreign students are often identified as foreign by language. For them it is Spanish; for me it is American English. While similar experiences allowed me to immediately identify with many of their experiences, I had to be cautious. I could not allow myself to make too many assumptions about their experience as "foreigners," based on my own. In addition, I had to allow myself to read their stories from the perspective of a researcher, not just an empathizer or peer.

As a black woman, I could again, identify with some racial encounters that students experienced. Further, some students may have felt more comfortable talking with me about issues of race. However, I had to again be cautious not to assume too much based on our similarities. My race may have also granted me greater access. I find that in Cape Town and indeed at UCT, my

colour stands out more than my accent. So before I speak, people assume that I am South African, and even after I speak some do not notice my accent. So as I moved through the medical school and hospitals, I was rarely identified as someone who does not belong.

Having spent time as an exchange student in the faculty of health sciences, I was again granted a degree of access. I am very familiar with Red Cross Hospital and Groote Schuur Hospital. I have established relationships with various employees of all professions at these facilities. So while access was a challenge from the medical school and the SADOH, it was less of a challenge at the hospitals. Some hospital employees were instrumental in helping me contact informants and accessing curriculum documents.

Each of my personal characteristics and experiences were helpful in my engagement with students and in permitting mobility in the field site. While some ethnographers feel the need to “display social characteristics, attitudes, and comportment similar or congenial to those they observe,” this was an effort that was largely avoidable because I am the same age and race, and have some similar experiences to my participants and indeed other medical students in the UCT context (Zimmerman & Weider 1977:479). For instance, it may have been difficult for a forty year old, male researcher of any race to blend in with a group of young medical students in a lecture hall.

Limitations

Not being able to engage in participant observation in the clinic was certainly a limitation. Not having any support from SADOH or consistent support from the medical school was also a limitation. It made getting information quite challenging. However, while their lack of support was limiting it was also telling of some of the issues, such as transparency, associated with the program.

Another limitation was that one of the Cuban trained students at UCT did not participate in the study. While he expressed an interest in participating, we never managed to coordinate an interview, and he did not attend any focus groups. So that is one less perspective that was contributed to the study.

Ethical Concerns

Throughout this research, it was my priority to protect the rights, privacy and dignity of participants and other informants who contributed to the study. As a post graduate student in the Department of Social Anthropology at the University of Cape Town (UCT), it was my obligation to employ the UCT Code for Research involving Human Subjects and the UCT Statement of Values at each aspect of the research process. Further, the ethical guidelines espoused by professional organizations such as the Association of Social Anthropologists of the UK and Commonwealth and the American Anthropological Association were considered.

The participants were provided with an informed consent (see appendix). The informed consent outlined the objectives of the study and participants' rights. I was particularly diligent about conveying that participation was voluntary, could be terminated at any time, and that great lengths would be taken to protect their privacy.

To ensure privacy is maintained in this thesis, I have changed the names of the participants. Each pseudonym is a male name. The reason is that of the seven students just two are female. So using female names in this thesis could potentially compromise the identity of the women participants.

Many groups, including students, physicians, researchers, and institutions were to some degree involved in this research study. The privacy protection procedures were developed with consideration of the various ethical issues that could arise during the course of the study. Those ethical concerns that were relevant to each group involved, is briefly discussed below.

Students and Graduates

Students and doctors were the primary participants in this study. They engaged in extensive discussions with me. During such discussions positive, negative, and personal and emotionally driven narratives surfaced. So it is important to protect participants' identity for a number of reasons. First, participants may not want their personal perspectives and experiences to be revealed to their peers, instructors, supervisors or the public. Second, students are financially

supported and academically evaluated by both South African and Cuban medical and academic institutions. Therefore, students may feel concern about potential repercussions of making statements that reflect negatively on those institutions. Fourth, students and physicians have spent significant time in Cuban and South African medical contexts, building relationships with peers, professors, supervisors and lay persons. As such, there may be concern about the impact of their statements on their relationships. Finally, there are debates in the public, media, and medical profession regarding the value of the Cuba Training Program. Thus, protection of participant identity will shield those who wish to remain uninvolved in such debates.

South African Ministry of Health and Cuban Ministry of Public Health

The Ministries of Health and Public Health have established a relationship through Medical Cooperative initiatives, such as the medical training program. As I engaged in research and writing, I strove to be conscious of their interest in protecting this relationship. Further, I extended the same privacy protection rights to those informants related to or within these institutions.

Other informants (ie. professors, academic or administrators, and doctors)

Like the students and graduates, other informants have relationships and commitments, which can be impacted by their statements or provided information. Therefore, for those who desired to protect their identity, the same privacy protection procedures outlined in the consent form, were implemented.

Chapter 3: Professionalization Experiences and Translating Theory to Practice

Anthropology has a rich history of examining medical training with particular focus on traditional healers. Evans Pritchard (1976) and Paul Stoller (1987) are among anthropologists who have explored such training. Training or professionalization of biomedical practitioners has not been explored as extensively. Professionalization introduces students to the political economy of health care access, certification programs, professional values, and illness explanatory models. SACMTP students go through professionalization as do students around the world, but their experience is unique in that they train in two international locations. The training institutions are embedded in different cultural, political, and economic contexts which uniquely shape local medical practice and consequently medical training. Thus, SACMTP students encounter varying professionalization processes that shape and challenge their understanding of the doctor's role. Some aspects of professionalization that significantly impacted students' understanding of the doctor's role were Cuban and UCT medical school curriculums, the rhetoric conveyed through SACMTP, and the Cuban concept of the Revolutionary Doctor.

In this chapter, I discuss the professionalization experience, how it shapes SACMTP students' theoretical understanding of the doctor's role, and their stories of translating theory into practice in Cuba and South Africa. Through the discussion I illuminate plurality of biomedicine between and within contexts. I achieve this by relaying student encounters with two different medical models during professionalization into the biomedical tradition. These models are the primary health care model and the biomedical model. Joralomen's (1999) discussion of how particular ways of understanding dominate within a plural medical system is helpful in understanding SACMTP students' experience. He suggests that dominance is dependent on a model achieving social or cultural authority in that society. He also demonstrates that practitioners of non-dominant models sometimes experience barriers to practice and other consequences. For instance, he discusses how in Peru, the Curandero tradition is marginalized and the biomedical tradition, which has social authority, is dominant (Joralomen 1999:67). In doing so, he highlights the medical plurality in that society. He does not discuss the plurality and dominance of particular models within the Curandero or biomedical traditions. Nevertheless, his critique is

helpful to the SACMTP case. By applying his perspective on the influence of social and cultural authority and challenges for those using the non-dominant model, to the SACMTP case, I demonstrate that plurality exists not only between traditions, but also within medical traditions, and in particular within the biomedical tradition. Additionally, I conjecture why particular models within the plural biomedical tradition dominate.

Professionalization Processes and Understanding the Doctor's Role

The Curriculums

The biomedical model has and continues to dominate biomedicine. However, discussions in the 1970's among healthcare stakeholders such as practitioners, medical institutions, and international health bodies, introduced alternative models for biomedicine to consider. In 1977, George Engel, an American psychiatrist, criticized the biomedical model and highlighted the value of the biopsychosocial model. His article had a widespread impact, placing "the biopsychosocial model firmly on the undergraduate teaching agenda of the world's medical schools" (Shorter, 2005:6). In 1978, at a gathering in Alma Alta, currently known as Kazakhstan, the World Health Organization (WHO) entertained the biopsychosocial approach through its promotion of Primary Health Care. The result of the gathering was the Alma Alta declaration which defined health as "a state of complete physical, mental and social well being, and not merely the absence of disease or infirmity" (WHO 1978:2). The WHO further stated that it "is a human right and that the attainment of the highest possible level of health is a most important worldwide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector" (WHO 1978:2). These are two primary examples of occurrences that spurred the medical profession in the late 1970's to incorporate PHC into training and practice. Despite acceptance of PHC and other alternative perspectives in global health institutions and many medical schools, translation into practice has been challenging (Kleinman, 1981). Nevertheless, medical schools continue to shape their curriculums in ways that deviate from traditional, biomedical approaches (Draper, 2005) (Irlam, 2009).

Cuban medical schools and University of Cape Town's medical school are among those international institutions which have attempted to broaden medical practice by introducing PHC.

Cuba had already begun to implement primary health care in 1959 and made improvements in the 1980's (Suarez, Sacasas, Garcia, 2008). I refer broadly to the Cuban curriculum because Cuba has a national standardized medical school curriculum which is designed by the Ministry of Health and implemented at every medical school throughout the country. South Africa on the other hand, does not have a standardized medical school curriculum. Rather, each individual medical school creates and implements its own curriculum. The following paragraphs compare and contrast Cuba's national curriculum to University of Cape Town's specific curriculum.

Cuban Curriculum

Cuba's current curriculum is the result of changes that took place in the 1980's, when a commission consisting of medical practitioners and educators, students, and Ministry of Education officials outlined desirable outcomes and roles for medical students and doctors (Suarez, et al. 2008:6). Suarez, et al. (2008) suggests that the changes to Cuban medical education involved making radical shifts and "deepening processes already in motion" (1). This statement likely referred to Cuba's long standing incorporation of PHC, and that this was an effort to expand and improve on methods of teaching PHC in medical schools. Speaking of the commission's outcome, Suarez, et al. (2008) suggest that the commission "agreed that a primary care doctor should be able to:"

- 1) Provide comprehensive medical care to individuals and their families in the context of their social surroundings, through health promotion, disease prevention, diagnosis, treatment and rehabilitation, carried out through a bio-psycho-social-environmental approach based on a primary health care model;
- 2) Carry out research, teaching, and individual study;
- 3) Manage health care programs, facilities, and resources;
- 4) Effectively communicate with patients, their families, and the community to generate participation in building health;
- 5) Apply the scientific method, critically assimilating scientific information; and
- 6) Project humanistic ethical values, including a vocation for service, human solidarity, and commitment to preserving the lives and health of Cubans and others who require their services" (Suarez, et al. 2008:6)

Following the commission's meeting, changes were made to Cuba's medical education curriculum to meet the professed goals for doctors. The resulting curriculum included elements

that provided for a continued strong emphasis on the biopsychosocial approach to medicine.

“The theoretical and practical approaches” applied to the new curriculum included:

- 1) Conceptualization of medicine as a sociobiological science, and of the curriculum as a whole, its contents interwoven to facilitate understanding of real-life processes.
- 2) Introduction of problem-based and other active learning methods, increasing students’ cognitive independence and reducing memorization.
- 3) Increased proportion of epidemiological and public health sciences in the curriculum.
- 4) Introduction of medical skills and basic clinical sciences at an earlier stage in training, with biomedical sciences closely linked to the practice of medicine.
- 5) Improved teaching methods, with emphasis on service learning.
- 6) Creation of Comprehensive General Medicine (Family Medicine) Departments in all medical schools.
- 7) Requiring a passing grade on the practical portion of an exam as a prerequisite to taking the theoretical portion: an approach that emphasizes specific skills to be mastered (Suarez, et al. 2008:6)

The medical education commission desired for doctors to operate through a biopsychosocial primary health care model, giving considerable attention to the social context of patients through health education, disease prevention, and curative and rehabilitative care (Suarez, et al. 2008:6) Commitment to this desired doctor role is made clear in the aforementioned changes. Looking at the actual curriculum (see appendix A), it is possible to see the biopsychosocial influence in classes like Philosophy & Health, Physical Education, History of Cuba, Psychology of Health Care, and Public Health. These classes demonstrate an interest in developing students who are aware of contextual elements that influence health and illness.

University of Cape Town Curriculum

The University of Cape Town’s curriculum, like that of Cuba, has gone through recent changes that have lead to the incorporation of a PHC emphasis. In 2002 the UCT Health Sciences Faculty integrated the PHC approach into the curriculum (Draper, 2005). The UCT “curriculum for the MBChB programme aims to produce a competent doctor with the requisite attitudes, knowledge and skills to enter the health care field with confidence. This programme emphasises a comprehensive approach to health care that entails a balance between preventive, promotive, curative and rehabilitative health care, in a Primary Health Care or community setting. In addition it promotes communication skills, teamwork, professional values and competent clinical

practice, in the context of the Primary, Secondary and Tertiary Health Care systems” (UCT Student Handbook).

In years one through four of the curriculum there are a significant number of “becoming” courses. These include *Becoming a Professional*, *Becoming a Health Professional*, and *Becoming a Doctor*. It is mainly in these courses that UCT students are introduced to primary health care.

During fifth and sixth years, students engage in rotations in a number of departments including obstetrics and gynecology, psychiatry and paediatrics. Considering the student handbook disseminated by the School of Child and Adolescent Health, which organizes the paediatric rotation, it appears that PHC principles continue to be promoted. The handbook outlines specific assignments for which students must engage with tenants of Primary Health Care. This suggests that beyond the fourth year, UCT continues striving to prepare students to provide care that is considerate of contextual factors.

Influence of Curriculums on SACMTP students’ concept of doctor role

According to students, what they learn from the Cuban curriculum and the context in which it is implemented, is that among other things, the doctor’s role is to (1) serve as a collaborator, not a dictator, in patient care and community health promotion, (2) “first prevent and promote,” to avoid the necessity to cure, (3) equally consider the biological, psychological, and social determinants of health in assessment and treatment of patients, and (4) serve the community.

SACMTP students enter UCT in the fifth and sixth year components of the UCT curriculum. By the time students reach UCT, they have a firm concept of the doctor’s role, and that concept incorporates the aforementioned points. At UCT, their encounters with PHC models when promoted in the classroom and espoused by some professors in the clinic, serve to re-affirm its importance to medical practice. These encounters also confirm that there are some professors and administrators at UCT who value ideas about medical practice that resonate with what they learned in Cuba.

Translation from Theory to Practice

On paper, Cuba's and UCT's curriculums look quite similar. The coursework overlaps, both exposing students to biological, chemical and medical sciences, as well as clinical work. Additionally, in each semester, the students engage with non-traditional, however pertinent, medical school coursework that exposes students to contextual issues that influence health and healthcare delivery.

However, my ethnographic data suggests that SACMTP students experience a difference in the degree to which PHC is promoted and practiced in the clinical training settings. In Cuba, PHC and a biopsychosocial theoretically informed practice is implemented by professors and expected of students in the clinical setting. However, at UCT, students experience implementation and acceptance of PHC as inconsistent. SACMTP students often feel they are discouraged from implementing PHC. Yet on some occasions, they feel that PHC is encouraged.

In a conversation that I had with Lungelo, he spoke specifically about experiences in which his attempt to recommend a PHC approach in the care of a patient was rejected by a professor. He believes that he is criticized because “they [some professors] don't understand how we were formed.” He was insinuating that some UCT professors do not understand that SACMTP students are professionalized into medicine within a paradigm that emphasizes prevention and health promotion through PHC and biopsychosocial models.

Vignette

I was in Jooste hospital. I was asked, ‘how do you treat this patient?’ I was taught that you start by treating a patient before you can give medication. You start by saying, ‘I treat by diet; I treat by modifying the lifestyle of this patient.’ You know what the doctor said? ‘I'm not talking about it here, I need a medication!’ But in my case, when I have to face medication, that's my tenth step, because in primary healthcare you start by preventing. You don't treat a disease you treat a patient. If I treat a disease I give an antibiotic and I'm done with it. But if I treat a patient, I treat all the fears of the patient. Hence in Cuba they start, by giving us philosophy. They [UCT lecturers] don't understand why we are given a lot of psychology. It's because those things, they teach us that a human being is a biosocial being, the biological and social factors. You look at those things, not just the biological factors.

One may look at Lungelo's comments and question if treating "all the fears of the patient" is possible. I do not think Lungelo was suggesting that he could literally treat every single fear of the patient. I think he was attempting to point out that only treating a physiological condition, is insufficient. To truly treat a patient, who is a whole person, one must consider psychological and social factors, in addition to the biological concerns. Such a holistic approach is not totally inaccessible to South Africans, many of whom consult traditional healers who do consider psychosocial and spiritual factors. Additionally, at UCT teaching facilities and various South African clinics, there are doctors who are very much aware of and consider social determinants of health. However, Lungelo's sentiments, as well as comments of some UCT professors and doctors do indeed suggest, that broad consideration of biopsychosocial factors throughout the medical fraternity has not yet been achieved.

Lungelo's experience demonstrates that expectations deviate quite sharply from the foundational and theoretical knowledge that they are taught in Cuba as well as UCT. In Cuba, classroom and clinical education emphasizes the importance of PHC. At UCT, academic guidelines and literature reiterate PHC's importance. However, when they enter the clinical context, PHC's relevance seems to be diminished in some circumstances. So Lungelo's suggestion that professors do not understand Cuban students' formation may be right. There is a disconnect between what is expected in many UCT clinical training sites and what is taught in other learning contexts of both UCT and Cuba.

Demonstrating the variation in acceptance of the PHC model at UCT, Lungelo recounted an occasion when PHC was encouraged by a UCT professor. Speaking of this particular professor who Lungelo finds to be a great teacher of the PHC approach, he said:

"That's why I love Professor Woods. He said 'I'm not going to teach you about how to treat a woman that's having a post partum hemorrhage. I'm going to teach you why she'll die.' He [Professor Woods] asks, 'how do you treat post partum hemorrhage. Where is treatment stored?' It is stored in the refrigerator. If there's no refrigerator, then there will be many women dying of postpartum hemorrhage. No matter how good, if government is not involved, PHC is hard to implement."

Access to medicine in the above case is a socioeconomic issue. The attention to socioeconomic factors demonstrates the professor's consideration of elements relevant to PHC. The interest of the professor in PHC, as expressed above, varies quite sharply from the previous vignette. SACMTP students felt that such encouragement of PHC in the clinic, as was expressed above, is less common. These students are not alone in this opinion. Some UCT students and professors express similar sentiments. Dr. "L" is a UCT alumnus and current family medicine doctor at UCT. He explained to me that he considers psychology, spirituality, and socioeconomic factors central to understanding and treating patients. He said however, that he "did not learn this in training" but gained such knowledge through independent learning. Professor "J," also a UCT alumnus and current staff member, believes that too much emphasis is placed on technical medicine and not enough on "prevention and primary care." Professor "E" believes that there is "just a small group of doctors at Red Cross Hospital and Groote Schuur [two UCT teaching facilities] who promote PHC."

In addition to UCT doctors and SACMT students, UCT students have also expressed variation in PHC practice at university facilities. Sentiments of some UCT students regarding the implementation of PHC are similar to those of the SACMTP students and the aforementioned doctors. Catherine Draper (2005), conducted an assessment to determine UCT students' perception of the PHC curriculum. She found that like the SACMTP students, some UCT students felt there was a gap between what they learn in class and what is feasible in the clinic (Draper, 2005). Draper suggests that such students "seemed to base their views on what they had seen in reality and the incongruence of this with the theory they had learnt" (Draper 2007:17c).

Having come from a health context where PHC has been successfully integrated for several years the experience of "incongruence" is particularly unfamiliar and frustrating for Cuban trained students. In Cuba, medical students do not seem to experience the same type of disconnect between theory and practice. This is because the context in which the PHC curriculum is implemented is very different. According to many SACMTP students, in Cuba, the entire society is cognizant of and cooperatively works toward PHC's success. This includes government sectors, the public, medical educators and health professionals. Students cite

many examples of this societal embracement of PHC. For example, students cite the education sector's success in achieving high literacy rates, and the government's use of media to disseminate health education, as major contributors to the public's health literacy. They also cite the health sector's provision of things like high nutrition food, blood pressure cuffs, and exercise classes as contributors to the public's ability to monitor and manage their health. Each of these things enable prevention and attention to the various determinants of health.

UCT does not enjoy the same universal support. PHC recognition is fairly recent, having been adopted by the South African government in 1994 and incorporated into the UCT curriculum in 2002 (Draper, 2005). Additionally, the presence of a private sector means that government has less influence on various societal sectors, including the media. Finally, South African is still recovering from the apartheid system under which sectors were structured in a way that facilitated unequal education, health, housing and resource access.

Essentially, two different models, existing in two very different contexts, dominate in Cuba and at UCT. In Cuba, the dominant model within the biomedical system is Primary Health Care, through which the biopsychosocial model is promoted. In South Africa, as in many capitalist countries and indeed significant portion of the world, the biomedical model is dominant (Singer & Baer, 1995). Anthropological understandings of medical pluralism include the concept that in complex societies, while one medical practice may dominate, there exist a host of other practices (Singer & Baer, 1995:181). Baer, Singer and Susser (1997:212) contend that in the current global pattern of medical pluralism, biomedicine is hegemonic exerting dominance over alternative systems. SACMTP students are professionalized in the Cuban setting where the biomedical model is not hegemonic. They then move to a setting in South Africa where there is administrative efforts to shift the dominance of this model. However the biomedical model remains dominant. As such, they experience challenges to what they understand to be the role of the doctor because they are now practicing in a setting where the role, as prescribed by PHC, is not fully supported.

What they are encountering is negotiation processes that take place in plural medical contexts. Medical pluralism is typically discussed as existing between traditions, but it is actually occurring within one tradition, the biomedical tradition.

Rhetoric Expressed through the SACMTP and Revolutionary Doctor Concept

SACMTP

For the Cuban trained students, their concept of their role as a doctor is shaped not only by a curriculum, but also by their participation in the SA-Cuba Medical Training Program. Through this program the South African Department of Health and Cuban administrators emphasize certain goals. Three particular goals are to (1) increase diversity, (2) address the doctor shortage in rural areas and (3) expand primary health care (Department of Health, 1999). These goals are in fact quite complementary to the professional expectations that are promoted in their Cuban academic experience. In addition to these goals the reality that students are participants in a political program is also conveyed. SACMTP students thus perceive themselves as part of political initiative and recognize that they have a specific purpose to impact the South African health system.

Each student spoke of the purpose of and their commitment to the program. On one occasion, Lungelo spoke quite passionately stating:

When I talk about this I get emotional, really! Because South Africa is my country and I love it to bits. The purpose of our program and why we had to be taken from the underserved areas, is because the majority of students want to go to the rich places. We won't forsake the underserved areas or communities. The program, when it was formed, they looked at those conditions.

I will look back at the people who are suffering and serve them. In South Africa, the government has to say I will give you more to serve there. But we [Cuban trained students] know poverty. It's what we walk and what we talk.

Lungelo's comments are indicative of how he perceives his role as a doctor. Lungelo sees his role embedded in service. Further, he conveys that his role is related to alleviating the doctor shortage in poor, underserved areas. Lungelo in fact, discussed the doctor shortage in other conversations. He says that he is aware of the commitment of many doctors to rural service. However he is also aware of the significant number of doctors who have no interest

in public sector or rural service, and the impact on those communities. This understanding of the various factors related to the doctor shortage and a commitment to help alleviate that shortage through service, was echoed by other SACMTP students.

Revolutionary Doctor

In addition to the program, rhetoric regarding the “revolutionary doctor,” also shapes students’ perceptions of the doctor role. In Cuba, doctors have a moral and requisite obligation to their society. According to the students this is evident in the concept of the revolutionary doctor whose task according to Che Guevara is “social medicine” and whose goal is to “learn that the opportunity of serving fellow man is much more important than a good income; that the people’s gratitude is much more permanent than all the gold one can accumulate” (Guevara, 1960:115). This is the perspective that students are given in Cuba, that commitment to a medical revolution in which social medicine and unwavering service to the populace is pertinent. Of such commitment, Lungelo once said, “I tell you we are formed not as doctors, but as revolutionary doctors. There is a transformation of our mind.” This transformation shapes the lens through which they view medicine. Medicine becomes more than a practice of curing; it becomes a practice of prevention and a practice of understanding peoples’ experiences and contexts. This understanding is then applied to an assessment of how those factors impact patients’ ability to achieve good health. This also enables SACMTP students to see the factors that impact a disease rather than just the disease itself.

Lungelo and Thabo once explained how he feels the revolutionary doctor concept is applied in practice.

Lungelo: You cannot say to someone whose poor, go eat cauliflower. You say cabbage because you know what they eat. That’s why when they say “revolutionary doctor,” you know who you are.

Thabo: As a revolutionary doctor you look at what causes disease. If it’s the water you ask, what is the government supposed to do? Maybe get water supplies and things like that.

The rhetoric that students are exposed to through the program and the concept of the “revolutionary doctor” emphasizes the role of the doctor as a devout public servant who cures

disease when necessary but most importantly prevents disease. Translation of both ideas from theory to practice in the Cuban settings is possible because the dominant medical model is preventive. In South Africa however, the biomedical model is dominant. Translation of devout service is certainly possible. UCT, through student literature and service programs encourages public service. Additionally, throughout the country, doctors are committed to public service.

Employing prevention is more challenging because for example, to treat certain cardiovascular illnesses, students say that in Cuba, they can send patients to a facility that provides nutritious food. Existence of such a facility is very possible in socialist Cuba. In South Africa however, a democratic country with a capitalist economic system, resources are not provided in the same manner. This illuminates the extent to which a context influences the feasibility and ultimately the dominance of certain medical models within a given tradition.

The Context's Contribution to Medical Model Dominance

Influence of Cultural and Social Authority

In plural medical contexts, a dominant tradition or model often emerges. When SACMTP students arrive at UCT, they encounter a biomedical setting in which the biomedical model dominates. Joralomen (1999) theorizes why certain healing traditions within particular pluralistic systems rise to dominance. This may provide further understanding of why the PHC model is dominant in Cuba, and why its dominance is limited by the biomedical model in South Africa.

Drawing on the work of Star (1982), Joralomen (1999:64) suggests that the authority of healers and their respective healing traditions stems from *cultural authority* and *social authority*. Joralemon (1999) demonstrates these two forms of authority through his ethnographic work with Peruvian Curanderos in 1993. Social authority stems from professionalization and legal support. Cultural authority comes from a resonance between cultural values of a healer and those of the surrounding community. In his study, Joralomen found that Cuanderos did not have social authority. They were not professionalized and thus had no legal support. The harassment that the Curanderos receive from police evidences their lack of support (Joralemon

1999:66). While Curanderos lacked social authority, they had cultural authority. The illness explanatory models of the community often matched those of the Curanderos.

In Cuba, the biomedical system or tradition is dominant, but within that system the PHC model has greater authority than the biomedical model. In fact, PHC has total social and cultural authority. Social authority exists because government policy supports PHC. Cultural authority exists because there is extensive government supported health education in Cuba that shapes citizens' understanding of illness. This understanding matches that of PHC.

In South Africa, the biomedical tradition is also dominant. However, within the tradition, the biomedical model seems to have greater authority than the PHC model. PHC has a degree of social authority because it is espoused by the ANC government. However because other sectors beside health are necessary for PHC's success, its social authority is limited.

Influence of government support on the dominance of particular models

Helman (2007) also considers how a particular tradition rises to or maintains dominance. He suggests that contextual factors such as government and economic support influence dominance. South Africa and Cuba have very different political and economic systems, which significantly impact medical practice.

Both Cuban and South African governments have adopted the PHC approach for their respective health systems. PHC requires cooperation of all health sectors and that is where management of PHC in each country differs. In Cuba, the various governments sectors work together to ensure that PHC is properly implemented. South Africa on the other hand has not yet achieved the same level of inter-sector cooperation. This means that in the health sector, it is challenging for health professionals to adequately implement the PHC approach. The Cuban Trained students have been witnesses to such challenges. In a discussion, Thabo once reflected on the differences in clinical practice in Cuba versus South Africa as a result of resource provision or lack thereof.

Thabo: [In Cuba] everyone has a thermometer. Those are basic things, that at home the temperature can be taken. And you can say, 'when the baby was born what was the temperature?' [The patient responds] Yesterday he had fever, and at night he also had a

fever. But now [in South Africa] when I go “thermometer,” they’re like what? It’s amazing, in Cuba, every family’s got a thermometer; every family has a stethoscope.

Thabo went on to say, “I used to have this guitar professor, and he used to take his blood pressure everyday and his blood glucose every day. His blood pressure, the minute it gets to 140 he goes to the doctor. So stroke is something that does happen but it’s very rare.”

These encounters demonstrate how dominance of a particular model influences practice. Such encounters where SACMTP students become aware of challenges to PHC do not subside once students complete academic training. Gift a SA-Cuba training participant feels that:

“South Africa wanted to establish something like Cuban primary health care. But it’s difficult here. They put us in an awkward position. You have medical training with emphasis on primary health care and you don’t have facilities to practice what you’ve been taught, or the resources, and you get sucked in to a curative approach.”

Influence of the Political and Economic Context on dominance of a medical model

The Cuban trained students are transitioning between two academic settings, both of which espouse primary health care as a central component to the medical curriculum. However, because the institutions are in different countries and thus varied economic, political and otherwise cultural contexts the students’ experiences within each context varies drastically. Therefore, Cuban trained students are ultimately taught very different things about the relationship between the professional medical sector and the popular sector, about the role of role of the doctor in society, and about which model dominates in particular settings. In Cuba the PHC model dominates. In South Africa, despite efforts, a more curative, biomedical model dominates.

Cuba is a socialist country. In student accounts they suggest the government devotes a tremendous amount of resources to the health sector and other sectors that impact public health. Further members of society theoretically have equal standing financially and socially. South Africa on the other hand is a democratic and capitalist country. Government resources are devoted to the public sector but not to the extent that they are in Cuba. Social and financial status is unequal and is dependent on one’s profession and family background.

As a socialist country Cuba is egalitarian socially and economically. Students suggest that most times, regardless of one's profession they are of similar economic standing to those in what a capitalist society may consider a lower status profession. Additionally, access to education and health is equal. According to Gift, "the way their society is structured, it makes you feel like everyone is on the same level. I enjoyed that feeling of being equal." He goes on to say that in Cuba, "the basic needs of all Cuban citizens are covered. Everyone in Cuba has food. Everyone has shelter. You don't find people on the streets. Things like education, in Cuba it's free. The health care that is provided to me as a doc and the guy sleeping on the street is the same for everybody. Everybody gets an equal chance in life."

Gift was alluding to the different political and economic systems of South Africa and Cuba. South Africa is a democratic country with a capitalist economic system. In such a system, resources are not equally distributed to citizens. Rather, people work and their payment and thus access to resources is determined by what they earn. While there is public welfare and social services, it is not as extensive as those which exist in Cuba's socialist system.

The SACMTP students expressed that provision of resources like education impact health care. Below is an exchange between Xolani, Thabo and Lungelo, all of whom are in 5th and 6th year rotations at UCT:

Thabo: at the end of the day you know what you're doing, the ship is sinking and you're just plugging wholes. It's so sad; patients don't know what drugs they are on. They don't know that they have high blood pressure. Why can't you tell them?

Xolani: it's very difficult for us in South Africa to have primary health care like Cuba. For them it's easy. They have one language. We have eleven. They have education. But in South Africa, some of them have not gone to school. Even those old ladies they can't remember these English names. It's hard to remember the name of a pill. They use their own terms to call a disease. They call diabetes sugar.

Thabo: its fine Xolani, let the person have an idea that they've got "sugar," but some patients just don't know. This patient is diabetic and the patient does not know. It's UNFAIR! It's even worse, you take a patients' organ, and the patient doesn't know she doesn't have a womb. They have an organ removal and they don't know!

Xolani: but you can't blame the patient.

Thabo: I'm blaming the system that we are not being taught that we should teach patients, that patients should be empowered. We can use radio. Almost everyone in South Africa has an access to radio. Once a week there should be a doctor talking about high blood pressure.

Lungelo: Cuban television does not have [commercial] advertisements.

Thabo: No, they teach

Xolani: alone we cannot make a change. We still have to go back to education. We need to educate our communities. Once we educate them then we can take it to the next level.

Thabo: the more the patient is educated the more empowered. But otherwise they can't understand you. It's very stressful.

In this exchange the students are addressing the relationship between education and empowerment. Xolani in particular is suggesting that there is a correlation between school education and health education. Thabo suggests that patients can and should be educated about their health education regardless of their formal education level. Overall, the conversations indicate the way in which inter-sector collaboration allows for PHC's success.

Conclusion

The biomedical tradition is often discussed in comparison to other healing traditions, thereby neglecting the pluralism within biomedicine. By highlighting the professionalization experience of SACMTP students, this chapter has demonstrated that there is great diversity in biomedical practice. Students encounter the PHC model in two contexts, but its implementation varies. This is likely because location, politics, and economics shape biomedical practice. Therefore in different settings the model that dominates within the biomedical tradition may differ. Additionally, the model promoted by individual institutions and practitioners within a context also varies. What this means for students is that they are among the primary actors in a negotiation of medical plurality in South Africa.

Chapter 4

One evening, I went to the home of some of the SACMTP students. While there, a discussion about how it actually feels to be at UCT while being perceived as ‘Cuban’ and therefore different or foreign, arose. Thabo turned to me and said, “just picture yourself in a university which is just meant for white people and you are a black person.” Siphso then added “to make it worse you come from Cuba!” Thabo then redirected the statement to his intended point. “No, just picture yourself like in those olden days when black people are not accepted. He knows that he’s not wanted there. Just imagine how he feels. That’s exactly how we felt.”

This vignette illuminates important issues that shape the experience of SACMTP students. Many SACMTP students feel unwanted, unaccepted, and misunderstood, in the UCT context. A couple students have even described their experiences as “discriminatory.” This sense of being unfairly treated, and particularly facing prejudice, has been expressed by SACMTP students at some other South African medical institutions (Reed & Torres 2008:51) Similarly, American students who train in Cuba, express feeling stigmatized upon return to their home country, the United States. For the six SACMTP students at UCT that I spoke with, the sense that they are unaccepted or face discrimination stems from interactions with some professors in the clinical setting. They believe that these experiences are related to the fact that they trained in Cuba and that they are perceived as different. While they have some very positive interactions with a few professors, the abundance and degree of what they feel are exclusionary experiences, seems to set the tone for how they feel about their learning experience at UCT.

In this chapter, I describe interactions in which SACMTP students feel they are treated unfairly because they are ‘Cuban,’ and delineate those factors which along with being ‘Cuban’, might identify SACMTP students as different. Portrayal of these descriptions is not an effort to accuse the entire UCT Medical School or affiliated teaching hospitals of discriminatory or otherwise unfair treatment of students. In fact, SACMTP students recognize that there are some teachers and administrators who positively impact their experience at UCT. Thus, it is rather an attempt to reveal and discuss particular, unfortunately common clinical interactions with some professors, that negatively impact SACMTP students’ learning experience.

It is important to discuss these experiences because, as Dr. Juan Ceballos, coordinator of SACMTP in Cuba, suggest, “the final year in South Africa is important for them [SACMTP students]” because “its there that they practice skills specific to the needs of their countries” (Reed & Torres, 2008:49). Since this period is so crucial, it is important to illuminate the experiences and feelings that impact the students’ experiences. Following the description of student experiences, I will provide an analysis that discusses how biomedicine deals with difference, according to some anthropological literature. This will serve to suggest why difference may matter in the biomedical context. Further it will provide some theories as to why difference may influence the experiences of SACMTP students. In my analysis of the above points, I draw heavily on medical pluralism literature, as it commonly assesses the negotiation of and response to difference in medicine.

Experiences in the Clinical Context

During focus groups, the SACMTP students shared a number of experiences that expound on the issues which were identified in the introductory vignette. They describe interactions with some professors with particular detail, describing what about the professor’s response, leaves them with a negative feeling about the interaction. In this section, I describe these scenarios in an effort to convey the students’ interpretation of their interactions, and the students’ notions about how and why they feel excluded and unwanted. The vignettes exemplify what SACMTP students describe as exclusion from activities, underestimation of their abilities, and stratification amongst other students.

Exclusion

Thabo began describing an experience in which he was excluded from an academic activity, a clinical exam.

Thabo: We are doing four blocks instead of eight. So we are doing a block in 4weeks instead of 8 weeks [UCT students have 8 weeks per block]. So with obs and gyne, [obstetrics and gynecology] I did obs for 2 weeks and gyne for 2weeks. So what is planned is after 4 weeks of obs there is supposed to be a clinical exam. So during that time I was doing my gyne block. So I had to go back to obs and do my clinical exam in that 4th week. So when I went there I was given a patient, and this lady [clinical instructor] came and was like “why are there four students here; why is there one more student here?” I was like I am a Cuban student, and she turned pink. And she was wearing a pink jersey and she was exactly the same color. You can tell she was pissed

off. And she says [to me] ‘you can’t just come in here and do my exam.’ I was like ‘no but I spoke to a registrar.’ And she says ‘no, you must go.’ And imagine how I felt. In front of a patient, while examining, I was told to leave.

As Thabo told this story, the others listened intently. They followed Thabo’s story with short statements expressing identification with what he had experienced. Particularly, Siphso said, “its things you face when you are here.” Lungelo agreed and Thabo concluded the story with “that crushed me.” Thabo sensed that the professor was angered by something that was out of his control and was disappointed that the consequence was dismissal from an exam that he was told he had the right to attend.

Underestimation

Siphso provided an example of his own experience in which he felt unaccepted. Again, the others listened intently, occasionally contributing short statements in agreement with aspects of Siphso’s story.

Siphso: Sometimes they really underestimate us. This past week they asked us what is a bletharitis. Before I could even answer she [the professor] said, this must be difficult for you. In my mind I’m like, ‘I’ve done ophthalmology; I know the answer to the question.’ I was saying that in my mind and I was really angry because it’s a simple thing. I wasn’t given the chance. They were like ‘it must be very difficult for you coming from a different background in Cuba you know,’ and just moved on to the other student.

Thabo: Sho that must have hurt.

Siphso: It didn’t hurt. I told you I don’t get hurt anymore by what they do

Lungelo: Even myself, I just laugh. Myself, I just laugh

Siphso feels that the professor “moved on” before giving him an adequate opportunity to answer the question. The action of suggesting that the question was difficult for him before allowing him to answer, is what left Siphso feeling that SACMTP students are underestimated by some professors.

Feeling that their capabilities are underestimated seems to be a serious concern for the students. Later in the focus group, Siphso and Thabo described experiences where they felt they were perceived as less competent because they were ‘Cuban,’ and were consequently treated differently. Such experiences lead them to raise the question and devise an interpretation of the way in which “they” [some UCT lecturers] see them. The whole group eventually transitioned from discussing experiences of being underestimated to making sense of those experiences.

Sipho: At the end of the day, if the professor doesn't know you, he will treat you like an ordinary South African student until the day he or she finds out you are a Cuban student.

Thabo: That's true.

Sipho: He won't notice anything because you'll be doing your work and doing fine. But if he finds out you are a Cuban student and you make a mistake then....

Thabo: For instance, we were working in Red Cross. Ok fine. The registrar told us she was really impressed. A week after that, she found out I was a Cuban and she starts going 'are you sure?' And I thought, but before you were impressed about the way I was working. Why are you asking me that now? You said you were impressed before.

Thabo and Sipho: The attitude changes.

Thabo and Sipho's comments are indicative that some SACMTP students feel that underestimation is paired with professors' knowledge of their different education background. In response to Thabo and Sipho's comments, Lungelo provided an interpretation.

Lungelo: You know I think it's the meetings. When they get together they talk of these Cuban guys, you need to help them because they don't know much. And they come saying 'if you want some help we'll help you,' and 'they're so pitiful.' They undermined what you are capable of doing.

Thabo: I wish I could see myself through their eyes and know what it is that they see.

Sipho: I've seen. They see this poor person.

The students seem to sense that conversations and impressions about the students precede clinical interactions. They also seem to see a relationship between their experiences and the professors' knowledge about their identity. They suggest that how professors see and perceive them, impacts how they treat them. Essentially, what is being indicated is that if professors do not see them as Cuban, then they set normal expectations for them. The students articulate a feeling that once professors see them as Cuban, they lower their expectations.

I spoke with a few lecturers and doctors to try to understand how SACMTP students are perceived. They had a wide array of perspectives on SACMTP and the student participants. This wide range of opinions is likely reflected in the experiences of the students who encounter some doctors who are encouraging and others who they feel are discouraging.

Those lecturers with a particular interest in primary health care (PHC) suggested that SACMTP students have a very strong understanding of PHC. Professor T says they have an exceptional understanding of PHC. She appreciates their perspective and encourages them to contribute to class discussion because she feels they enhance the conversation. Another lecturer, Professor J, said that those he encountered were “quiet,” but performed well. SACMTP students also express that they are positively received by some lecturers. For example, Thabo once explained to me that a particular lecturer encouraged him to share his knowledge about diseases he encountered in Cuba.

Not all lecturers positively receive the perspective and unique knowledge of SACMTP students' responses. Contrary to Thabo's experience, Lungelo explained how a lecturer once said ‘when you guys are asked a question, don't ever say a disease or whatever pathology that you see in South America.’ In a conversation I had with a lecturer, Professor B acknowledged that the students understand PHC, but felt it was unnecessary for South Africans to go to Cuba to learn about PHC. Dr. L also suggested that they are strong in the area of PHC, but felt that they are not as strong in the area of clinical knowledge. A perception that students are not as strong clinically may stem from a few factors. There are in fact, some clinical skills that medical students do not practice at the undergraduate level in Cuba. According to Dr. Juan Ceballo, these include “caesarian sections, deliveries, and anesthesia” (Reed & Torres 2008:49). Additionally, upon arrival at UCT, students' clinical knowledge is in Spanish. So while they are informed about clinical skills, during their initial weeks at UCT, they may take longer to respond to questions. In fact, several students recounted experiences in their first weeks at UCT in which they knew the answer to a question, but did not translate it fast enough from English to Spanish, to convey that knowledge to the instructor.

Stratification

In the previous focus group excerpts, a few students felt that professors set lower expectations of them while maintaining standard expectation of UCT students. This leads some SACMTP students to feel that they are unequally stratified relative to other students, in

a hierarchy. SACMTP students also feel that this impacts how UCT students perceive them. Relaying this feeling to me, Thabo said he feels their interactions with professors in the clinic “influences the students as well.” Siphso followed by saying, “the students now think they’re better than us because they [lecturers] put them in the upper level and us underneath. I’m a 6th year; you can’t ask me, do you know how to draw blood or how to put up a drip? I mean simple procedures.”

Siphso is suggesting that such questions may stigmatize him, sending a negative message to other students about his capabilities. In the same conversation Siphso later suggested feeling stratified relative to foreign exchange students as well.

Siphso: Have you seen the way they treat the elective students? They are so precious. They treat them better than you [a South African] are supposed to be treated. Hello! I’m South African! Students that come from England you should see. Smiles go to them. When they [professors] talk to the Cubans, you don’t even see a smile.

Siphso’s statement reiterates a sense that there is an unequal placement of ‘Cuban’ students in the medical student hierarchy.

The experiences that SACMTP students have are to some extent, a normal part of university life and particularly medical professionalization. Stratification in a hierarchy, competition among students, and challenging interactions with professors is common. Thus, some aspect of what SACMTP students are experiencing may be a part of the normal identity formation process in medicine. Kleinman (1981:252) for example, suggests that medical professionalization is a dehumanizing process. However, considering perceptions of SACMTP, as expressed by many doctors, it is likely that some of their experiences result from their identification as ‘Cuban’ and in some ways different.

Indicators of Difference

SACMTP students' have a different educational background, which in some ways differentiates them in the South African and particularly, UCT clinical context. Differentiating factors include language, time spent at UCT, medical school affiliation, and theoretical clinical orientation.

The experience of Cecil Helman (2004), a South African doctor working abroad, clues us into the factors that alert hospital colleagues to another's foreignness. Speaking of his own experience in a country that he was not trained in Helman (2004) said:

“The year I spent at as a Visiting Fellow at Harvard Medical School illuminates some of the social differences between Britain and the USA – and their two medical systems.”

During grand rounds he asked himself, “where is the patient?” At Harvard, the patient is not included during grand rounds. Not knowing this he asked one of the attending physicians quietly, “But where's the patient?” I ask. ‘When are they going to bring him in?’ The man looks at me askew. My accent, my lack of a white coat, my question puzzle him. ‘The patient?’ he asks, frowning, shaking his head in disbelief. ‘The patient?!’ (Helman, 2004: 226)

Language, particularly his accent, his attire, and concept of position of the patient as doctors ‘gaze’, all identified Helman as a ‘foreigner.’ Likewise, the students’ language and understanding of how doctors relate to the patient, in other words, their medical philosophy or model, identifies them as foreign.

Of the above factors, language may initially be the most noticeable differentiating factor about SACMTP students. They are completely fluent in Spanish, having spent five years prior to arriving at UCT, immersed in a national and academic setting where Spanish is the dominant language. They often socialize, think, learn, practice medicine and as Siphon once said, “even dream in Spanish.” So when they first arrive at UCT, they go through a process of adjusting to the language difference. They are learning English medical terminology and acclimating to clinical practice in English. During this early transitional period, they understandably interchange English with Spanish medical terminology on occasion. Use of Spanish terminology in an English speaking clinical context is an immediate signifier of foreignness or difference.

In addition to academic use of Spanish, one may encounter the Cuban trained students walking through the halls of UCT hospitals speaking in Spanish, as well as Xhosa, English or another South African language. However, it is Spanish that signifies difference. In fact, one of the Cuban trained students expressed feeling stigmatized by his use of Spanish. He says he at times tries to avoid socializing in Spanish, or feels frustrated when other Cuban trained students begin speaking in Spanish when in his company. The reason he cited was that “he just wants to be his own person,” and not identified as a ‘Cuban’ or as different all the time.

Besides language, Cuban identity signifies difference. The Cuban trained students are indeed, South African. They speak South African languages, bare South African names and spent their childhood in South Africa. However, in daily conversation, they are often spoken of as ‘Cuban’ and understood to be new comers who are “from Cuba.” As such, they are associated with another country and to some, perceived as foreign.

Many doctors refer to them as Cuban, and they refer to themselves as Cuban. In a focus group, I asked the students how they felt about the Cuban identification. Siphwe said he did not mind because “he lived there.” Lungelo and Siphwe echoed similar sentiments. However, they did emphasize that they are not Cuban and have expressed in other conversations that they “love” South Africa. The person who might have had a concern with the Cuban identification would be Keke who once expressed that he wants to be “my own person,” and that he sometimes avoids things, such as speaking Spanish, that associate him with a group identity. Keke however was not present when I asked students how they felt about the Cuban identification, so I cannot say conclusively that he is opposed to it.

The prevalent use of ‘Cuban’ by doctors and students may be because of expedience. Longer alternatives might be ‘South African, Cuban trained students.’ Another term might be ‘Cuban trained,’ which is the term I have purposefully used throughout my fieldwork, in an effort to avoid confusion and be clear about their identity. In this dissertation I refer to them as South African- Cuban Medical Training Program (SACMTP) students for the same reason. However, I admit, that although accurate, the phrase is not as convenient. I imagine that in medical settings, expediency is crucial. Still, I question the impact of the ‘Cuban’ designation. It serves to

illuminate where they have been trained, but also designates and likely contributes to a perception of them as 'foreign.

It may not just be SAMCTP students' 'foreignness' that leads them to feel unaccepted. It may also be the particular type of foreignness that they represent in the UCT context that may lead to a sort of cultural clash in the clinic, thereby exacerbating their difference. First, they are coming from Cuba which is a developing country situated in the global South. Second, Cuba has a political relationship with South Africa that is welcomed by some and contested by others, because of the role Cuba played in resisting the apartheid government. Third, their training emphasizes implementation of biopsychosocial considerations in a PHC treatment approach that promotes prevention first and curing second. This approach is also taught at UCT and implemented by some UCT lecturers. However, as was highlighted in the previous chapter, there seems to be some aspects of the clinical learning experience in which prevention and other aspects of PHC are minimized. So Cuba and therefore the 'Cuban' term may be associated with a less desirable type of foreignness or difference. The word 'Cuban' may be associated with many things including a different healthcare model, developing nation, and politics. While in reality, these factors may not translate into inadequate medical preparation, they can still influence interactions in the clinical setting.

How does the Biomedical Professional Sector deal with difference?

Leslie (1976) suggests that there is an effort to minimize medical pluralism. In an ethnography of the Indian medical system he delineates the various medical traditions that exist, including biomedicine which he calls cosmopolitan medicine, and "indigenous" traditions like Ayurveda, Yumani and Siddha. He suggests that at that time, in India and the world there were efforts to:

- (1) standardize curricula for training health specialists
 - (2) reserve the legal practice of medicine to individuals with requisite training
 - (3) enforce a hierarchy of medical authority dominated by doctors
 - (4) limit access of laymen or other curers to the technology of cosmopolitan medicine
 - (5) eliminate or narrowly restrict all other forms of medical practice
- (Leslie 1976:513)

Following Freidson (1970), Kleinman (1980) likewise suggests that efforts to exclude or minimize pluralism or difference in medical practice, are made. Fadlon (2005) who conducted an ethnography on alternative medicine in Israel, makes a similar claim. Helman (2004) draws attention to intra sector difference in hi discussion of prejudices towards the general practitioner within biomedicine. Each of these anthropologists portrays biomedicine as a dominant system that marginalizes other ways of understanding illness.

These cases represent response of biomedicine to different healing traditions within and outside of biomedicine. While there are some cases, as in China, in which pluralism is found to be beneficial, or plural traditions manage to coexist; in most settings, biomedicine tends to remain dominant (Baer, 2007).

What these anthropologist's works suggest about biomedicine's response to foreign practices or ways of conceptualizing medicine, is that the biomedicine tradition strives to maintain the dominance of the biomedical model through hierarchy, standardization, and legal professionalization. This is done through various efforts that seem to minimize the successful introduction or increased prevalence of other models. This is in some ways similar to the case at UCT where efforts are made to fully incorporate PHC into the curriculum. Yet, various factors, both internal and external, challenge its translation from theory to clinical practice. A central question that arises here, is what does this underlying resistance to PHC mean for SACMTP students who as 'Cubans' may be closely associated with PHC.

Why does difference matter in medical context?

Divisions in Medicine

Foreignness or difference is relevant in biomedical culture. Identifying difference serves to create divisions, subdivisions, and hierarchies within medical contexts that are very diverse. Biomedicine for example, consists of a number of health professionals including doctors, nurses, mid-level clinical practitioners, pharmacists, and allied health professionals such as occupational and physical therapists. Mental health and social welfare professionals often work within the biomedical environment as well. However, such diversity is not limited to disciplines. Additionally, difference and divisions exists even within the particular professions. Most

relevant to our discussion is those divisions amongst doctors who are members of a fraternity that consists of numerous specialties and sub-specialties. Within each of these categories, there are various hierarchical levels. Among such a diverse group of professionals within one sector, there is an inclination towards role designation and status appropriation.

Such delineation of difference and the accompanying divisions between and within medical professions is documented in medical anthropology, medical sociology and various other disciplines that explore the biomedical profession. This literature tends to reference two types of internal differentiation within biomedicine (Stevenson & Barker 1996). The first type is differentiation between doctors and other professionals within or associated with medicine. The second type of differentiation is that which occurs amongst doctors (Kumpsalo 2009). Such differentiation is attributed to differences in philosophical or theoretical perspectives on medicine and patient care, variation in practice setting, educational level and difficulty, and hierarchy which simultaneously contributes to and is created by difference.

Philosophy

Stevenson and Barker (1996) refer to the philosophical and theoretical differences as variation in “world views”(Stevenson & Barker 1996:48). Specifically, in a discussion about multidisciplinary healthcare teams, they say that there are a “complex of ‘world views’ that distinguish disciplines” and that there are different ways in which “different world views explain and ‘deal with’ health problems (Stevenson & Barker 1996:48). Essentially, one’s perspective and experience influences their explanation for illness. Kleinman refers to this as an explanatory model (Kleinman 1988). Stevenson and Barker (1996:49), delineate the way in which varying “world views” or explanatory models impact treatment decisions. “Clinical psychologists are more likely to invoke 'psychic' or non-physical explanations and to offer 'treatment' based on psychodynamic or cognitive theories of human condition. Social workers, by contrast' are likely to favour an explanation that acknowledges the influence and potential usefulness of environment and social context” (Stevenson and Barker 1996:48). According to Stevenson and Barker (1996), these different approaches lead to conflict, which is a common problem between and within health professions.

Stevenson and Barker (1996) refer specifically to conflict in multidisciplinary teams consisting of doctors, nurses, social workers and others. However, their discussion is relevant to understanding differentiation within particular professions where subdivisions or specialties exist.

Setting

Another differentiating factor in biomedicine, is the setting in which medicine is practiced. Doctors work in a wide range of settings. As such, the learning environment for medical students and residents varies according to the emphasis of a medical school or specialty. Depending on the specialty, residents and interns may train in hospital wards, surgical theatres, or primary clinics. Since medical students rotate through various specialties, their learning environment oscillates between tertiary, secondary, and primary healthcare facilities. However, the amount of time spent in each setting is not necessarily equal. Medical schools that emphasize primary health care may facilitate opportunities for more time in primary care facilities. Alternatively, hospital settings may be prioritized by other medical schools.

Kumpsalo et al (2009), studied “internal differentiation within medicine” giving significant consideration to the absence of literature about “hospital based physicians,” and to the notion that “there are fundamental differences between the technical and social environments of hospital clinicians, primary care physicians, educators, and researchers”(Kumpsalo, et al.,2009). In their study they suggested that these differences would impact the socialization and correlate with the identity variation between specialists. Kumpsalo et al (2009) did indeed find that certain characteristics were more prominent in certain types of doctors. Five major professional identities emerged. They were “humanist, bureaucrat, health promoter, scientist, and healer” (Kumspalo et al. 2009:69). It is notable that “marked differences in the professional identities of the physicians in hospitals, in primary care, and in other sectors” were also found (Kumpsalo, et al. 2009:72). “Humanists, bureaucrats, and health promoters were more often in primary care, healers in hospitals, and scientists and health promoters in the research and education sector” (Kumpsalo, et al. 2009:72).

Drawing focus to the differences between hospital and primary care physicians, Kumpsalo, et al. (2009) stated that the former were “more technically oriented curers,” and the later “were more humanistically and socially oriented curers” (Kumpsalo et al. 76). Kumpsalo, et al. (2009) explained these differences as being related to the different perspectives promoted in each setting.

Hierarchy

Yet another factor influencing differentiation is hierarchy. Doctors are at the top of the medical hierarchy, where they are “conceptually equal” (Helman, 2000:61). However, there are a set of hierarchies within the medical profession, which differentiates and orders the various medical specialists such as cardiologists, obstetricians, surgeons, internists and primary care doctors. Within each of these specialties there is yet another hierarchy in which “experts down to novices” are placed (Helman, 2000:61).

A number of factors influence one’s placement in the medical hierarchy. These factors include knowledge, the conditions one treats, and power. The value of one’s knowledge is determined by the amount and perceived quality of knowledge that they have acquired. The amount of knowledge is determined by how much training one has had. Therefore, an intern is perceived as having more knowledge than a medical student, and resident or medical officer has more knowledge than an intern. Beyond training, number of years in and scholarly contributions to the field signify level and amount of knowledge.

The quality of knowledge is determined by two things. First, the theoretical focus of a training program or discipline is relevant. Programs may focus on a biomedical approach, a primary health care approach or a biopsychosocial approach in varying combinations or in isolation. Further their knowledge and techniques may be informed by technology and science in varying degrees. The approaches that traditionally hold the greatest value are those that are biomedical, technical, and scientific. For instance, according to Stevenson and Barker (1996), “in Western societies, those disciplines that can demonstrate knowledge based on scientific research are seen as having ‘better’ knowledge. Biomedicine claims such a scientific knowledge base” (49). Stevenson and Barker (1996) contend that this preference for scientific knowledge is what places

doctors at the top of the healthcare hierarchy. Considering this perspective, one could then conclude that because emphasis on biomedicine varies amongst doctors, that those who practice it, likewise are perceived as having 'better' knowledge.

The second influential factor on perceived quality of knowledge is the competitiveness of entry into a particular training program or subdiscipline. Finkler conducted an ethnography on medical practice in Mexico. Interviewing one doctor he was told that "in Mexico there is a hierarchy in the medical profession and the specialists hold the most important positions and esteem. It is like a military service with only generals and colonels. To the lament of the generalists, it is the specialists who enjoy the greatest prestigebecause not all medical school graduates are admitted into residencies in government institutions" (Finkler 1991:69-70).

The final factor that influences hierarchical order is the physiological and anatomical focus of a specialty. Helman suggests that among the "the 'real' doctors, the consultants, as compared to the non-specialists, there is a strict hierarchy, based on the conditions they treat and the parts of the body they focus on. (Helman 2004:161) The heart and the brain are important organs, thus, the cardiologists and neurologists have greater status among specialists. Surgeons, who are curers, also have greater status.

The ward round, a ritual in hospitals where patients are presented to a diverse team of health professionals and students, is often cited as a common place where hierarchy and difference is vividly expressed (Helman, 2004), (Stevenson and Barker, 1996). In *Suburban Shaman*, where Helman recalls experiences in ward rounds, he recounts practices which he believes stems from prejudices.

"The weekly display of medical hierarchy often goes together with a certain ritual, but polite humiliation of 'the GP'. This mythological figure appears as a minor character in several of the case presentations: as a figure of fun, the Joker in the pack, the bumbling, well-meaning generalist with supposedly limited diagnostic skills ('the GP, of course, thought it was only a cold', 'I'm afraid the GP just gave him some cough medicine and sent him home', 'the GP only referred him to us when it was already much

too late'). Many of the Consultants in this hall seem to see the local GPs as honest craftsmen and artisans, decent, well-meaning folk, but not 'real' gentlemen – or 'real' medical scientists – like themselves. In Britain, all these peculiar prejudices have a long history.” (Helman, 2004:160)

Helman's (2004) experience in ward rounds poignantly demonstrates the way in which the aforementioned differentiating factors play out in the medical setting. The factors included philosophical or theoretical perspective on medicine and patient care, variation in practice setting, educational level and difficulty, and hierarchy. As compared to specialists, GPs work outside of the hospital, often in primary and community clinics; as opposed to a biomedical or technical perspective, they are often described as having a more holistic, psychosocial perspective; and while specialists train for several years beyond the primary medical qualification, GPs train for one to three years in programs where entry is less competitive. While these differences may not truly signify the value of a GP's knowledge, the differences are perceived as having meaning, thereby designating GPs to the lowest position in the medical hierarchy. What is more, the hierarchy position signifies difference. The resulting actions displayed by doctors according to Helman are “prejudices.”

How is biomedicine's approach to difference relevant to SACMTP students?

The above literature demonstrates first, that pluralism in the biomedicine tradition is immense. Differences between doctors are shaped by numerous factors including “world view,” medical models, practice setting, training experience, and other factors. Second, the literature suggests that negotiation of difference in biomedicine is constantly occurring. These points may contribute to understanding of SACMTP students' experiences.

The literature suggests the types of things that commonly occur as difference is negotiated. Hierarchical stratification and competition is common. Additionally, there is great variation in which models or perspectives are valued. The value placed on perspectives depends on various contextual factors and personal factors. So to an extent, SACMTP students' encounters with such trends, as expressed earlier in the chapter, may be a part of professionalization into

medicine. However, some experiences of students seemed to stem from miscommunication and misunderstanding of the SACMT program.

The above discussion even illuminates why they might sense that they are unequally stratified. The hierarchy, according to literature, seems to be set based on a few criteria. The criteria includes quantity and perceived quality of knowledge, the conditions one treats, and power. While Cuban trained students have spent the same or greater number of years in medical school, the amount of time at UCT is shorter, just two years. Relative to their peers who have been training at UCT for up to six years, this is a short amount of time. So the quantity of their knowledge may be perceived as relatively smaller. In biomedicine, Western biomedical approach is preferable. Although UCT medical school espouses primary health care, experiences of Cuban trained and UCT students alike suggest that the clinical setting leans heavily towards biomedicine. In such a setting, the quality of Cuban trained students' knowledge may not be valued as highly. Finally, the primary health care and biopsychosocial approaches necessitate treatment of social, behavioral and psychological concerns prior to physiological or anatomical concerns. So a hierarchy based on the part of the body one treats, may undervalue the perspective and thus the position of those doctors which espouse PHC and the biopsychosocial model.

The presence of these differentiating factors seems to be a source of conflict. Considering these issues, it is therefore easier to understand why Cuban trained students may at times sense a lack of acceptance. Negotiating difference is something that is both challenging and necessary in medicine, where diverse perspectives on the body and healthcare exist. Cuban trained students are encountering the challenge in the UCT context.

Conclusion

This chapter demonstrated that while SACMTP students have some positive interactions and support at UCT, they also commonly have experiences that lead them to feel unaccepted at UCT. These sentiments develop largely because of experiences in the clinical setting. It may be suggested that what SACMTP students are experiencing are normal processes in a competitive setting, and particularly in the medical setting. However, it is unlikely that this is the only

reason. It is possible that their identity as ‘Cuban,’ and misconceptions about SACMT program and students is shaping certain experiences at UCT.

It seems that unfavorable interactions with professors significantly influence their experience at UCT and as they transition from the Cuban to the South African medical context. The consequences of this are multiple. First, UCT students may witness interactions in which SACMTP students are excluded, their perspectives are rejected, or their abilities are undermined. This may subsequently impact some students’ perceptions of and interactions with Cuban trained students. Second, the capabilities of Cuban trained student may be undermined. Ultimately each of these issues make the transition experience into the UCT and broader South African context unnecessarily challenging and unwelcoming. Such an experience distracts from the aims of the training program which is to uplift South Africans from disadvantaged backgrounds and prepare them to serve their communities.

This chapter has also illuminated the vast plurality in biomedicine. Opinions of doctors and lecturers varied greatly. Similarly, experiences of students and the sense of acceptance varied.

This suggests that negotiation of difference and plural perspectives is an ongoing process.

Chapter 5: Conclusion

There are various ways of understanding and approaching illness. Exploration of such variation has for many years, focused on differences and interactions between the professional sector, of which biomedicine is a part, and the folk sector, of which traditional healing modalities are a part. Amidst such works, there are increasing numbers of ethnographic studies that recognize and explore pluralism within biomedicine. This study of the experience of South African-Cuban Medical Training Program students is situated within this growing body of literature. It demonstrates biomedical pluralism on a global level, between Cuba and South Africa; and it demonstrates it on a local level within UCT medical school. Thus, this thesis is an effort to expound on notions of medical pluralism, and present the way in which two models, the biomedical model and the primary health care model, are negotiated through the SACMTP. It is also an effort to relay some of the SACMTP students' experiences and to understand their preparedness to meet program objectives.

Toward the later aim, immersion into the field allowed me to learn about the wide range of experiences that SACMTP students have. Their entire engagement in SACMTP from application to the program, to training in Cuba, to integrating back into the South African context is filled with phenomenal experiences. SACMTP students say they gain international experience, grow into responsible global citizens, and develop an impeccable commitment to service during the program. I chose to focus on those experiences which were most relevant to the students at the time that I met them. Thus this thesis discusses their experience of re-entering the South African context at UCT. Their experiences are in part, shaped by their medical education background, and by the multiple models that they are introduced to in Cuba and South Africa. Thus, their experiences demonstrate negotiation of biomedical pluralism.

In Chapter three, I raised the issue that SACMTP students' theoretical background in Cuba and UCT and clinical training in Cuba focuses on the PHC approach. However translation of this approach into the UCT clinical setting is challenging as it is encouraged by some lecturers but seems to be discouraged by others. In Chapter Four, I relayed their expressed feelings and

experiences at UCT, as students who have trained in a different medical setting. This is yet another demonstration of plural perspectives in the biomedicine tradition.

SACMTP to some extent, facilitates medical pluralism. The aims of the program are to increase the number of doctors from disadvantaged backgrounds, improve health provider shortages in rural areas, and increase the PHC orientation of medical providers in the South African health system. The first two aims are met because each of the students in this study are from rural areas and plan to work in rural areas upon graduation. They explicitly expressed a personal, moral commitment to serving in their communities. This moral commitment in addition to their expressed future plans suggests that they may remain in the public sector, where doctors very much needed.

The third program aim is met in the sense that these students demonstrate a keen understanding of PHC, and have expressed plans to implement it in their communities. However, considering those issues discussed in chapters three and four, there will be some challenges. For example SACMTP felt that not all doctors encourage PHC. They also sense that greater structural issues such as poor education and access to other resources, hinder appropriate provision of PHC.

This paper has demonstrated that there is tremendous plurality within the biomedical tradition. This plurality can cause differences between doctors and administrators that need to be successfully negotiated. This negotiation is required for two reasons. First, there is diversity in biomedicine and second, medicine is intertwined with cultural arrangements, producing different professionals with different views that must be negotiated in multidisciplinary settings (Baer, 1997). While negotiation of differences may be challenging, plural medical perspectives lend an opportunity to consider other interpretations of and approaches to illness management. This illuminates the potential benefit of SACMTP and the contribution that student participants can make to efforts to improve the health care in South Africa.

Appendix A

University Polyclinic Medical Training Program (UPMTP), Cuba, 2008-2009 Academic Year*

YEAR 1
Semester 1
Morphophysiology I: Cellular & Tissue Level, Prenatal Development (10 weeks)
Morphophysiology II: Integumentary and Musculoskeletal Systems (8 weeks)
Morphophysiology III: Nervous System (1 week)
Comprehensive General Medicine (Family Medicine) I (20 weeks)
Philosophy & Health I, Health Information Technology I, English I, Physical Education (17 weeks each)
Semester 2
Morphophysiology III: Nervous System (11 weeks)
Morphophysiology IV: Metabolism, Endocrine and Reproductive Systems (10 weeks)
Family Medicine II (22 weeks)
Philosophy & Health II, English II, Physical Education II (22 weeks each)
YEAR 2
Semester 1
Morphophysiology IV (continued), History (6 weeks each); Family Medicine III, English III, Physical Education III (16 weeks each)
Morphophysiology V, History of Cuba (10 weeks each)
Morphophysiology I (1 week)
Semester 2
Morphophysiology I (continued, 9 weeks) Morphophysiology II (12 weeks)
Family Medicine IV, Psychology of Health Care I, Health Information Technology II, English IV, Physical Education IV (21 weeks each)
YEAR 3
Semester 1 Introduction to Clinical Medicine and Medical Semiology, Clinical Laboratory, Imaging, Psychology of Health Care II, Pharmacology I, English V (20 weeks each)
Semester 2 Internal Medicine, Pharmacology II, English VI (20 weeks each)
YEAR 4
Semester 1
Family Medicine V (6 weeks) General Surgery (10 weeks) Obstetrics & Gynecology (10 weeks) English VII (24 weeks)
Semester 2
Pediatrics (16 weeks) English VIII (13 weeks)
YEAR 5
Semester 1
Public Health (9 weeks) Family Medicine VI (7 weeks) Psychiatry (6 weeks) English IX (10 weeks)
Semester 2
Traumatology & Orthopedics (6 weeks)
Urology, Otolaryngology, Ophthalmology, Dermatology, Tropical Medicine (3 weeks each)
English X (11 weeks)
Forensic Medicine (12 weeks)
YEAR 6
Internal Medicine (12 weeks) Pediatrics (12 weeks) Obstetrics & Gynecology (8 weeks) Surgery (8 weeks) Family Medicine (8 weeks)

*Source: Ministry of Public Health, Havana. Vice Ministry for Medical Education and Research. September 1, 2008.

Appendix B

Semesters 1 and 2 (first year)

PPH1001F	Becoming a Professional
HUB1006F	Introduction to Integrated Health Sciences: Part 1
CEM1011F	Chemistry for Medical Students
HUB1007S	Introduction to Integrated Health Sciences: Part 2
PHY1025S	Physics
PPH1002S	Becoming a Health Professional

[Note: A student who fails any first or second semester course must register for the Intervention Programme before continuing with semester 2. The Intervention Programme or IP is outlined under FBA6.3 below.]

Semesters 3 to 6 (second and third years)

LAB2000S	Integrated Health Systems Part IB
PPH2000W	Becoming a Doctor Part IA
SLL2002H	Becoming a Doctor Part IB
HUB2017H	Integrated Health Systems Part IA
PPH3000H	Becoming a Doctor Part 2A
SLL3002F	Becoming a Doctor Part 2B
LAB3009H	Integrated Health Systems Part 2
MDN3001H	Introduction to Clinical Practice

In semester 4, one of the following Special Study Modules:-

PPH2002S/HUB2020S/LAB2002S/ OBS2001S/MDN2001S/PRY2001S/AAE2001S/PED2001S/CHM2001S/RAY2004S

Semesters 9 to 10 (fifth year)

AAE5000H	Anesthesia
PPH5000H	Primary Health Care Elective
PED5001W	Paediatrics (including Paediatric Surgery)
MDN5002W	Medical and Surgical specialties (including Dermatology, Neurology, Neurosurgery, Ophthalmology, Otorhinolaryngology and Rheumatology)
OBS5003W	Obstetrics and Gynaecology
CHM5003W	Surgery (including General Surgery, Plastic Surgery and Urology)
MDN5003H	Pharmacology and Applied Therapeutics
CHM5004H	Trauma
CHM5005H	Orthopaedic Surgery
LAB5008H	Forensic Medicine

Semesters 11 and 12 (sixth year)

CHM6000W	Surgery
MDN6000W	Medicine (including Dermatology)
OBS6000W	Obstetrics and Gynaecology
PPH6000W	Family Medicine
PRY6000W	Psychiatry
PED6000W	Paediatrics (including Paediatric Surgery)

*Source UCT Health Sciences Faculty

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