‘I know my place’- The hidden curriculum of professional hierarchy in a South African undergraduate medical program: A Qualitative Study

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Research Article

Keywords: Hidden curriculum, medical education, hierarchy, decolonisation,

Posted Date: August 5th, 2021

DOI: https://doi.org/10.21203/rs.3.rs-745000/v1

Abstract

Background

The hidden curriculum of professional hierarchy refers a tacitly acquired perception of a power differential between medical students and their clinical teachers. This power gradient is enforced and maintained by means of humiliation and race- and gender prejudices. The consequences of these pedagogical approaches include disillusionment, anxiety, depression and suicide among student populations. Little is known about this phenomenon in the post- colonial African setting.

Objectives

The aim of this study was to explore the hidden curriculum of professional hierarchy as it is perceived by medical students. The objective was to define how it manifests and to describe the mechanism that enforce and maintain it.

Methods

An ethnographic study was conducted at a South African University. Through twelve in- depth interviews and 6 months' participant observations in the clinical setting an understanding of the students' experience was explored. NVivo software was used to perform a thematic analysis using an open coding method. The themes were then progressively refocussed as broader themes emerged and a deeper understanding of the hidden curriculum developed.

Results

From the interviews and the observations, we found that humiliation of students, racism and sexism was used to enforce the professional hierarchy between clinical teachers and students. Students felt discouraged and demotivated by such encounters.

Conclusions

The hidden curriculum of professional hierarchy plays a significant role in how students understand and find their place in the clinical setting. Humiliation continues to play a role despite institutional policies and guidelines and the transition to a democratic dispensation in 1994 in South Africa. Our findings resonated with the findings of international studies exploring the hidden curriculum. Using a historical perspective of the medical school where the study was conducted, the post-colonial lens offers a useful local analysis of the hidden curriculum in the local context of continued gender-based violence, racial, socio-political and economic inequalities in South Africa. It may allow for a more critical engagement with the students' experience and hopefully assists in exploring institutional values in more profound ways.

Background

The hidden curriculum refers to an implicit 'set of influences that function at the level of organisational structure and culture', in contrast with the formal curriculum which is 'the written, stated and intended curriculum.'(1) Discrepancies between what is taught and what a student learns can somewhat be explained by the hidden curriculum, which is evident in the implicit day to day activities in the learning environment.(1–3) Clinical teachers are often unaware that their behaviour contributes to the enculturation of students(4), and how it shapes and impacts students by the tactic imparting of values which often contrasted with the ethics taught in the formal curriculum.(1–6)

The 'acceptance of professional hierarchy' (pg770) was described as contributing to a number learning processes identified as part of the hidden curriculum.(3) Hierarchy – which in this context, is the perception of |the difference of power between student and teacher- is recognised as a central aspect of the enculturation and socialisation processes, through which students learn their 'place' in the clinical setting.(6–8) However, the hierarchy in the socialization into becoming a doctor is not benign: Studies from the United States, Australasia, Europe and Asia support the perception that professional hierarchy makes medical students vulnerable to victimisation, sexual harassment and racism in the clinical setting.(8–10) It may also result in aberrant role modelling, propagating a cycle of abuse.(11) Teaching through humiliation i.e. aggressive questioning, public shaming and the highlighting and exaggeration of gaps in students' knowledge has been widely identified as a factor in enforcing hierarchy.(3, 9)

Besides the adverse effect of these experiences on a student's ability to learn and conceptualise information,(11–13) the students and junior doctors exposed to the hostile hierarchy may suffer from anxiety, substance abuse, depression and suicide.(8, 9, 14–16)

In the medical curricula design globally the hidden curriculum of professional hierarchy has had limited acknowledgement (17) and while it has been described in the global West and Asia,(3, 8, 10, 14) less has been published about this phenomenon in the African setting.

Aims and Objectives:

The aim of the study was to explore the hidden curriculum of professional hierarchy as perceived by medical students, how hierarchy manifests in the clinical setting, and to describe what tools are used to implement and enforce it.

Setting and context:

The study was conducted at a South African medical school which offers a 6-year undergraduate medical program. The data was collected in a teaching hospital in South Africa where fifth year medical students were placed. The medical school where the study was conducted was established in South Africa the 1950s during the rise of apartheid. It was unique as it was set up specifically to train 'black' doctors (18) which, under the apartheid-defined racial classification included 'Black' (African-indigenous), 'Indian' (descendants of moistly indentured labourers originating from India) and 'Coloured' ('mixed-race') and excluded 'White' students (those of 'European descent'). The medical school has a fascinating and

complex history (18) (touched on briefly later) and many of the stalwarts and activists in the anti-apartheid movement and later government leaders in the post-1994 government, as well as the decolonisation scholar and black-consciousness leader Steve Biko (18), studied there.

With the transition from the apartheid government post-1994, in line with a national transformative agenda of redress and affirmative action, the university admissions sought to rectify the unequal access to medical training in the country (19) and since then has used racial quotas (and continuing to use the essentializing race-classifications from the apartheid era), favouring previously disadvantaged groups. In 2018, the student population in the undergraduate medical program was comprised of a majority (69%) “Black”, “Indian” (18%), “Coloured” (9%), and “White” students (3%) and 1% Asian (people of Asian descent, excluding those classified as Indian), which is moving to reflect the demographics of this region. The university as a whole has also been very active in engaging in transformation as part of broader transition following the 1994 change in government and reform of the higher education sector. This is reflected in the vision and mission statements, strategic repositioning of the university to reflect redress of the injustices and inequities of the past and its contribution to a just and fair society. It is evident in policies and processes for teaching and learning and research as well as specific policies and clear processes in dealing with discrimination of any form (for staff and students) within the institution. (20)

An important contextual development for universities in South Africa since 2016 has been a nation-wide student movement and protests, initially under #rhodesmustfall and then the #feesmustfall that has called for the decolonizing of higher educational institutions. It challenged the pace and degree of transformation that has taken place up to now and the focus has not only been on structural and institutional dimensions (such as fee-structures being a barrier for a transformation of the student population) but also a call to systematically decolonize the curriculums in higher education in South Africa. The brief history above points to a complex and fraught environment for both students and staff in teaching and learning the medical curriculum.

Methods

The research is situated in an interpretivist research paradigm and used an ethnographic approach. The data collected included in-depth interviews of students and participant observation conducted in the clinical teaching setting.

Data collection, analysis and reporting was carried out in line with the consolidated criteria for reporting qualitative studies (COREQ) 32 item checklist.(21)

Selection of participants

The participants were medical students in their 4th to 6th years of study and were approached face- to-face at the university residence and on campus and requested to participate in the study. Two participant who were approached declined to take part in the study, citing lack of time as the reason for not wanting to participate in the study. No participants dropped out of the study. Three students from each year were

selected by means of purposive sampling, reflecting, demographically the medical school population. Even though racial classification is associated with the apartheid past, we continued to refer to it in this study as it is being applied locally.

Data collection and the positionality of the researchers

The first author (JS) collected the data during his internship. He graduated from the medical school where the study took place three months prior to conducting the interviews and the participant observations. Having been so intimately involved in the clinical setting, and having just recently graduated, he had deep knowledge of both the insider and outsider context of the study which was critical for a deeper understanding of many of the subtleties that emerged.

The second author (BG) is senior faculty at the medical school and did not have direct engagement with the participants in the study. He has been engaged in curricular work as well as educational research at the institution and thus had a deep understanding of the current curriculum, educational practice and context.

Reflexivity

An iterative process of reflection involving the 2 researchers took place throughout the study, from its conceptualization, development of research proposal, data collection and data analysis. The potential influence of the participation, the insider-identity of the first research as well as a deeper reading of the history of the medical school was engaged with to increase a reflective exploration throughout the study.

Interviews

Twelve semi-structured in-depth interviews lasting between 15 and 45 minutes were conducted. The interviews followed an interview schedule with five initial questions covering the objectives of the study and followed up additional reflections and explorations based on the responses from the participants. The interviews were conducted at student's home or university residence rooms during the first semester of 2017. Only the interviewer and the participants were present during the interviews.

The interviews were audio-recorded and then transcribed to text verbatim. Non-verbal responses were documented in the researcher's field journal during interviews.

Participant observation

A process of participant observation was conducted over a 6 month period at the teaching hospitals where 5th year medical students were placed. The observations were conducted by the first investigator mentioned above who documented interactions during ward rounds, tutorials and clinical teaching. Observations, which focused particularly on interaction between students and teachers, were documented in shorthand in the observer's field journal as soon as possible after the event and then written into more detailed narratives within a day of the events taking place, to ensure as accurate recall as possible. .

Analysis

Both the data from the interviews and the participant observations were initially analysed by the first investigator, and reviewed by the second investigator. The data from the 2 sources were treated separately and computer assisted data analysis software (NVivo®) aided in data analysis for the interview data. An open coding method was employed to group the data into themes, the codes and data were reviewed by the second investigator and were then progressively refocussed as broader themes emerged. These were then iteratively reflected on, compared and contrasted with the observation data. A deductive - inductive strategy was used for the coding. Major and minor themes are discussed in the findings below.

Measures to ensure trustworthiness were based on Guba's criteria.(22) Credibility was ensured through persistent participant observation over six months in the clinical setting and through triangulation of the data sources between the interviews and the participant observation. Researcher triangulation was conducted, as the first investigator analysed the data, and the second rigorously reviewed the analysis process.

All data collected from field notes and transcription of interviews were cross- referenced and analysed by both researchers, increasing its dependability.

Ethics

The study proposal was reviewed and approved by Bioethics Research Committee (BREC Number BE381/16) of the University of KwaZulu-Natal. Gatekeeper permission was obtained from the University's Registrar's office, the School of Clinical Medicine, the Provincial Department of Health and from the Medical Managers of the hospitals in which observations were conducted. Written, informed consent was obtained from the participants of the in-depth interviews and their engagement in the research process was voluntary.

Findings

The findings presented below are covered under the headings of the major themes that were identified.

Disinterest in teaching and marginalisation of students.

A perception of apathy towards teaching on behalf of clinical teachers, exclusion and humiliation of students and race and gender prejudices in the clinical setting were themes that emerged regarding students' negative experiences of hierarchy.

Students felt unwelcome in the clinical setting as they perceived their teachers to be disinterested in teaching.

One student recalled what was said at orientation before her first clinical exposure in third year, here the student describes what he/she perceives to be an explicit display of apathy on behalf of the clinical

teachers.

'[The consultants] said… "this is Med-school survivor edition, you must survive. There is no time for you- you just fit in where you can… we're not committed to your learning."' (I001) [Interview number 001]

Similarly, students felt excluded in the clinical setting, alluding to the hostility of the learning environment.

'…you're made to feel like an annoyance…. They give you this sense of "why are you here?", like "why are you here bothering me?"' (I002)

'They step in front of you or physically push you out the way so they can be right at the bedside and not let you see anything or look at results or discuss anything with you'. (I011)

This theme resonated in the participant observations, in this particular observation, the clinical teacher's reaction to a student's request to observe a consultation serves to increase the power gradient between student and teacher by means of humiliation, marginalisation and enforces the perception of disinterest in teaching.

Dr AJ (consultant) is visibly upset, she tells Sr C (nurse), in front of the doctors and students that she doesn't want to consult with a student observing, because, 'they don't read, they ask stupid questions and they get in the way.' (PO09) [Participant observation record number 09]

Humiliation of students.

Students described incidents of humiliation, verbal abuse and physical intimidation. They felt that this negatively affected their ability to understand concepts, it enforced the hierarchy between student and teachers and added to the apprehension students felt in approaching their teachers.

'I have been sworn at and kicked out of ward rounds for asking too many questions or standing too close to the bed where the consultant is working.' (I011)

In some instances, gaps in knowledge were used to humiliate students, and this also served to increase the power gradient between the student and the teacher.

'There are times where I have asked a question in a tutorial and the consultant will either reprimand me or tell me that I shouldn't be pursuing medicine with that type of thought processing.' (I001)

Another student reflected on the long-term effects of this humiliation.

'…You can't break someone down. You don't know what type of human you are breeding once you have broken them down.' (I004)

Students also recalled instances where verbal abuse and humiliation had escalated to physical intimidation. The following interaction left the student feeling physically unsafe in the learning

environment. This sort of interaction wold serve to reinforce hierarchy, by stripping the student of his/her power and leaving him/her feeling helpless.

'I was sworn at in front of the patient… The patient tried to interject, the doctor reprimanded her… and banged on the table and actually broke a physical… comfort zone and was in my space.' (I005)

Racism

Black African students felt more marginalised and victimised than their other colleagues and perceived greater privilege afforded to white and Indian students.

'[The] consultant did not teach us at all, we were all black [Africans] in the group but when I moved in the following block … there were more Indians and coloureds and there were two or three black [Africans] and we were actually actively taught.' (I004)

This perception of privilege appeared to be appreciated by clinical teachers as well as by students. Here, the student recalled an interaction during a bedside tutorial between a black African student and a black African consultant where the consultant admonishes the student for sub-par performance, the consultant goes on to explain that the student need to work harder to achieve the same results as his/her Indian and white peers.

'The consultant said to him in Zulu, "you're not one of the people that comb their hair with their hands. [Here referring to Indian and white people] You're disappointing us and you're essentially going to fail. You don't have an uncle in the system that is going… to privilege you to pass. [When] you do that in an exam you are going to fail… You are black and you're not Indian… or white so you would have failed this case on [that] basis. Do not make this mistake".' (I004)

Some students described a perception of discrimination based on their physical appearance. This student felt that she was being subtlety discriminated against because of the texture of her hair, and her race.

'I'm mixed [race]. I have curly hair and wear it in a ponytail. I've been told it is unprofessional, and to pin it up, whereas the other Indian students on my team would come with dishevelled hair that's down in their face, but not be reprimanded for that. During ward rounds, I've had seniors ask me where I'm from, and mention stereotypically mixed-race areas…' (I011)

Similar generalisations were noted during the participant observations, in this case, an Indian senior doctor was speaking to a 'coloured' student at the bedside of a mix-race patient during the ward round. In this interaction, the teacher humiliates the student by use of racial stereotyping and humiliation. This sort of othering increases the level of hierarchy.

'Why can't you just use your brain? You should know the common causes of a cardiac disease in your Woodland's connections. The man is obviously an alcoholic. Just ask (Sr C) she can tell you all about

your people.' (PO09)

Woodlands is a historically traditional 'coloured' residential area.

Gender

Students described sexual discrimination and harassment in the workplace. Female staff were perceived to be less knowledgeable than their male counterparts.

'…A female consultant wouldn't be taken as seriously as a male consultant in their teams…. The male registrar would be favoured…' (I009)

Female student felt objectified, marginalised and felt as though they weren't been taken seriously in the clinical setting.

'Medicine is still largely populated by males and they make it difficult for you in the workplace. They… make inappropriate jokes and "put you in your place" and don't hear out your opinion even if… you're well prepared, have done enough reading and research to join the conversation as part of a team' (I011)

'…we were a group of three females and soon as we entered automatically that was commented on; and we were told we weren't in the right place.' (I012)

In the participant-observations, sexism was often overt. The following interaction occurred during an academic ward round between a black student and an Indian consultant (AJ). The consultant condescendingly implies that the student's ambition to become a cardiologist is unachievable and that the student should aim to be a cardiologist's wife.

[Student AO says that she finds cardiology very interesting. Dr AJ and the two medical officers laugh together before AJ responds, 'Cardiology? And you don't even know how to calculate ejection fraction? My darling, you're a very pretty girl. Aim a bit lower and maybe you'll marry a cardiologist.'] (PO12)

The effect of hierarchy

Self-confidence

Hierarchy was perceived to negatively affect self-confidence. This student describes how the system of hierarchy in the clinical setting made him/her feel inferior.

'I think the hierarchy system it makes me a lot less confident. I feel inferior before I even say anything.' (I012)

One student began to reconsider studying medicine.

'It does definitely take a knock on your confidence and it does make you actually consider the sort of profession that you are in' (I005)

Relationship with the patient

Patients were often witness to the dynamics between students and clinical teachers and some students felt that this affected their learning, because when patients had lost faith in them, they would refuse to allow students to examine them.

'…When you're just trying to introduce yourself, and [the patient would say], "I saw you and [you were] being shouted and [you are] not a good student doctor, I don't want [you]"' (I006)

Conversely, students felt that their low place in hierarchy made them more relatable to patients.

'It… brings you closer to your patients… patients… know you are at the bottom of the food chain, a large majority of them feel that they can associate with you more than they can with the senior doctors' (I011)

Perpetuation of hierarchy

Hierarchy was accepted and enforced amongst students. Students in the clinical years had their own hierarchical system based on seniority. There appeared to be a power gradient where final year students to fourth years,

'It's one thing to be ahead of someone in terms of progressing in your studies and … to have the seniority over them but not make them feel it… You can be a sixth year and still be nice to a fifth year as opposed to be a sixth year who is just like, "shut up and stop bothering me" …' (I002)

Discussion

The power differential between students and clinical teachers was described as a given – that this was an accepted (and perhaps acceptable) environment for education to take place. The hegemonic position of this acceptance is an important point of departure for the deeper analysis of understanding of hierarchy in medical education.

During this study we found that a hierarchy was enforced and maintained through marginalisation and humiliation of students (through public shaming, race and gender prejudices) and apathy towards teaching- on behalf of clinical teachers. .

Humiliation as part of medical education is well described in the literature and that it negatively impacts their ability to conceptualise and retain information.(3, 23, 24)Teaching by humiliation reinforced and encouraged the perpetuation of hierarchy. (8) It prevented students from seeking clarity when concepts were poorly understood. Our findings resonate with the literature regarding both the processes and consequences of how hierarchy in medical education is used. Students experienced low self-esteem, high levels of disillusionment, and a loss of idealism.(3, 7, 10–12, 16). Sexism and racism are commonly experienced in the clinical setting, and that this has a profoundly negative impact on the students' experience and academic performance.(15, 25–28)

In our findings a particular aspect of the instrumentalization of hierarchy is how race and gender prejudices were used to humiliate students and to enforce and maintain hierarchy, which in the context of the post-1994 South Africa – and the medical school where the study was done – is of particular interest. (18) In an exploration of the history the medical school, Vanessa Noble noted similar themes to our findings in her research.(18) In her study, she explored how perceptions of intimidation, racial and gender inequality among medical students and teachers has been an issue of significance since the genesis of the institution.(18) In Noble's book, she reflects on apartheid policies that racialised everyday interactions, influenced the teaching context, and played a critical role in the way medical students understood themselves and their role in society. She noted overt racial abuse and sexism was evident in the oral histories that she collected. Female students felt marginalised and objectified; and were made to feel inferior to their male counterparts. From the 1950's, Black African students have felt as though their Indian counterparts were unfairly favoured in the clinical setting. So even within a context of a medical school that exclusively catered for 'non-white' students, dynamics of racism and sexism were evident. And, the medical school was already perceived as second rate, due to its exclusive admission on 'non-white' students. (18)

It is striking that students are still experiencing victimisation, racism and sexism in an academic institution that has actively engaged with transformation 25 years after the official dissolution of apartheid in 1994. How is it possible that the same themes that emerged from accounts of alumni from the 1950's are being reported by students today?

Post-colonial scholars such as Spivak, have written in-depth critiques on how ex-colonial states perpetuate colonial inequities after liberation (29) and hierarchy was a means of gaining and maintaining power over the oppressed.(30) Biomedicine was both used to justify colonialism and as an agent in establishing and maintaining the colonial power imbalance.(31–33)

Turning to medical education, Noble (18) argues that in establishing the medical school in question, black medical students became "the ideological and practical instruments of a growing biomedical empire in South Africa…" (pg. 187).(18) Biko, an activist and Black Consciousness scholar who was a student at the medical school from 1966 to 1972 and was murdered in detention by the apartheid police in 1977, asserted that "the most potent weapon of the oppressor is the mind of the oppressed"(pg.74).(34) A critical dimension of the colonial curriculum is in how it reproduces the status quo of power-relations.(35) In this, students are subjected to a use of hierarchy that ensures that they 'know their place'. The hidden curriculum – the experienced and tacit values system of the institution – reinforces the hierarchy and, as medical students progress, they accept and perpetuate the same hierarchy and find their place in the hierarchy.

It is therefore not merely the locally relevant context of apartheid and current inequities that explains our findings of the mechanisms of hierarchy in the past and present, but rather, how larger hierarchy in biomedicine echoes societal inequities that shape the hidden curriculum of medical education. The wider discourse on decolonization medicine, for instance in Global Health, explores how biomedicine both in

the past and the present is instrumental in reproducing hierarchies and inequalities throughout the world.(36) Indeed, Pillay and Kathard (35) in reflecting on how the curriculum in health sciences remains colonial, identify 'dis-othering' (making the Other less) as one of the central features. The dis-othering may be understood at the level of populations, patients or, as we explored in this study, students.

The call for decolonizing the curriculum as part of the #rhodesmustfall and #feesmustfall movements in South Africa insists on a revision and repositioning of the curriculum that acknowledges the past and challenges the reproduction of the same (colonial) hierarchies that the curriculum has perpetuated up to now. It is a call to a universal humanism that resonates Biko (34) and Fanon (37) and insists that education should be emancipatory.(38) And, in relation to the curriculum, as Ndlovu-Gatsheni (39) argues, the challenges are at the epistemic orientation in how gendered and racialized relationships are embodied and reproduced.

The post-colonial lens offers a useful local analysis of the hidden curriculum in the local context. South Africa is still one of the most unequal societies in the world with racial and gender-based socio-political and economic inequalities of the past continue to have a significant impact.(40) It is unsurprising that this inequality is evident in the clinical setting(41) and that the hidden curriculum of the medical hierarchy at the medical school continues to resonate the societal inequities, injustices and prejudices – which is not unique to the local context.

The Medical School has been a site of struggle for social justice, inclusion, and fairness since its inception.(18) In exposing aspects of the hidden curriculum, a deeper engagement with how hierarchy is used to reproduce unjust power relations despite a positive policy environment of the university must be explored and challenged. The medical school remains a site of struggle.

Conclusion

The hidden curriculum of professional hierarchy plays a central role in defining how students know their place in the clinical setting.(10, 13) In this study, we were afforded unique insight into hierarchy in a particular historical setting, even though hierarchy seems to manifest in similar ways though out the world. Placing it in a historical, local and global context, allows a more critical engagement and hopefully assists in exploring institutional values in more profound ways.

Declarations

Ethics approval and consent to participate

The study was conducted in accordance with the Declaration of Helsinki. The study proposal was reviewed and approved by Bioethics Research Committee (BREC Number BE381/16) of the University of KwaZulu-Natal prior to commencement of the study. Gatekeeper permission was obtained from the University's Registrar's office, the School of Clinical Medicine, the Provincial Department of Health and from the Medical Managers of the hospitals in which observations were conducted. Written, informed

consent was obtained from the participants of the in-depth interviews and their engagement in the research process was voluntary.

Consent for publication

Not applicable

Availability of data and materials

The dataset collected as part of this study is kept in a password protected, encrypted file on an external hard-drive in a safe location by JS as per research protocol that was approved by the ethics committee mentioned above. The dataset includes the audio-recordings of the interviews with the participants, the transcripts of the audio-recordings, the rough field notes and detailed field notes that were written as part of the participant observations. The dataset is not publicly available as per approved research protocol but are available from the corresponding author on reasonable request.

Competing interests

JS is a postgraduate student at the University of KwaZulu-Natal, the institution where this research was done, and has no competing interest to declare.

BG is employed as an associate professor and head of department in family medicine at the University of KwaZulu-Natal where this research was done, and has no competing interests to declare.

Funding

The research received no external funding.

Authors' contribution

The study was designed jointly by BG and JS. The data collection was done by JS. BG and JS iteratively interpreted and analysed the data. JS wrote the first draft of the article and BG revised and completed it. The submitted version has been approved by both authors.

Acknowledgements

The participants in the study are acknowledged for freely sharing their experiences during their medical training.

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