A critical ethnographic study of discriminatory social practice during clinical practice in emergency medical care

A research thesis presented to the Department of Emergency Medical Sciences, Faculty of Health and Wellness Sciences, Cape Peninsula University of Technology in fulfilment for the degree of
Master of Emergency Medical Care

by
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DECLARATION

I, Tshepo Nelson Maake declare that this Research Project Report is my own original work. It is being submitted in fulfilment for the degree of Master of Emergency Medical Care at the Cape Peninsula University of Technology. It has not been submitted before for any degree at this or any other University.

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Emergency Care Practitioner

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DEDICATION

This work is dedicated to:

my late mother Mrs. Elisa Sewela Maake, for grooming me into becoming a person that always strives to succeed at every opportunity granted,

and

my daughter Ms. Thatoentle Tshepiso Maake, define your existence in life, and claim your space in the Universe.

ABSTRACT

In the post-apartheid era, South Africa adopted an inclusive education system that was free of discrimination. This study uses an auto-ethnographic approach within the conceptual framework of Critical Race Theory using critical ethnographic methodology to explore how discriminatory social practice continues to manifest during clinical practice. As a qualitative study it examines the experiences and/or perceptions of racial discrimination between emergency medical care students and clinical mentors, emergency medical care students and patients, and clinical mentors and patients within the Emergency Medical Service during clinical practice. It is hoped that understanding the nature of discrimination may contribute towards recourse and its future management thereof.

Semi-structured interviews were conducted, recorded and transcribed to enable the author to conduct thematic analysis. The study purposively sampled 13 Bachelor of Emergency Medical Care students and 5 Emergency Care (EC) providers for participation. Focus was placed on understanding racial discriminatory experiences of students and emergency care providers but due to the nature of the study, other forms of discrimination emerged during data analysis.

While working with their mentors, student participants reported experiences of racial and gender discrimination during work-integrated learning as they were treated differently by their mentors and patients on the basis of skin colour and gender which denied them an equal opportunity to learn during clinical practice. Language was used as an intentional barrier to isolate students from the patients during work-integrated learning because EC providers would intentionally speak in a language not understood by the student and also fail to translate vital medical information about the case to the student. This practice, therefore, prevents the student from engaging in clinical decision-making or partaking in patient care. Consequently, clinical attachment is viewed as counter-productive and the work-integrated learning environment is not considered conducive for learning to take place.

Not only does unfair discrimination within the pre-hospital setting have an impact on the learning opportunities of students but it also exists between EC providers. Such practice violates basic human rights and has the potential to negatively affect the clinical management of patients, thus it has the potential to violate the patient's rights. This study confirms the existence of discriminatory practices during work-integrated learning which usually goes unnoticed and unreported, and as such, lacks a structured approach to redress the lack of inclusivity and equal access to clinical education.

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ABBREVIATIONS

ALS: Advanced Life Support practitioners inclusive of ECT, CCA, BEMC, NDip EMC and BTech EMC qualified practitioners

BEMC: Bachelor of Emergency Medical Care

BTech EMC: Bachelor of Technology in Emergency Medical Care

CCA: Critical Care Assistant

Clinical Practice: The work integrated learning (WIL) component of an emergency medical care education programme

CPUT: Cape Peninsula University of Technology

ECT: Emergency Care Technician

ECP: Emergency Care Practitioner

EMC: Emergency Medical Care

EMS: Emergency Medical Service: a health care organisation with provincial government whose mandate it is to render pre-hospital access to health care.

HPCSA: Health Professions Council of South Africa

IR: Institutional Racism

NDip EMC: National Diploma in Emergency Medical Care

NHRI: National Human Rights Institution

Pre-Hospital Environment: The out-of-hospital environment where health needs prevail

WIL: Work-Integrated Learning

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CHAPTER ONE: INTRODUCTION

1.1. Introduction

This chapter provides the background and context and a brief description of the research problem as well as an explanation of how the results may be used by South African institutions currently involved in the training of Emergency Medical Care (EMC) students. The literature review will follow in Chapter 2.

Critical Ethnography is a qualitative research methodology that allows for this critique of experiences in emergency medical care practice. In an attempt to contribute to an aspect of change in society through this research the ethnographer looked at emergency medical care culture through the lens of prestige, privilege, power and authority to document discriminatory social practices during emergency medical care education and practice. Although focus was placed on racial discrimination, other forms of discrimination emerged during data analysis (and further resonates with the work of: Bonilla-Silva, 2010 and Delgado & Stefancic, 2000). Here, I raise a caveat in acknowledging personal previous experiences of discrimination within EMS Clinical practice which might potentially have undue influence on the analysis. To counter this I have undertaken to be reflexive throughout the research process, and vigilant about possible bias.

South Africa is a racially and culturally diverse country. It's Constitution (Constitution of the Republic of South Africa, 1996), therefore, does not condone or support any acts of unfair discrimination. This is mainly owing to the country's social history which still has a significant impact on the daily lives of present South Africans. As such, many South Africans learn to look past the country's history and respect post-apartheid morality and humanity. However, as an undergraduate National Diploma in Emergency Medical Care (NDip EMC) student, I observed and (rather painfully) experienced discrimination with fellow EMC students during time in clinical training practice within the pre-hospital setting in Johannesburg and Cape Town. Later, in my Bachelor of Technology in Emergency Medical Care (BTech EMC) undergraduate research project, racial discrimination was one of the themes that emerged as participants shared their experiences in clinical practice.

Through the theoretical framework of Critical Race Theory, therefore, this study documents the existence and extent of racial (and other) discrimination within the Emergency Medical Service (EMS) in South Africa.

This study is also intended to increase the depth and scope of the enquiry into discriminatory social practices that appear inherent in clinical practice interactions between students in a university emergency medical care programme and a provincial government EMS. It is hereby acknowledged that disclosures of discriminatory experiences may represent alleged human rights violations and victimology. I am therefore aware of my responsibility to be sensitive to the rights of all concerned and to manage the risk of social harm inherent in such a discourse.

1.2. Background to the Study

This study is, therefore, a qualitative Critical Ethnographic study which incorporates a vital element of auto-ethnography.[1] During the research process, experience from the past may emerge as memories or events and this may result in the author's memories filtering into the research. This has been described by Butz et al. (2009) as an autoethnographic sensibility. In other words, sensitivity to the autoethnographic characteristics of what is learnt during a research project as well as one's own experiences in relation to the people being studied. When something triggers one's memory through an event or cultural formation it evokes a feeling or an emotion that provides ideas and details to enrich the research project. It will also encourage a more critical appraisal of the research engagement (Butz et al. 2009; Custer 2014).

[1]Autoethnography is a style of autobiographical writing and qualitative research that explores an individual's unique life experiences in relation to social and cultural institutions (Custer, 2014).

The study of racial discrimination[2] appears to have little presence (or voice) in the EMS discourse, but within the South African Healthcare sector some studies have documented discrimination experienced by medical students during their clinical attachment to a hospital. According to Thackwell et al. (2016), the so-called 'Race Trouble' paradigm was documented from participants who challenged the notion of a 'Black trainee' in a White-dominated profession. This theoretical framework critically analyses discourse, particularly in racially divided contexts.

In the same study (Thackwell et al. 2016), a total of 18 participants reported experiences with racism[3] at some point during their training and further indicated that it was not overt racism[4] but covert racism[5] which collectively accumulated to feeling unwanted within the working environment. While it was subtle racism (but not experienced as subtle) and difficult to pinpoint it was also difficult to address with facts and evidence. Alleged perpetrators of such behaviours were nurses, fellow doctors, patients and patients' families. Participants reported that they were viewed as incompetent and not deserving of the opportunity to train, where, in some instances, their medical decisions given to nurses on patient care would be confirmed with a White doctor before intervention.

In addition, Thackwell et al. (2016) indicate that 'race fatigue' was also reported by participants who felt under pressure to constantly prove themselves to their

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[2] Any reference to race, ethnicity or culture during this thesis is on the premise of redress or as a critique. The author does not wish to perpetuate apartheid racial categorisation as normal or legitimate. This is terminology is only used on the basis that this was the language of the participants and of the research cited. Through this research, it is hoped that I shall to come to terms with my own experience of discrimination and related victimology as an emergency medical care student and graduate.

[3] Steven (1998) defined racism as an unsupported belief that among humans there are biological hierarchies in the form of different races and attempts to justify the political, economic and social exploitation of certain social groups by others. He further went on to describe it as a phenomenon that is socially pervasive and obscures imbalanced social relations.

[4] Overt racism is more profound and deliberate, it is seen through acts of intolerance and hatred showed by an individual or group towards the other.

[5] Covert racism was being often hidden and the perpetrator usually does not seem to be racist because the behaviour is indirect.

superiors in a hostile environment intolerant to Black trainees, which therefore caused them unnecessary stress. They further felt undervalued and scrutinised because of the widely held belief that they only had the opportunity because they were Black and not deserving of the opportunity. Thackwell's study further uncovers that the lack of Black African role-models in the training experience contributes to the lack of Black academics: thereby resulting in a repeated cycle of lack of Black mentorship. Another contributor to negative Black trainee experiences is also indicated by Thackwell et al (2016) as institutional obstacles to career development; these range from trainee experiences such as feeling unwelcome and being perceived as incompetent because they did not receive senior privileges as most clinical opportunities were given to White doctors who were more junior. Often, black trainees were given the role of assistant during a procedure while a White student would be given a leadership role.

In a study conducted by London, Kalula and Xaba (2009), incidents of medical specialists reporting racial and gender inequalities during training were documented. Inequalities mostly related to the fact that the institution's medical programme was a formerly racially exclusive training institution in South Africa for White students. Although the institution had changed its policies to attract and recruit more Black students, racial transformation seemed to be only about the numbers. The same study indicates, however, that to recruit and retain additional Black and/or female students, the learning environment has to be positive for incumbents. Discrimination had a negative impact on teaching and learning as it directly affected the student's learning opportunity when both White and Black students reported personal experience of race discrimination (London, Kalula & Xaba 2009).

This present study also attempts to uncover discriminatory challenges experienced and perceived by EMC students and EC providers during work-integrated training. It will also demonstrate the impact that discriminatory practices have on students and thereby lead to an understanding of how racial discrimination is experienced or perceived by victims (or perpetrators) of racial discrimination. Thirteen fourth year BEMC students and five EC providers were

interviewed using semi-structured interviews. Emphasis was placed on understanding and deriving meaning from their experiences.

This study, therefore, contributes to the discourse about racism from a transformative stance. It intends to promote dialogue and debate between practitioners which may eventually motivate relevant stakeholders to address issues around racial and other discrimination within the EMS. Transformation of racial discrimination within organisations and broader society presents challenges to the training of emergency medical care professionals. Hopefully this could initiate structures to support students and EC providers to address racial discrimination and related injustices to reduce the risk of recurrence.

Another conceptual framework suitable for this research is Critical Race Theory (CRT). This is because, as part of Critical Theory, human beings are empowered to go beyond the constraints placed on them by race. Critical Race Theory enables an exploration of the meaning of social life, its historical problems and social struggles (Delgado & Stefancic 2001). It should also provide an understanding of the oppressive aspects of race and racism within the EMS as an organ of society.

1.3. Problem Statement

According to the Health Professions Council of South Africa (HPCSA, 2008) qualified and registered Emergency Care Providers are expected to offer emergency medical care to all patients in need without subjecting the patient to any form of racial discrimination. Failure to do so is a violation of the patient's rights and undermines adequate patient management. Although patient-practitioner relationships in medicine are well defined, incidence of racial discrimination and subsequent practitioner victimology[6] within the pre-hospital environment has been anecdotally reported but what this means in Emergency Medical Services has not been documented in any South African publication.

Nonetheless, over the last 11 years, two anecdotal examples of discriminatory reports have been made in the media:

- In 2009, a paramedic was suspended by a private EMS company after posting discriminatory remarks on his personal Twitter account that read:
  "Dear Jesus please let the storm take a few White people, I'm kidding not a few #capestorm". This status was posted after a severe storm affected an area in Knysna (Western Cape Province) which left thousands of people in need of evacuation from strong wind and fire. The storm eventually claimed the lives of five people (News24, 2017/06/09, 16:34).
- In 2013, two White paramedics were suspended by a private EMS company after a video, taken by a bystander, exposed the two neglecting a Black patient who had a bleeding head wound after being struck by an axe. Instead, the paramedics chose to attend to the uninjured White attacker before leaving the scene (News24, 2014/11/13, 15:28).

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[6] Victimology is a scientific discipline which studies the occurrences and of relationships of events resulting in victimizations also known as *victimogenesis*, victim's experience and the consequences of the response to the occurrence of victimizations (Cinini 2015; Dussich, 2006;).
Victimization- refers to an event where an individual, society and/ or institutions are injured or damaged as a result of violation of their human rights or disruption of their well-being (Dussich 2006).

From my own experience, the student-practitioner relationship with clinical mentors, in particular, is a poorly defined one and fraught with inequitable and unfair power dynamics and racially charged undertones. This is problematic if students whose experiences of discrimination go undetected and without redress and offenders continue to enjoy impunity.

This study undertakes a qualitative understanding of the notion of the EC provider as perpetrator/victim of discriminatory social practice and the notion of an emergency medical care student as victim/ perpetrator of discriminatory social practice. Therefore, the perceptions of participants' experiences will determine the racialised discourse in emergency medical services and, more specifically, how it manifests in clinical practice interactions. The motivation for clinical practice as the context for the study is that experiences of discriminatory practice at this time may undermine and detract from the intended value of clinical practice by promoting cognitive dissonance.[7] Experiences of discrimination in clinical practice have the potential to undermine clinical decision-making and the public's confidence in it.

1.4. Researcher's Position

The concept for the study problem arose from my personal experience and as such, an autoethnographic licence is used to share an awareness of racial discrimination both as a student and as a qualified paramedic during work-integrated training in clinical practice. The attempt to find evidence about racial discrimination in the EMS did not lead to any South African written resources that spoke directly about discriminatory social practices in the Emergency Medical Care training context. As a result, an autoethnographic mindset was used to approach this research since this would also give meaning of my own experiences; however, as a novice and partial autoethnographer, I was constantly aware of the impact of bias towards the study.

Emergency Care providers have a unique opportunity to respond to priority calls, engage with other pre-hospital practitioners from different service providers, and

[7] Cognitive dissonance is defined as a state of having inconsistent belief or thoughts related to change in attitude, behavioral decision and perceptual changes (Cooper 2019).

offer emergency medical treatment to different patients. During any incident, the highest qualified EC provider on the scene usually takes over the senior role which entitles the senior to delegate other roles to the less qualified/student crew. Unfortunately, this situation makes for a potentially coercive context that is often poorly understood.

It is in such a context that multiple incidents of racial discrimination within the EMS have occurred and been witnessed. An example is when qualified Emergency Care providers prioritise patient care on the basis of colour regardless of the patient's condition. I was personally involved in one such incident (a Pedestrian Vehicle Accident (PVA)) where the EC provider (a White male) was the first to arrive on the scene. Two patients were involved: the most seriously injured (Patient A: Black, male) was sitting down disorientated with an open head wound injury that was bleeding profusely, while the second patient (Patient B, a white, male) was standing next to his car with superficial burns on his arm caused by the deployment of the airbag. In this case, the EC provider was seen prioritizing treatment by applying a burn-shield[8] around Patient B's arm. This prioritization was immediately questioned but the response was he was aware of Patient A and was going to attend to him as soon as he was done with Patient B.

The questions that arose from this experience were:

- If a qualified Paramedic who was taught how to prioritise multiple patients or a triage (to sort) without racial prejudice, then why make false clinical judgements on when and who deserves to be treated first?
- If both patients are not refusing patient care, why then is care being withheld from the patient that needs it the most?
- Could this be a case of discriminatory emergency medical care practice?

These then became some of the questions motivating the study.

[8] Burnshield – This is a 100mm x 100mm 40g emergency gel dressing for burn care, it's a sterile hydrogel that will help with cooling scalds and burns. It reduces skin irritation and damage whilst promoting wound healing (Caroline 2008).

According to Section 27(3) of the South African Constitution no person may be refused emergency medical treatment in South Africa, it is a universal and absolute right that must be guaranteed even at a basic level and without limitation or justification. In an acute life-threatening medical emergency, fundamental emergency medical treatment is a basic right which should disregard any economic, political or legal policy (Kramer, 2008). A dilemma discussed by Kramer (2008) is that if one is confronted with a medical emergency that threatens the life or limb of a patient anywhere in the world, the prevailing health care organisation or system is obliged to provide medical treatment without favour, fear or undue financial demand. It also outlines the fact that South African emergency medicine health care providers and practitioners of allied disciplines are bound by the Constitution that every person in South Africa receives the most appropriate emergency medical care when required.

Other common incidents personally witnessed relate to the mentorship relationship between EMC students and the supervising paramedic or emergency care practitioner during work-integrated training. There seemed to be more willingness to teach or transfer knowledge from a Paramedic/ECP to the student when two students were of the same ethnicity but when the two are of different backgrounds (for example, a black student and white[9] Paramedic) the relationship between the two tends to become more strict and intense. From the Paramedic's perspective there is little room made for mistakes from the student despite the fact that negative judgement and critique collectively creates an unproductive learning environment. This is a behaviour witnessed and experienced both by myself as a student and also as a qualified Paramedic.

[9] It is uncertain how this dynamic changes if the mentor is Black and the student is White. There are disproportionately fewer Black paramedics/ECP's compared to their White counterparts.

According to my experience within the Emergency Medical Service, there have been many situations where some patients refused to be treated by a paramedic of a different ethnicity to their own, even though that particular paramedic might be highly qualified and could provide more clinical management. Consequently, despite having been called to help in an emergency, one's race, colour, ethnicity or some other particular characteristic may determine if one is able to access patients. This then raises the question: How do we address a situation that protects the paramedic's professional identity and the patient's needs? Such experiences have motivated this study. It is entirely plausible that my demographic as a black African male and my previous employment as a soldier in the South African Military Health Service renders me particularly sensitive to any racial injustice. As a soldier, I was defending our constitution, it was of great concern that some citizens employed in our public institutions (such as EMS organisations and universities) were, through their conduct, undermining our constitutional principles.

In the clinical context of the study, a scenario that does not qualify as discrimination would be if clinical judgement was made by the Emergency Care provider or by the student to benefit the patient's condition and promote a positive prognosis in relation to the patient's condition or clinical needs without any violation of their human rights as per The South African Constitution (1996) or the Patient Rights Charter (as per the Health Professions Council of South Africa 2008). For example, in a case whereby the underlying condition of the patient is critical and the practitioner's clinical judgment leads him/her to treat a patient of their race, gender or ethnic group this should not necessarily be described as discrimination, but as a qualified practitioner taking over or taking lead on the case because the patient is critical or need urgent medical assistance (Martin, 2010).

1.5. Aim

To explore, through Critical Race Theory, how discriminatory social practice manifests during clinical practice interactions between emergency medical care students and clinical mentors.

1.6. Research Question and Sub-questions

The main research question is therefore:

How do social discriminatory practices manifest within the pre-hospital environment during BEMC work-integrated learning in clinical practice at a South African University?

The three sub-questions are as follows:

- SQ1: How do final year emergency medical care students at a University perceive of or experience racial discrimination during work integrated learning?

- SQ2: How do professional Emergency Care providers (latent mentors) perceive and experience racial discrimination in the emergency medical service?

- SQ3: How can critical ethnography give voice and reflexivity to victims of racial discrimination during work integrated learning in clinical practice during the BEMC degree course at South African universities?

1.7. Significance of the Research

The study of racial discrimination appears to have little voice in the EMS discourse in South Africa. In the post-apartheid period and 25 years into the democratic era there is still a paucity of evidence about racism in the EMS industry despite evidence of waves of xenophobic and racial discrimination elsewhere (Classen, 2017) such as the recent xenophobic attack in Pretoria (South Africa) which

targeted foreign-owned businesses and resulted in the deaths of 12 people (News24, 12/09/2019, 05:40).

This study, therefore, will contribute to the discourse about racism from a transformative stance. It intends to promote dialogue and debate amongst personnel working within the EMS, including students and EC providers. It is hoped that this analysis will eventually motivate relevant stakeholders to address issues around racial discrimination within the EMS.

From my own experience of racial discrimination it is a complex topic that is often difficult to confront due to confusion about the burden of proof and the sense of hopelessness it produces (Dladla, 2017). This study may provide awareness and promote redress where there is injustice. It may encourage those who experience or perceive racial discrimination or any form of discrimination to freely speak of it knowing that there is literature that has documented its existence.

1.8. Research Design and Methodology

The paradigm lens is that of Critical Theory which encompasses Critical Race Theory (CRT). Critical Theory is concerned with the inequitable balance of power in the historical construction of knowledge. The appeal for me, and its distinction from other paradigms is that it is promotes transformation as change. This provides the philosophical stance to respond to the topic in a responsible and scholarly manner. There is an epistemological fit as racial discrimination is indeed historically constructed (such as through colonialism and apartheid), socially situated (such as within health care organisations) and in need of change (for the sake of human rights and the protection of human dignity).

Given the context of emergency medical care education and the topic of racial discrimination, this study was enabled by Critical Ethnographic methodology. The qualitative research was therefore aimed at gaining an in-depth understanding of discriminatory social practices during work-integrated clinical practice in an undergraduate health care programme. The analytical framework of Critical Race Theory (CRT) was viewed as the most appropriate framework to make meaning of the data. Critical ethnography and CRT are further discussed in Chapters 2 and 3.

The study sampled fourth year Emergency Medical Care students and qualified Emergency Care providers working as clinical mentors or supervisors during work-integrated learning. The data collection, involving individual semi-structured interviews, was conducted at a South African University of Technology. Critical ethnography supports the use of an autoethnographic approach to allow me the opportunity to infuse my personal experience of racial discrimination into the study and to engage in reflexivity, and eventually be able to bring meaning to participant's experiences and through creative writing avail information to a larger audience (Adams, Ellis & Jones, 2017).

1.9. Ethical Considerations

Permission to use fourth year Emergency Medical Care students and to use the research venue within the department to conduct the interviews was obtained from the Department of Emergency Medical Sciences. The Health and Wellness Sciences Research Ethics Committee granted institutional ethical clearance. The Western Cape EMS was also approached and an application for permission to interview their staff members was granted in writing. Emergency Medical Care students and Emergency Care providers also gave their informed consent to participate in the study and also signed the consent form provided. Further discussion on ethical concerns are located in Chapter 3.

1.10. Sequence of Chapters

The content of each chapter was logically arranged in a report style that would allow readers to understand how social discriminatory practices manifest during work-integrated learning in clinical practice within the pre-hospital environment

Chapter 1: This chapter describes the problem statement and the aim of the study. The research objectives for the study are also identified.

Chapter 2: This chapter presents a detailed literature review of the study, which mainly focus on the history of racism during and post-apartheid period, discrimination within the health care sector and EMC student's work integrated learning in a clinical practice. Philosophical assumptions are also located here.

Chapter 3: This chapter outlines the Critical Ethnographic methodology used in the thesis. It describes how in this qualitative research; auto-ethnography was used as an approach within the analytical framework of Critical Race Theory. It also describes the sampling technique that was employed, how data was collected and how it was analysed. The reader will also find information pertaining to the trustworthiness of the study and ethical considerations.

Chapter 4: This chapter presents data from the findings. It will also provide the reader with rich descriptions that emerged from the data analysis. The findings reflect experiences and perceptions of the participants. Direct quotes from the transcriptions are provided as textual evidence from the interviews.

Chapter 5: This chapter discusses the main themes and sub-themes derived from the finding in Chapter 4. The themes are discussed in relation to the supporting literature.

Chapter 6: This last chapter provides recommendations and limitations that the study encountered. It provided an overall conclusion of the study.

1.11. Summary of the Chapter

This first chapter serves as an introduction to the study, informing the reader about the background which then leads to a discussion of the research problem as well as research questions. In this section the opportunity to share my position was taken in relation to the study. It provided the study with an aim and a brief description of the philosophical assumptions. The literature review follows with a narrative analysis of what is known and not known in relation to this study's topic.

CHAPTER TWO: LITERATURE REVIEW

2.1. Introduction

The following chapter focuses on defining racism, discrimination and explains what discrimination is not. It also discusses racial discrimination that students may experience during their work integrated learning within the healthcare sector. In addition, it will offer a detailed description of the framework and methodology used in the study. The literature review also describes previous studies regarding discrimination within institutions of higher learning and it will provide a brief South African history of racial discrimination. In addition, a narrative analysis of what is known and what knowledge gaps might exist is provided in relation to the research where no direct literature is found about racism in Emergency Medical Care during work-integrated learning. Instead, the literature indirectly related to the field of EMC, namely medicine and nursing was reviewed.

2.2. Racism

The concept of racism is complex as it goes beyond justifying an individual or a group's discrimination against another. Steven (1998) defines racism as an unsupported belief that among humans there are biological hierarchies in the form of different races and attempts to justify the political, economic and social exploitation of certain social groups by others. However, to define racism one must first define the term 'race'. Race was initially used among social scientists to describe people and their societies in terms of ethnicity or national identity, even though such a definition is perceived as being biologically meaningless because there is greater genetic variation *within* 'racial' groups than *between* 'racial' groups (Murji & Solomos, 2005). In this respect, it can be seen that human skin colour has no natural association with a group or individual's behaviour, ability and/or inability. On the other hand, Clair and Denis (2015) define the term "racialization" as a process of analysing the patterns of physical differences such as skin colour, nose shape, lip size and so on with the aim of classifying the groups of people into 'races' (Clair & Denis 2015).

During the expansion of Western colonialism and slavery, the concept of race was used to prescribe and justify the domination, violence and exploitation against people classified as non-White (Clair & Denis 2015). Over the centuries, race has been based predominantly on a person's skin colour, although scientifically, race cannot be biologically categorised (Fiske 2010). Race is also not ethnicity; ethnicities are defined by perceived history, various cultural practices and ancestry (Cornell & Hartmann, 2006).

A study by Phiri and Matambo (2019) argues for the use of 'Fanonian analysis'[10] in that the credibility given to the conception of race has been overrated, as the argument associated with the conception of race or racism gave it an ontological significance thus making 'race' a standard factor to decide who is human and who is not. For this reason, Phiri and Matambo (2019) have suggested that discussions about race should view the concept as nothing but a construct because it has no bearing on the actual essence of humanness. It is rather an artefact of human imagination and perception.

According to a study conducted by Dladla (2017), racism can be described as being complex and should not be narrowed down in terms of ethics and political philosophy. Dladla (2017) states that the existence of systemic racism is a consequence of structures within society. In the past 20 years, race and racism in South Africa has also been studied through a 'Critical Philosophy of Race' lens, which brought in a new perspective of race and racism. While viewed as a relevant philosophical subject, it also had two implications for philosophy. Firstly, that Western philosophy is complicit in the production of theoretical racism and racist thoughts and continues to be explicit. Secondly, that philosophy is not able to assist in practical or theoretical problems caused by racism. However, the same

[10] Fanonian analysis originates from a book titled *Black Skin White Mask* by Frantz Fanon, the analysis expands the concept of humanity to describe decolonization theory as a commitment to individual human dignity of every member of society, he dismisses the conception of race as a product of humanity, thereby rendering it as an ontologically bankrupt, describing it as nothing but a cultural artefact (Phiri & Matambo 2019; Bazana & Mogotsi, 2017).

study uncovered the racist roots of philosophical education and practices which remain unchanged and which still exist in post-apartheid South Africa as political and ethical injustices. This has since resulted in various student uprisings and has been understood in the philosophical field as a symptom of the continued marginalization of African philosophy and the philosophy of most indigenous people conquered in the unjust wars of colonisation. An auto-ethnographic approach was adopted in conducting the study with the conceptual framework based on Critical Race Theory (CRT), and for this reason it is the most suitable definition of racism within the context of CRT.

Christian, Seamster and Ray (2019) have argued that Critical Race Theory has shown its importance by better explaining continuous racial inequality than theories grounded in a progress paradigm. Their study also indicates that CRT enables a wide generative perspective when studying racism in social, legal and political life, which indicates the relevance of CRT for empirical research and sociological theories. Sociological adaptation of CRT includes four key tenets;

- understanding racism as a permanent feature;
- changing historical mechanisms which reproduce racism;
- understanding racism formed through White supremacy; and
- understanding experiences of racial oppression through narrative storytelling (Christian, Seamster & Ray 2019).

Racial discrimination within the pre-hospital setting, as I experienced, has little to no redress. There were times when I would pretend not to acknowledge that clinical supervisors would treat White students with a more welcoming approach than me. Therefore, adaptation of a wider Critical Race Theory perspective may help the EMS industry or work-integrated learning environment for EMC students overcome what Mueller (2017) describes as “racial ignorance”: an epistemological position that refuses to accept the significance of racialised structures despite valid empirical evidence of its existence.

The definition of racism has, over the years, changed and evolved. Its definition/ classification may be attributed to the surroundings or status quo, which are some of the aspects that have contributed in making its definition difficult. The constructs of racism bring about an understanding of the different ways that racism may be simply defined, as indicated by Balibar (2005). Racism is viewed in Critical Race Theory as an ordinary way that society conducts its business and as a common everyday experience for a Black person. The CRT, therefore, sees race as a political and social construct that may be manipulated by society when it is convenient. Lastly, CRT believes that different groups are racialised by the powerful elite at different times to achieve their economic agenda thus continually prioritising profit over people (Delgado & Stefancic 2001).

As outlined by Christian, Seamster & Ray (2019), CRT's multiple definitions of racism are:

- as positive or negative prejudice that could be damaging especially when directed towards oppressed people;
- as a system whereby one social group is been overpowered by another for the purpose of economic, social and political benefit ; and
- as a social and institutional power perspective in that there is the mal-distribution of resources or inequality in access to resources.

In a racist environment, therefore, a person is disabused of their ability to make decisions or the ability to define their own reality. Racism also provides an advantage for one group to benefit over the other. Christian, Seamster & Ray (2019) uses CRT to define racism through the notion of White supremacy whereby White people's thoughts, beliefs and actions are considered superior to that of Black people's norms. It also states that racism is not the same as discrimination, hatred or racial prejudice because racism involves a series of systems embedded through institutional policies and practices in society that ensure that one group has the power to discriminate, shape cultural values and beliefs that eventually support these racist policies and practices.

One education department in (Commonwealth of Australia 2012) has described racism as being a destructive act that diminishes a person's individuality by disabling them. It is seen as creating a separation within society which threatens the community's unity. Racism is also described as going against democratic principles that promote equal opportunity and fair judgement of people and also described as being overt (explicit) or covert (subtle) through a survey compiled by the Australian Indigenous Doctor's Association (2017), the findings of which reveal bullying, racism and lateral violence in the workplace.

The Australian Indigenous Doctor's Association (AIDA) has, on several occasions, received reports from doctors and medical students experiencing racism. Racist remarks or behaviours as well as systemic racism was supported by an inadequate reporting structure which was seen as the major contributor to hindering the growth of Aboriginal and Torres Strait Islander doctors and medical students. Participants in the survey indicated behaviours of systemic racism were condoned in the workplace and remain unresolved by:

- exclusion and avoidance;
- demeaning, stereotyping and racist comments;
- the belittling of indigenous people's identities; and
- accusations of playing the race card in order to gain advantage.

Participants further indicated that they felt humiliated in the presence of their patients and colleagues on the basis of their Aboriginal origins and some indicated that they resigned due to intimidation and threats of physical violence (Arabena 2013).

The negative attitude from their colleagues towards their cultural identity as Aboriginal and Torres Strait people arose from a misconception that they were privileged by being provided with an easy pathway through medicine (Williams 1999). The AIDA report concluded that racism is prevalent among AIDA's members in the workplace and the structures to address racism were inadequate. It stated that more work was required to improve cultural safety in the workplace as a contributing factor towards a culturally safe health system.

Racism has been described as both overt and covert and operates at multiple levels and dimensions of society. Overt racism is more profound and deliberate; as seen through acts of intolerance and hatred shown by an individual or group towards the other. Covert racism is often hidden and the perpetrator usually does not seem to be racist because the offensive behaviour is indirect. Systemic or institutional racism is when policies and organisational structures treat one ethnic or racial group differently to the other (Coates, 2008).

The definition of racism is usually described as an individual prejudice but racism may also be systemic and be embedded in the disadvantages and advantages of cultural artifacts, institutional realities and ideological discourses that work together with individual bias (Salter, Adams & Perez 2018). The driving force that may enable one to understand racism is the ability to acknowledge a person's belief, attitude, and behaviours of prejudiced and biased individuals. To enable a better understanding of the subject Salter, Adams & Perez (2018) discuss three insights on the psychology of racism by using a cultural-psychology framework:

- Firstly, racism can be found imbedded in our daily world, which implies that the concept of classifying people according to their race, nationality and ethnicity was historically used to derive superiority and inferiority amongst groups; therefore, this concept has cultural-psychological roots which can be traced back to colonisation and the Transatlantic Slave Trade when White people self-defined themselves as more developed and more human compared to other human groups with darker skins (Bonilla-Silva et al. 2003).

- Secondly, history plays a role in our everyday practice of culture and maintains a racialised context in our daily selections and preferences through its representations from the past. Therefore, racism affords the construction of a reality that usually serves the interests of maintaining White racial dominance (Mueller, 2017). For example, some people may choose not to celebrate the Thanksgiving holiday in the USA because they see it as a national glorification theme that minimises the experiences of indigenous people by a

commemoration of the Pilgrims triumph over cold, hunger and impending death. So, this serves as reproduction of racism through preference and selection (Salter, Adams & Perez 2018).

- Thirdly, by the racially relevant ways of seeing the world such as empirical and statistical evidence indicating the disparity in employment, health, education and income between Black and White Americans. White Americans tend to see less racism compared to contemporary minority groups. Cultural psychology suggests that the difference in the perception of racism between Black and White people stems from the fact that in predominantly Black American school students have had more exposure to perceptions of racism, are made aware of racism and therefore support anti-racist policies compared to predominately White schools (Salter & Adams 2016). One tool used to promote an ignorance of racism is the colour-blind ideology which indicates that people should see each other beyond racial barriers (Bonilla-Silva 2003); however, the notion that race does not matter denies the reality of racial inequalities and makes it possible for people to accept injustice.

'Everyday racism is racism, but not all racism is everyday racism. From everyday racism there is no relief' (Essed 1997:202*).* This statement is helpful in unpacking covert racism. The first part of the statement implies that daily exposure to racism does not justify or make it acceptable within society because it is still perpetuated by racist individuals and will be received by the victim as racist. For example, when I, as a Black man crosses a path with a White woman holding a bag, she may tend to hold it even closer to herself as she passes me or unnecessarily change her course, thus moving away from me (the Black man as perceived danger). Such an action may be experienced as everyday racism (Balibar 2005).

The second part of the statement ('but not all racism is everyday racism') means that not all acts of racism occur daily; some are isolated incidents which happen once in a while but they are still received as racist. For example, a Black patient in hospital being mistreated by a White practitioner due to their race may not experience that particular form of racism again because he was only admitted to the hospital once for a specific reason (Coates 2008).

However, the last part of the statement 'From everyday racism there is no relief' implies that as the person cannot change their skin colour; they will always be subjected to everyday racism. For example, law enforcement may decide to increase surveillance of certain laws in specific communities and increase the likelihood that selected racial groups may be involved in more criminal activities than the other. Everyday acts of subtle, covert racism offer neither respite nor recourse due to its perceived normative nature (Beckett, Nyrop & Pfingst 2006).

According to Adorno *et al.* (1950), racism is also a medical discourse in the mental health field that can transform understanding the cause and nature of racism as a pathological condition. The American Psychiatric Association's experts have expressed grave concern regarding declaring racism as a psychological pathology because in some people it was not a mental illness but 'normal' behaviour. For example, forms of bigotry and anti-Semitism have occurred due to negative attitudes created by central beliefs. It was difficult to understand why a competent Paramedic failed to triage and make a clinical judgment that would see him first treat a patient with an open and actively bleeding head injury over a patient that had superficial burns on the arm. Could such abnormal behaviour be interpreted as normal?

The term 'pathology' is defined as the study of diseases. It stems from the Greek word *pathos* and *logos (*Marcovitch, 2005). For the purpose of this research I will be forming a correlation between racism and social pathology. Social pathology is the study of disease in the society which affects the society, organisations and institutions (Clair & Denis, 2015). Social pathologies are best understood in the social institutional context because when an institution fails to address the needs of the people it will inevitably lead to a social problem. According to Clair and Denis (2015), anthropologists argue that all human beings share common bio-psychological problems and as such they have more or less similar basic interests, questions, and fears. For sociologists, racism is the study of the relationship between racism, racial inequality, and racial discrimination (Clair & Denis 2015).

Greene and Blitz (2012) contend that clinicians or medical professionals practising as therapists in multiracial societies should embrace racial differences and open themselves up to having honest conversations about race and their client's experiences of racism. The study stated that this is even more truthful and necessary for White therapists who may have clients or patients of different races. The varied manifestations of racism (namely, interpersonal, social, cultural, and institutional forms) that impact people in society result in the creation of systems that disproportionally benefit White people and place People of Colour[11] at a disadvantage.

People of Colour (regardless of class or culture) are subjected to vicarious racism[12] and the indignities of micro-aggressions[13] that contribute to racism-related stress (Harrell 2000). Greene and Blitz (2012) suggest that White people's inability to relate to micro-aggressions experienced by People of Colour renders them unable to be empathetic to their friends and colleagues who are People of Colour. It would appear, therefore, that the interventions should focus on the denial of responsibility of White people for micro-aggression, before attempting to promote empathy.

In the field of psychology, a case study by Greene and Blitz (2012) describes a female patient (a Person of Colour) who shows up late and frustrated for an appointment with her White therapist. She has just had an experience in the building lobby where she feels she was racially discriminated against by the security guard who requested to see her identification prior to letting her enter the building, this is in spite of her having seen the security guard seven previous times for appointments in this very building. In trying to explain herself for being late to her therapist she makes a bold statement: 'They don't like Black people in this

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[11] People of Colour refers to people who are non-Whites (Coates 2008).

[12] Vicarious racism is sharing of racial prejudice that is experienced by family members or friends (Tatum 1997)

[13] Microaggressions are frequent, often daily, and subtle and usually unconscious insults that happen to People of Colour. Examples of the more obviously toxic microaggressions include jokes or stories that make fun of People of Colour or perpetuate stereotyping (Franklin, Boyd-Franklin, & Kelly 2006).

building'. Faced with the challenge of not knowing the full context of her racial experience, the therapist is now supposed to suspend her psychodynamic interpretation of her reaction to the security guard, recognise his actions as having been experienced as an unintentional microaggression, and get to know her client more intimately.

Bonilla-Silva (2003) suggests that the majority of White people in the USA see racial equity as being colour-blind but this notion tends to allow for stress and insults of micro-aggressive racism to be invisible to White people. The same study also indicates that disclosing one's own past struggles with racist feelings and sharing cultural values may encourage a trustworthy relationship between two people. When one fails to acknowledge race, it often results in minimisation, denial or rationalisation of social injustice and individual experiences of discrimination (Monnat 2010). Burkard et al. (2006) are of the view that talking about racism will improve engagement and one of the benefits is to help build a more trusting relationship.

Solorzano, Ceja & Yosso (2000) have used the Critical Race Theory as a framework to describe microaggression as automatic or unconscious subtle insults which may be portrayed visually, verbally and through nonverbal actions towards People of Colour. The study reveals that racial microaggression had harmful consequences on Black student's academic and social space via a negative racial climate which caused them to experience self-doubt, frustration and isolation. This meant that Black students had to simultaneously excel at their academic performance while negotiating conflicts coming from people who had negative perceptions about them and their background. This overt racial microaggression and stereotyping resulted in Black students underperforming academically and eventually to drop a class, leave the institution for somewhere else or change their major (Solorzano, Ceja & Yosso (2000).

During my third year of study towards a four year BEMC degree, I was part of a group of six (6) black students who covertly planned and executed a move to another institution. The move was a result of multiple incidence of racial microaggression that I and fellow black students within the department

experienced on different occasions. It was the constant reminder of being inadequate as a Black EMC student and the unfair treatment we endured compared to our White counterparts. This eventually gave us two options, deregistration from the programme (as some black students eventually did) or change of institution (as we black students did). Unfortunately, due to financial constraints some black students could not afford to move to a different institution which afforded the same programme and had to endure the racial microaggression within the department and during the clinical attachment. Being treated differently as a Black student affected my confidence which eventually reflected on my academic performance; however, a change in environment after moving to a different institution altered my attitude towards the EMC programme and EMS profession as a whole which also positively reflected on my academic results. The new environment was a multi-racial department, so there was a sense of racial sensitivity that indicated racial transformation. This collectively created an environment that was conducive for learning to take place.

2.3. Racial Discrimination

In the 1950s, during the first years of apartheid in South Africa, race was classified into three categories, namely: Native, White and Coloured (Population Registration Act 1950). Later, this became four (4) categories Bantu (Black), White, Coloured and Others as per the Population Registration Act No. 24 of 1976 (SAHO,2019). Originally race was used as a unit of biological classification, but the *Population Registration Act 1950* legally used physical appearance and social acceptability.

As described above, when racial discrimination is expressed in actions this is known as overt racism. Sometimes racism can also be covert which is more hidden and not easy to identify because it is not as explicit. Since the end of apartheid, however, overt racism has been widely replaced by covert racism (O'Neil & Holdaway 2007), which is, by its nature, hidden and difficult to address. It can also be institutionalised within private organisations in a form of a discretionary use of rules (Coates 2008).

Racial discrimination within the South African Emergency Medical Services has never been scientifically identified hence the scholarly value in the subject; however, various forms of racial discrimination have been reported and documented in the workplace and Universities in general. The South African Human Rights Commission (SAHRC) (2019) indicated that the majority of the complaints received over the past year were related to allegations of racial discrimination against Black South Africans. The commission reported that race-based complaints included the use of the 'Kaffir'[14] word as well as Black people being called 'monkeys' and 'baboons' and were not limited to healthcare, equality, social security, water and sanitation, labour relation and administrative actions. One such example of a complaint of racial discrimination that the commission had to deal with was a case against Ms. Vicky Momberg, an estate agent who called a Black police officer and a 10111 operator a 'Kaffir' after she had been a victim of smash and grab, her actions were caught on camera as she shouted the word 'Kaffir'. Vicky Momberg was found guilty by the Court of Law and ordered to pay Const. Clement Mkhondo, the victim, R100 000. She was also ordered to apologise to Mr Mkhondo on her social media platform and to publish the apology on the SAHRC website (News24, 2019, 10:25).

The SAHRC, established in terms of Section 181 of the Constitution, is to support constitutional democracy, it is an independent National Human Rights Institution (NHRI) with a mandate to:

- promote respect for human rights and a culture of human rights;
- promote the protection of human rights, attainment and development of human rights; and
- assess and monitor the observance of human rights in the Republic of South Africa.

[14] Kaffir – is a word derived from Arabic for non-believer or infidel, the word is used to describe a person that has closed their heart from the truth constituted by Islam, the general meaning of 'Kafir' as derived from its roots is 'non-Muslim'. In South Africa this term has an ugly history because it was almost exclusively used by White racists to denigrate Black South Africans generally, being called a 'kaffir' described one as being a lazy or stupid person, the assumption behind the word was that one was behaving like a typical Black person (Baderoon 2004).

In terms of the Constitution and the SAHRC *Act 40 of 2013* (SAHRC) the commission is empowered to investigate and report on the observance of Human Rights in the country, educate people on human rights, see to it that they are being implemented, and also that there is compliance.

The South African Human Rights Commission's inquiry (SAHRC 2016) found that there was unfair discrimination on the basis of race, gender and disability in the workplace. It was clear that despite all efforts placed on policies and legislation promoting equality and social justice this was not enough to eliminate discriminatory practices. In 2019, the SAHRC (SAHRC 2019) found that in the past 20 years the public universities in South Africa have failed to sufficiently transform, and discrimination remains prevalent on the basis of gender, race, disability and socio-economic class. There was, therefore, a disjuncture between institutional policies and real-life experiences of students and staff.

The Cape Peninsula University of Technology (CPUT), as an institution of higher learning that provides emergency medical care programmes, recognises the existence of racism within society or the potential for students coming across such experiences. The main purpose of CPUT's position statement (Transformation, Social Cohesion and Diversity) on social cohesion is to position its community as an organ of social justice; it therefore recognises all humans irrespective of race, nationality, ethnic origin, colour, and that racism is a violation of human rights (CPUT 2010). It further acknowledges that Africans from different nations and races played a role in South Africans gaining their democracy and therefore pledges to speak out against racism. Therefore, through Social Cohesion 'the institution aims at promoting unity amongst students and staff members through its vision, mission strategic planning and values thus establishing a new culture within the institution' (CPUT 2010).

In the USA, Harrell (2000) has indicated that experiences of racial discrimination and harassment in the workplace may be portrayed in different forms and can also come from different sources; namely, colleagues or co-workers, supervisors, patients and clients and the organisation itself through its policy practice.

According to Wilson (1999, p.14), ‘an ideology of racial domination’ is at the root of racism where biological or cultural superiority of a racial group is used to justify the inferior social position and treatment of other racial groups. Social racism is divided into two phases which were shaped by the social forces and social actors after World War II (Clair & Denis 2015). In the first phase, during the nineteenth to mid-twentieth century, racism was considered a set of explicit attitudes by certain individuals; however, the second phase considers that racism encompasses the individual’s attitudes along with the implicit processes and bias constructed and enacted at the macro-level.

This latter definition of racism includes:

- **Racialization,** which becomes racism when it involves the socially significant and hierarchical assessment of racial groups (Murji & Solomos, 2005).
- **Racism,** which is analytically different from racial inequality and racial discrimination.
- **Racial discrimination,** which occurs when there is an unequal treatment of races; and
- **Racial inequality,** which takes place when there are unequal outcomes (Clair & Denis, 2015).

The knowledge gap in the literature is whether the experiences and conduct of emergency medical care students and the conduct of clinical mentors constitutes or relates to racialisation, racism, racial discrimination or racial inequality.

Contemporary forms of discrimination and racial inequality are not always the immediate results of contemporary racism. Current approaches to racism focus more on explaining the racial inequality and racial discrimination (Pager & Shepherd 2008). It does not focus much on the victim of racism as an individual, but on understanding the institution and/or the organisation. This approach allows an insight into how the institution or organisation contributes towards racial inequality, which may be portrayed in the form of unequal criminal sentencing, wealth distribution, health disparity and policies that are meant to alleviate racial inequality and discrimination between different races (Matthew 2017).

There were times that I would choose not to verbally address racism as portrayed by patients because I would find it difficult to address it in the moment and would sometimes choose to ignore patients who did not see anything wrong with what they were doing. This seemed useless and also might have prevented me from providing care that was needed by the patient. However, this also meant that indirectly I was accommodating racist behaviour which was being portrayed by patient.

In the USA, Kimani (2012) has focused on the accommodation of patients' racial preferences and medical culture. Kimani's study proposed three policy solutions created to alleviate the need for accommodating the patient's preference. Firstly, there is 'The case for accommodation and its limitation'. Patients reported high level of satisfaction in cases whereby the healthcare provider was of the same racial background and this is accompanied by significant benefit to their health. There was more patient-to-healthcare provider communication when both individuals were from the same race,[15] which often encouraged the patient to participate in decision-making and contributed to a diagnosis. According to a study conducted in Britain by Howie et al. (1991), a patient's consultation time with the healthcare provider was notably much longer when the two are of the same 'race'; this also encouraged the patient to discuss more about their problem and therefore contributed positively to the healthcare provider coming up with a diagnosis and treatment. This collectively contributed to an improved health outcome.

The second policy solution is known as 'The limits of accommodation' (Kimani 2012) when patient and healthcare provider 'concordance' (agreement) contributes to the patient's overall health, it also remains important to clearly understand the difference between racial preference originating from patient and

[15] Race was initially used among social scientists to describe people and their societies in terms of ethnicity or national identity, even though such a definition is perceived as being biologically meaningless because there is greater genetic variation *within* 'racial' groups than *between* 'racial' groups (Murji & Solomos, 2005).

healthcare provider concordance and one which is based on racism. Patients may prefer to be treated by a healthcare provider of a specific 'race' based on their prior experience with a healthcare provider of that race. Comfort also plays a role; the patient may feel more comfortable with a healthcare provider of their own ethnicity or cultural background (David 2001).

The third policy solution offered by Kimani (2010) is termed 'Beyond accommodation' when it is clear that both prior solutions do not adequately address the race-based health disparities and healthcare provider bias. Therefore, the healthcare system, including the pre-hospital setting, should go beyond accommodating the patient's preference and focus more on long-term solutions in addressing this concern. The medical profession has since focused on cultural competence training; this enables healthcare providers to be sensitive to cultural diversity amongst patients (Kimani 2012). Perhaps the Emergency Medical Service should consider focusing more on cultural awareness to promote more interaction between patient and healthcare provider of different races. An increase in diversity within the profession will also likely encourage an understanding of other cultures. However, this is exactly the knowledge gap that South African Emergency Medical Services ought to fill.

The sad reality of racial discrimination and racism continues to be observed in our society alongside other forms of hate speech, sexism, prejudice and xenophobia. During the UN's 'World Conference against Racism, Racial Discrimination, Xenophobia and Related Intolerance' (UN 2001), it was acknowledged that slave trade and slavery were tragedies in the history of humanity and a crime against humanity. This has been seen as the major source and manifestation racial discrimination, racism, xenophobia and related intolerances. It was also recognised during the conference that racial discrimination, racism, xenophobia and related intolerance are by-products of colonialism and that Africans, Asian and other indigenous people were victims of colonialism and continue to be victims of its consequences. As such evidence shows, the negative impact in different aspects of society and the Emergency Medical Service in South Africa in particular are not immune to such consequences which have also been worsened by our apartheid history.

In an attempt to address racism and discrimination and promote equality, the National Action Plan (2019) indicates that South Africa has a strong equality and anti-discrimination legal framework through its constitution that requires the state to respect, promote, protect and fulfil the rights in the Bill of Rights. The state is given the primary responsibility to guarantee that everyone may exercise their rights, should they wish to do so, to achieve the constitutional goals of human dignity, equality and human rights.

The National Action Plan (2019) outlines that the Bill of Rights serves as a cornerstone of democracy in South Africa as it empowers the rights of all people living in the country and emphatically states the democratic values of human dignity, equality and freedom. However, as described by the former president of RSA Mr Thabo Mbeki in 1998:

> South Africa is a country of two nations, one is White and the other Black, with White having access to developed economy, education, infrastructure and able to exercise their rights to equal opportunities. The second nation which is the majority is Black and poor, lives under grossly underdeveloped economy, education and infrastructure with no possibility to exercise a theoretical right into a reality" (South Africa, DIRCO 1998).

The subconscious existence of two nations exposes the reality that divisions exist on the basis of race, gender and class amongst other forms of discrimination contrary to the principles of the *Promotion of Equality and Prevention of Unfair Discrimination Act* (South African Government. Equality Act, Act No.4 of 2000). This Act gives effect to section 9, Chapter 2 of schedule 6 to the Constitution of the Republic of South Africa (1996) which prevents and prohibits unfair discrimination and harassment, promotes equality and eliminates unfair discrimination, and also prevents and prohibits hate speech.

2.4. Intersectionality

Intersectionality is a metaphor for understanding how multiple forms of inequality and disadvantage are compounded to create challenging obstacles for a person (Crenshaw 1991). Often, they are not understood within the conventional way of thinking about anti-racism, Feminism or any other social justice structures. Intersection creates a platform to understand certain kinds of problems; for example, a Muslim Black woman is a mother, wife, sister, daughter, professional paramedic, and member of the South African Military Health Service as well as being a homemaker and home-cleaner and cook. One woman, many facets/roles − all interconnected and all affecting one another. Should any form of discrimination occur against her it affects all facets of her being. This could include ageism (discrimination on grounds of age), sexism, racism, fat-ism (discriminating against people who are large/fat/obese), discriminating against people who are disabled (by not providing wheelchair ramps in a building or a lift); any form of discrimination against religion, or xenophobia (discrimination against foreign nationals. Therefore, intersectionality may be understood as a combination of different aspects of a person's being.

Segalo's (2015) definition of Intersectionality is drawn from a South African context by describing Intersectionality as important in addressing past patterns of discrimination. She recognises that Intersectionality, in its simplest form relates to different attributes that play a role in the discrimination experience. There is often an overlap of social attributes such as race, religion, gender, sexual orientation, nationality, ability, age, size, and class. Segalo's (2015) exploration of Intersectionality provides an understanding of how social inequality and systemic injustices occur on multi-faceted levels and we can comprehend that traditional notions of oppression such as racism and discrimination on the basis of gender are not independent but may occur simultaneously interconnected. Thus, the 'Intersection' of multiple forms of discrimination interrelate and generate a system of oppression.

Crenshaw (1991) further defines Intersectionality in three different forms.

- **Structural Intersectionality:** states that, based on the geographical location of a Black woman the intersection of race and gender would make

her view or experience rape, violence and remedial reforms differently from a White woman.

- **Political Intersectionality:** suggests that historical issues facing Black woman have been marginalized by (United States) antiracist and feminist politics.
- **Representational Intersectionality:** explores the concern in racist and sexist narratives derived from image production of Black woman drawings, as well as how woman of colour have been marginalized due to criticism from these representations.

According to Carastathis (2014), intersectionality is able to capture how oppressions are experienced simultaneously, and how it can simultaneously theorize the convergence, constitution and interwoven system of oppression. Without fragmenting those experiences through categorical exclusion, the concept of intersectionality aims to render visible phenomenological experiences of people facing multiple forms of social exclusion. A study by Modiri (2012) has introduced Critical Race Theory (CRT) in post-apartheid South Africa , and it describes the importance of understanding the origin of Critical Race Feminism as a disciple that focuses on intersectionality and anti-essentialism. Critical Race Feminism developed from a feeling that feminist theories did not acknowledge the racial aspect in gender oppression and sexism, as well as CRT not being able to adequately address gender issues and feminist concerns.

Groenmeyer (2011) has looked at intersectionality in apartheid and post-apartheid times. His journal paper explores the struggle that South African woman have experienced with regard to economic justice and gender equality. This arises from various affirmative action policies that have contributed to a greater representation of woman within the public and private sector. For example, while male privilege in SA has been won in land reform and economic policy; the inclusion of women threatens their newly found position and this has been the cause of tension as women are also entitled to claim land taken from their families during apartheid (Groenmeyer 2011). As described in Groenmeyer's paper, within their respective families' men are considered to be head of the family but with respect to tradition,

a patriarchal framework exists within African culture resulting in women having little power even though the law supports their emancipation.

The establishment of policy changes to promote affirmative and employment equity positively has resulted in an increase in women participating in the economy, with an employment ratio of 6 women to 10 people employed (Casale 2004). Van der Westhuizen's (2007) study has revealed that even though the employment equity between men and women was improving, racial discrimination still exists because White women earn more than their Black counterparts. However, Casale's study has noted that Black women with formal tertiary qualifications earned the highest salaries, and the majority of women only secured employment as unskilled workers which paid less. Overall, White women who had a better education largely benefited from these opportunities. In this case, gender intersects with race and the outcomes are also influenced by historic events in South Africa.

Since intersectional analysis focuses on exposing multiple identities (Groenmeyer 2011) it enables an exploration of different types of discrimination and disadvantages due to a combination of different identities. It also describes the way in which racism, class oppression, patriarchy and other forms of discrimination collectively create structural inequality for women. This approach also considers the political, social and historical context that informs the current practice because people can experience privilege and oppression simultaneously. Intersectionality is also a Feminist theory that enables an analysis of how identities are constructed, deconstructed and reconstructed (Groenmeyer 2011). For example, a woman can be a respected and highly qualified Emergency Care Practitioner in-charge of an EMS station with both men and women reporting to her, yet still suffers domestic violence in her home.

2.5. Privilege

Mcintosh (1992) documents five basic aspects that describe privilege. Firstly, it is a unique advantage that is not normal or universal. Secondly, the individual does not earn it by talent or merit; it is granted. Thirdly, it is an entitlement that comes in relation to a preferred status. Fourthly, it is exercised to benefit the recipient but to the exclusion of others, and fifthly, the person possessing a status of privilege is often not aware of it.

The study conducted by Black and Stone (2005), uncovers that society may enable a person to benefit and prosper because of advantage, entitlement and dominance. Privilege is usually not directly proportional to personal merit, intelligence or ability but solely granted as a birth-right. The privileged person will remain unaware of the impact of this privilege and would believe that it is their own personal qualities that ensured their inclusion into this group. It is also widely believed by the privileged group that those who are not part of the group show lack of effort, which means that their exclusion is due to their own personal defect.

Social privilege is at the root of entitlement and is defined as any power, immunity, entitlement and advantage which is granted to a person by the dominant group solely by birth-right membership; often expressed through race, religious affiliation or gender (Black & Stone 2005). Social privilege has a different dimension but for the purpose of this study racial privilege as a dimension will be the focus. Black and Stone also have explored principles of racial privilege are rooted in historical white supremacy.[16] The United States has a patriotic ideal stating that all men are created equal and possess certain inalienable rights but at the root of the belief is that a racially privileged status exists. The ideal explores the notion that 'all men' only referred to Euro-American men, and in retrospect, rights and privilege were given only to Euro-Americans men to exclude enslaved Africans, indigenous people and female Euro-Americans. It would be fair to say that the concept of

[16] Historical White supremacy means being White has been and is viewed as culturally valued and all other races are to be evaluated against it. (Gibbons 2018)

racial privilege denies the need to be inclusive of other races and that society can be multi-ethnic.[17]

A study conducted by Mathews (2012) has focused on White privilege in South Africa, it provided an understanding about the persistence of White privilege in the post-apartheid period and suggests how White people could be involved in anti-racist work to erode White privilege. Drawing a contrast between 'White privilege' and 'White supremacy' provides a better understanding of racial injustice in the post-apartheid era (Sullivan 2007). White supremacy was defined as a conscious deliberate form of White domination and White privilege as being caused by a combination of subconscious and psychic habits formed through exposure to a racist world which have the capacity to maintain White domination (Sullivan 2007). This may have made anti-racist strategies used to oppose White supremacy less effective in opposing White privilege, but White privilege may have been as destructive as White supremacy (Mathews 2012).

Sullivan (2007) argues that White people today have developed a mental and physical form of engagement that operates unconsciously making White racism operate like a habit (for example, White people feeling tense when surrounded by Black people). In addition, White privilege enables us to understand that White racism is not only ideas and beliefs but may also be witnessed through body language or reaction, therefore White racism may not be narrowed down to being the result of ignorance. Since such White privilege habits are unconscious it makes it difficult for White people to acknowledge that the habits exist (Mathews 2012). Sullivan (2007) has suggested that to oppose White privilege in the post-apartheid time, White South Africans would have to reflect and respond to continuing White privilege as well as unlearning habits of White privilege.

In a book titled *Run racist run: Journey into the heart of racism*, McKaiser (2015) argues that even though not all White people are perpetrators of anti-Black racism, they all benefited and they still do; he describes this as 'unearned privilege'. It is indicated in his book that as White people reveal a certain degree of

[17] Multi-ethnic people are viewed as non-White and the ethnicities which they belong to marginalize their identities.

racism there are degrees of Whiteness and privilege that come with it. McKaiser (2015:63-69) also points out that White people appear to be blind to their racism and view Black people as race obsessed in order to rationalise their ignorance. It is evident that the common denominator when it comes to one being described as privileged is the inability to acknowledge an unfair advantage over the other. They remain oblivious to this, thus perceiving the status of privilege as one that is normal and deserved on their part.

In terms of Black families in SA, the first generation of Black students at university are often not in a position to seek help or support from their families; however, it is something which is available to White students who mostly or usually come from families that have previously had access to higher education (Young & Campbell 2014). Similarly, this can be equated to the course in Aquatic Rescue (which includes surface water rescue and swift water rescue) which forms part of the 4-year degree in Emergency Medical Care curriculum. For a student to be competent in that module they are subjected to a practical assessment of challenges which include, among others, swimming a specific distance under a predetermined time, swimming a specific distance in open water, retrieving objects under water, swimming under water (UJ, 2020).

Being a Black student myself within this programme I felt that White students were privileged because most, if not all, already knew how to swim before enrolling into the programme. I felt that the level of swimming proficiency that was expected from me as a Paramedic student was unfair because as a Black person who grew up in the township, there was no access to swimming pools in our area or in our back yard, unlike the average White person who gets exposed to this at a very young age. I had to learn how to swim within the duration of the course which obviously took time away from my studies and placed me at a disadvantage compared to my White counterparts.

We observed, as Black students, that the university and our lecturers within the department (all of them were White) were ignorant of this problem and viewed it as something that we had to make time and fix on our own (which we eventually did by outsourcing a swimming instructor at our cost and making time to practise

in between classes and during school breaks). Some of our White colleagues did not view themselves as being privileged because during informal discussions as a class they indicated that we all had the same number of hours within the day so it is up to everyone on how they use them; so by these terms everyone should be competent in swimming. This demonstrates a certain level of White privilege ignorance seeing that all students do not come from the same background. Unfortunately, not all Black students could afford to pay for a swimming coach and not all Black students passed the swimming practical assessment and as a result during my years as a student in university, four of them were eventually deregistered from the programme through academic exclusion.

2.6. Racial Inequality in South Africa

Racism and segregation were informally practiced under former White rulers in South Africa. According to historians (SAHO 2019) when Cecil John Rhodes became Prime Minister of the Cape Colony in July, 1890 it was further entrenched.

> One of Rhodes' most notorious and infamous undertakings as Prime Minister in South Africa, was his institution of the Glen Grey Act, a document that is often seen as the blueprint for the Apartheid regime that was to come. On 27 July 1894, Rhodes gave a rousing speech, full of arrogance and optimism, to the Parliament of Cape Town that lasted more than 100 minutes. In this speech Rhodes was opening debate on the 'Native' Bill that he had been working on for two years… The Glen Grey Act was to pressure Africans to enter the labour market firstly by severely restricting African access to land and landownership rights so that they could not become owners of the means of production, and secondly by imposing a 10 shilling labour tax on all Africans who could not prove that they had been in "bona fide" wage employment for at least three months in a year. This land shortage coupled with a tax for not engaging in wage labour would push thousands of Africans into the migrant labour market. These were all measures essentially designed to ensure a system of labour migration which would feed the mines in both Kimberley and the Rand with cheap migrant labour. This section of the act instigated the terrible migrant-labour system that was to be so destructive in 20th century South Africa. Another pernicious outcome of the Glen Grey Act was its effect on African land rights claims and [that it] restricted and controlled where they could live.

However, in 1948 the policy of apartheid was legally introduced[18] in South Africa by the National Party government and remained in place over the next 46 years. During this period the country was deliberately divided on the basis of 'race' which resulted in profound inequalities. The system was structured in such a way to benefit White people (especially the Afrikaner Whites). White people were seen as the power brokers at all levels with the majority of black people being marginalized and exploited (Stevens, Franchi & Swart, 2006).

Racism was not only created for segregationist purposes; it was also used as a means to justify racial hatred which perpetuated indignity by Whites towards non-Whites (Durrheim Mtose & Brown 2011). The indignity took place when non-Whites had to abide by the master-servants system where Whites were referred to as *Baas* (White master) and white children referred to as *Kleinbaas* (little boss). The whites would express their frustrations towards so-called non-Whites by using racial slurs[19] (Durrheim, Mtose & Brown 2011). Such language is likely to constitute hate speech in the new SA dispensation to protect people from the indignity of their usage.

The National Party government signed over 100 Acts into law, such as the *Group Areas Act* No. 41 of 1950 and the *Bantu Homelands Citizenship Act* No. 26 of 1970. Under such legislation non-Whites were forcibly removed to racially demarcated locations. According to Durrheim, Mtose & Brown, (2011) 3.5 million people were forcibly relocated into Bantustans[20] and homelands. The *Dompass*[21]

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[18] Racism and segregation were already practised under Cecil Rhodes and earlier when SA was a British Colony.

[19] It is untested what limits hate speech regulation has on academic freedom. Notwithstanding, I choose to not repeat them in this text.

[20] Bantustans (bantu or Black homelands) wereBlack areas primarily set aside (like Indian reservations in the USA and aboriginal reservations in Australia) for indigenous Black South Africans to live and were usually located far from urban areas on rural land. They were established by the apartheid government (Durrheim, Mtose & Brown 2011).

[21] A 'Dompass' was a document carried by Black South Africans to validate their identity as well as detailed where they could work or live (Durrheim, Mtose & Brown 2011).

(passbook*)* was issued to all Black males who were above the age of 16 to enable them to travel outside their Bantustans. Once these men were in the city they had to adhere to a strict curfew which restricted their movement at night. If the curfew was broken, they would be arrested. All of this gave rise to the power and control that Whites had over Non-Whites (Durrheim Mtose & Brown 2011; Essed 1991; Thackwell et al. 2016).

The development of struggle or resistance movements arose during the 20th century. In 1912, the working class, the Black educational elite and the chiefs formed the African National Congress (ANC). The party became a resistance movement alongside other organisations like the Industrial and Commercial Workers Union and Communist Party (Steven, 1998). In 1944, the ANC Youth League, led by Nelson Mandela and Oliver Tambo, were in the forefront of the defiance campaign (Durrheim Mtose & Brown 2011).

In 1956 the Freedom Charter was drafted as an alternative conceptual frame to apartheid and racism. One of the aims of the Freedom Charter was to form a non-racist society. The National Party government received pressure from the international and national communities to release political leaders like Nelson Mandela in 1990. In 1991 the Convention for Democratic South Africa (CODESA) (the negotiating forum) paved the way to the Multi-Party Negotiating Forum which began its negotiations in 1993 (Durrheim Mtose & Brown 2011; Thackwell et al. 2016).

Apartheid policies institutionalised and decided people's identity on the basis of race before 1994 (Stevens, Franchi & Swart 2006). The apartheid era saw one country divided into two which eventually gave birth to the constant political war for coexistence with equal opportunities and quality of life. The first democratic election in South Africa occurred in April 1994 and ended the prolonged dominance of Whites as well as the anti-apartheid movement struggle for equality and independence.

Notwithstanding the change in political power, there is still an unequal balance of power in South Africa, largely due to the tension between the political, cultural and economic majorities and minorities. While the Black African has the political majority, the cultural majority remains questionable; it remains unclear if the Black political majority have the 'Power' or if power still in the hands of the White minority. [22]

Among fellow Black Emergency Care providers there is a perception that White people believed that the EMS industry belonged to them and only they should be entitled to the Advanced Life Support (ALS) paramedic status. To bring meaning to such a perception it is of value to look into the history of South Africa with reference to employment opportunities within the EMS at an ALS level. Historically during the apartheid era, the country was divided on the basis of race and majority of the Black people had limited access to basic education (known as 'Bantu Education'[23]) and few in this system were afforded the opportunity to access tertiary education (Collins & Millard 2013) compared to their White counterparts. This obviously created an imbalance in employability as most Black people were limited to jobs which did not require any set skills that had to be studied at an institution of higher learning, making them perceived as unskilled workers. The skilled workers at that time would be those who studied for a specific discipline or specialised in a specific skill; for example, a pilot, paramedic or an engineer, and the majority of those were White people (Coovadia et al. 2009).

In 1974, the impact on the Emergency Medical Care field led to the acknowledgment of the need for an upgraded training in the EMS by the Medical Association of South Africa in 1974. Before this, the ambulance service was mainly staffed with volunteer first aiders who were primarily responsible for

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[22] The African National Congress came into power with a total of 12,237,655 valid votes, which afforded them 252 seats in the new parliament (National and Provincial Election 1994).

[23] Bantu Education was designed by the Nationalist Government; It was a development of the Native Education policies for the 'Bantu' or the' Natives' of South Africa. It was a product of the economic and political structure of the country during apartheid. The aim of Bantu Education was not to raise the cultural level of the Africans, nor to develop the ability of an African child to the full, but was aimed at solving the cheap labour problems in the country (SAHO 2019)

transporting a patient from the scene to hospital where emergency medical care could be provided to the patient. The first 'ambulance training college' was established in 1978 in Cape Town. The college offered a course for ambulance personnel called Basic Ambulance and Rescue Medic for one week. After the establishment of the ambulance training college, several courses would be introduced and provided ambulance personnel with more theoretical knowledge to enable them to practice more complex skills within the pre-hospital environment. Courses would range from Emergency Medical Assistant I (introduced under the College of Medicine of South Africa by the Pre-Hospital Care Committee), and was followed by Ambulance Medical Assistant to later become the Critical Care Assistant course (MacFarlene, Van Loggernberg & Kloeck et al. 2005).

In 1980, a two-week Basic Ambulance Assistant course and the Ambulance Emergency Assistant course were introduced. In 1985 there was an introduction of an Advanced Life Support CCA course which took 4-months to complete but later in 1999 an additional five months of clinical attachment or work-integrated learning was added to the course. The National Diploma in Ambulance and Emergency Medical Care was introduced in 1987 by the then Natal Technikon (currently Durban University of Technology) but later changed the name of the course to National Diploma in Emergency Medical Care (Cermark 2016).

These courses were introduced and conducted during the apartheid era but were continued in the post-apartheid years, with the bias in selection intact. What further contributed to the limitation in access to Emergency Medical Care Training in South Africa for Black people is that by 1996 there were a total of six institutions in country accredited by the HPCSA to conduct these courses, namely; four provincial ambulance training colleges and only two higher education institutions (HPCSA 2014).

2.7. Institutional Racism

Another approach for explaining racial inequality deviates from the normative approach to racism which focuses on the individual to consider if institutions are critical role players in racial inequality and discrimination. Theories of institutional racism are essential in explaining policies, practices and norms of organisations, structures and systems which are normally taken for granted (Clair & Denis 2015).

The general instances of racial discrimination, exploitation, inequality and domination in institutions and organizational structures is referred to as Institutional Racism (IR) as described by Stokely and Hamilton (1967). Clair and Denis (2015) have described racism as being both overt and covert, when the effects of racism are visually displayed in society or on television result in human harm; this is referred to as covert. The latter type is more subtle with less evidence about the perpetrator; it is embedded within the organisation and often goes unnoticed because it receives far less condemnation from the public. While society often reacts to IR it often does not see anything wrong with the unfair discriminatory practices within an organisation or community. There is the pretence that there is no need for solutions to the problem if it does not exist. This may also be evident through unequal distribution of resources between two opposite race groups (Durrheim Mtose & Brown 2011). Processes, rules and opportunity structures that allow such practice are what collude to form institutional racism.

In a study done by Perez, Ahmed and London (2012) the existence of racial discrimination within a university in South Africa was documented during the apartheid era. The findings were that racial discrimination had an impact on the overall training of Black students enrolled into the University to study medicine. Black medical students were not allowed to treat White patients during their work-integrated learning; the best tutors were assigned to White students; and some hospitals also refused Black students to enter White patient wards. During the apartheid system, Black medical students were also denied access to university residences and participation in extra-mural activities and social functions. The environment at university and outside university was not conducive for learning to take place thus directly affected the Black students' academic progress.

London et al. (2002) underline the significance of challenging and changing institutional culture as a strategy to address discrimination. They have suggested that racism had direct practical consequences for careers through reducing and restricting opportunity for training. It also indicated the lack of equal minimum requirement or standard between Black student and White students as Black students reported that they had to work twice as hard to be seen to perform. In the discourse on diversity in health sciences education these observations remain relevant post-apartheid.

The Rhodes Must Fall (#RMF) movement and the Movement to Decolonize the University indicated Black students' awareness and acknowledgement of the existence of institutional racism and patriarchy within the University of Cape Town (UCT). The initiation of the RMF movement was sparked by a Black student who threw human faeces at the statue of British imperialist, Cecil John Rhodes in March 2015. In the attempt to decolonise racial structures within the university, students established their own framework and detached from UCT's Euro-American dominant model of knowledge. Their 'decolonised' framework centred on Black Consciousness, Black radical feminism and Pan-Africanism. The mission statement of the #RMF characterised the lived experiences of Black students at UCT as 'Black pain' or the 'dehumanization of Black people' (Ahmed, 2019).

An empirical study conducted by Ahmed (2019) sought to uncover a deeper understanding of the student's radical movement beyond the removal of the Rhodes statue because even after the Rhodes statue fell the movement still continued and maintained its name. It concluded that the formation of #RMF was a direct response to an oppressive and anti-Black university structure, simultaneously Black students were also offered space to reflect and organise, thus providing them with a sense of belonging because it is a space that they may not have had elsewhere. Ahmed further suggests that, the university's environment was at a paradoxical position because it offered empowerment through 'Black liberation' and dehumanised 'Black pain' for those on the margins.

The Rhodes Must Fall movement developed a de-colonial framework that gave rise to the concept of 'Fallism'.[24]

Cultural practices, knowledge, values and ways of knowing are predominantly endorsed by educational institutions in South Africa and often place students from other cultural influences at a disadvantage. This tends to give way to what is known as 'cultural capital', which is a concept that describes the interaction between education and culture that results in a reproduction of inequality (Young & Campbell 2014). Admission and access to universities do not necessarily include access to its social spaces and there is still informal segregation between Black and White students (as demonstrated by another study conducted by Koen and Durrheim 2010) which indicated that seating patterns in lecturer theatres were racialized.

Mbembe (2016:30-31) argues that 'decolonization' of universities is the new direction. He provides various examples in which universities may consider decolonising their institutions which include:

Democratization of access: government investing in universities in order to increase access to higher learning.

Decolonization of buildings: the infrastructure at university should not resemble apartheid architecture as this may serve as a reminder of the past which will not be conducive for learning.

Creating the University classroom: creating a classroom environment that is conducive for learning and encourages student's intellectual and moral lives to be independent.

Decolonize the system of access and management: because this discourages students and lecturers from pursuing knowledge freely.

The mania for assessment: he indicates that this takes enormous amount of time and energy from the faculty because they have to complete administrative demands for ongoing assessment and review of programmes.

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[24] Fallism is a descriptive term primarily used to refer to multiple student movements using the "Must Fall" hashtag such as #RhodesMustFall and FeesMustFall. Methinks 'Wall St must fall' was earlier in the US.

Methods of evaluation of faculty: faculty member's ability to teach are based on statistical data which looks at number of publications, committees served, publications, courses taught, ect.

Breaking the cycle that tends to turn students into customers and consumers: this is seen through students' loss of interest in knowledge or studying, but focus is placed on enrolling into programmes that have an open market which provides employment, students themselves become consumers and the university takes the role of keeping the customer happy.

2.8. Critical Ethnography

Given that health is a socio-political phenomenon influenced by dominance and power, the Critical Ethnography methodology is well suited for a health research (Cook 2005). This methodology focuses on human experience and its relationship to truth and power and provides an opportunity to examine health challenges closely to enable a study of the experiences of those affected by them on a daily basis.

In qualitative research, the author pays close attention to the discourse and how the participant conducts himself; analysis is inductive or abductive and the study is usually done in a natural setting. Data collection is done by the author and should not depend on relationships to accurately collect ethnographic description from an internal perspective (Rubin & Rubin, 2005). Through ethnography an exploration of different aspects and meaning about a group's culture, behaviour, values and beliefs is possible. Creswell (2007) describes the capacity to examine culture through the lens of power, privilege, prestige and authority using critical ethnography. This enables the author to respond to ethical responsibilities in an attempt to address injustice and unfairness in order to achieve positive social change (Brown & Dobrin, 2004).

The critical ethnographic approach in this study was to better understand the Emergency Medical Care Student and Emergency Care provider's discriminatory social experiences during work-integrated learning. According to Carspecken (2013), Critical Ethnography in an educational setting was considered to be useful for research conducted by nurses. The use of Carspecken's (2013) method during

qualitative research was mainly to facilitate social action explanations. It supports efforts of change by exposing inequality and oppression but also suggests that cultural power intersects political and economic power thus making some groups dominant over others. Carspecken (2013) noted that cultural condition and resources can influence meaning of an action, but an important aspect in this approach is the interpretation of meaning and communicative structures used when interacting.

According to Carspecken (2013), critical ethnographers should start by assessing their own values and bias to articulate if the relationship of power, truth and thought agree with cultural safety and the nursing code of ethics. To give voice to those who were marginalized by economic, political and historical events, Cultural Safety[25] is used to expose pre-exiting events and outcomes of power inequities. To gain sight and understanding of other people's belief, researchers and practitioners must acknowledge their own belief (see autoethnography section 2.8.1). Carspecken (2013) also points out that researchers must also be aware that the potential impact their own perspective has on the data-making and interpretation process.

2.8.1. Autoethnography

Adams, Ellis and Jones (2017) describe autoethnography as a method used for documenting and reflecting on personal experience. In short, autoethnographers believe in the infusion of personal experience within cultural or political norms and expectations, they also engage with self-reflection, usually referred to as 'reflexivity', in an attempt to identify and interrogate an intersection between the self and social life. The sole intention for autoethnographers is to show people the process of knowing what to do, how to live and what their struggles mean (Bochner & Ellis 2006).

[25] Cultural Safety refers to the ability to understand the relationship between minority status and health status to try and bring about change on nurse's attitudes that continue to support the current dominant practices and system of health-care to those that are more supportive of the health of minority groups (Smye & Browne 2002).

An intersection of ethnography and autobiography is required to understand autoethnography fully; autobiography is writing about yourself and reflecting on previous experiences, sharing past experiences with others, examining personal journals and photographs, and other achievements related to life events. These experiences are then written using storytelling devices such as character development, narrative voice and dramatic tension so that a text creates an evocative representation of a specific culture or cultural experience to give a sense of how it feels like to be in those experiences (Bochner & Ellis 2006).

Ethnography requires one to participate, observe and write about culture or cultural experiences. During ethnography, therefore, more interview time is devoted to the cultural field to gather additional data from participants' experiences in terms of their thoughts and feelings. The ethnographer's approach is characterised by the community and what they write is guided by their observation and this is what they eventually describe as 'Findings'. The ethnographer creates a connection between their findings through formal research of the data. Ethnography aims to create a representation of cultural practices that will be familiar to cultural outsiders. To offer the reader a sense of being there in the experience requires the use of vivid, rich and concrete descriptions. Collectively, the principles, process and practice of ethnography and autobiography contribute to the way autoethnography is written and practised (Adams, Ellis & Jones 2017).

Autoethnography is presented in this study for five main reasons. Firstly, the study focuses on personal experiences of Emergency Medical Care students and Emergency Care providers. It will allow me to speak against social discriminatory practice during work-integrated learning and provide alternatives to unjust stories and stereotypes (Boylorn, 2014). Secondly, I will be able to articulate and share with the readers my own experiences of racial discrimination as a student and practitioner and as an insider to discuss issues of racial discrimination (Adams, Ellis & Jones 2017). Thirdly, it allows me to describe how racial discrimination affected me and also allows me to encourage other autoethnographers to write about discrimination during work-integrated learning (Crawford 1996). Fourthly, choosing an ethnographic method allows me to describe everyday experiences of

social discriminatory practice in work-integrated learning during clinical practice that other traditional methods of research would be unable to capture. The final goal of autoethnography is to avail information through text that can be accessed by a larger audience, especially those outside the academic environment (Adams, Ellis & Jones 2017).

The process of autoethnography uncovered different emotions for the author and the participants as victims of racism. It is therefore hoped that individual perceptions can be altered by an autoethnographic approach to change the future in terms of transformation.

2.8.2. Critical Race Theory

To fully understand racial discrimination from a critical ethnographic approach as people tell their stories, Critical Race Theory (CRT) has been used as a special and adequate tool to examine how socio-temporal notions of race can neutralise oppression and normalise racial inequality in society (Delgado & Stefancic 2000; Rudkin 2002). According to Crenshaw (1995) the expression of power is usually related to inequality and oppression, therefore transformation of utterance from one discursive context to another is explicit and formal.

Critical Race Theory (CRT), as a movement represents scholars and activists with an interest in studying and transforming the relationship between power, race and racism. The movement engages in civil rights and ethnic discourses but positions the studies in a larger perspective which includes history, economics, context, feelings and the unconscious. Traditional civil rights embrace advocacy of change by degrees, whereas with CRT, foundations of the liberal order are questioned, including legal reasoning, equality theory and neutral principles of constitutional law (Kimberlé et al. 1995).

Critical Race Theory also contains an activist dimension and may be used to understand issues of hierarchy, tracking and controversies over history. Delgado & Stefancic (2000) state that:

> Through critical race theory not only do we try to understand our current social situation but it gives us the opportunity to change it, it helps the society to organize itself along racial hierarchies… transforming it to be better.

Critical Race Theory gives a theoretical understanding of racial discrimination and is guided by five basic principles as follows:

- The first feature is that **'racism is ordinary and not aberrational'** (a departure from what is normal). It is considered an 'acceptable' way in a society for how people live their everyday lives and becomes an 'everyday', normative experience for people of colour. This means that racism is difficult to address or cure. Similarly, colour-blind racism refers to a set of scripts and styles used to justify and explain the racial *status quo* without sounding racist (Bonilla-Silva, 2010).
- In the second feature is known as '**interest convergence'.** This kind of racism advances the interests of both the working class and White elites and means that the majority of such a society will have little incentive to eradicate it.
- The third theme of critical race theory is called the '**social construction'**, meaning that race is a product of social thought and relation. It further explains that people from the same origin with the same race share certain physical traits.
- The fourth feature has more to do with the **'racial economic structure'** within the labour market, where people are given first preference for specific jobs or the person's skin colour serves as an advantage for one to get the job (Bonilla-Silva et al. 2010).

There is a notion of a unique voice for Colour, which is where victims of racism are in a position to share more theoretical and practical experience about racism (Delgado & Stefancic, 2000). According to Taylor (1998), Critical Race Theory is described as being rooted in the reality of singled out racial experiences with a general agreement among African-Americans, Whites and others who have experienced suppression. Thus, CRT embraces and acknowledges perceptions of fairness, truth and justice.

Taylor (1998) also sees storytelling as one of the most effective ways to challenge society's dominant mind-set because stories create a shared communal understanding. Hence, most CRT researchers often use storytelling as an approach in contesting and engaging negative stereotyping.[26] While the same study also creates awareness about Black and White criticism of CRT as being hopeless or cynical, Taylor (1998) affirms that within CRT constructs there are ways of overcoming hopelessness and helplessness and give voice to those who share common experiences of being oppressed.

Yosso (2005) has used Critical Race Theory to conceptualise a community's cultural wealth. The CRT, therefore, has shifted focus by exploring cultural knowledge, abilities and skills of the marginalized groups that are usually not acknowledged or recognised. This same study focused on the knowledge and skills brought to the classroom by students of colour (as learnt from their community and homes). Yosso then uses CRT to challenge and criticise the Bourdieuean Cultural Capital theory of traditional interpretation, which argues that the middle and upper class knowledge is 'capital' valuable to a hierarchical society. This further states that to attain such knowledge one would have to be born into a family that already had knowledge that was considered valuable, but there was also an opportunity for one to get such knowledge by going through middle or upper class schooling. This theory is an attempt to explain why academic and social outcomes are lower for People of Colour than for Whites.

Community Cultural Wealth, therefore, is an alternative concept derived through CRT by Yosso (2005) and is used to challenge this assumption. The concept demonstrates that there is knowledge developed within Communities of Colour as Morris (2004) had indicated when he advanced the idea that cultural capital was shared amongst Black people and developed their social capital to survive racism and discrimination. In this way the community mobilised collectively to create access and equity to education for African Americans.

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[26] Stereotyping is described as biased beliefs and thoughts, a flawed generalization (Salter, Adams & Perez 2018).

African-American students, especially to those attending predominately White schools, have found schooling to be problematic due to racism. They usually felt physically isolated and culturally alienated, and remained silent (Ladson-Billing & Tate 1995). For them, CRT was considered useful to explore such a phenomenon, although CRT was mainly used in legal research. Since then its use has further expanded to research within the education sector. It has now emerged as a significant analytical and theoretical framework within education research (Duncan 2002). This present research, therefore, aligns with that medical, legal and education context. According to DeCuir and Dixson (2004), CRT may be used to examine qualitative data by analysing counter-stories while there is still an opportunity to further develop CRT as a framework and a method that can be used to analyse education research. When using the CRT in education one needs to be critical of race and its deployment through policies and practice.

In post-1994 South Africa, CRT has been applied to past apartheid structural legacies and interpersonal tensions as witnessed in a number of universities in South Africa (Soudien 2010). While the termination of apartheid brought formerly segregated people together more still needs to be done to promote equality (Vincent, 2008). Conradie's (2016) study demonstrates how the tenets of CRT were used in post-apartheid studies in South Africa. According to Soudien (2010), the CRT framework concept consists of five principles:

- Firstly, an approach to racism as endemic;
- Secondly, dismantling prevailing ideologies;
- Thirdly, a commitment to social justice;
- Fourthly: experiential knowledge of research subjects; and
- Fifthly: interdisciplinary work.

These five principles may be briefly summed up as providing a CRT lens that not only looks at racism and discrimination in isolation but also incorporates all changes that happened post-apartheid in an attempt to promote equality with different aspects of society. Through a CRT lens the study would be able to uncover challenges faced by both Emergency Medical Care students and their mentors during work-integrated training experiences. These are further discussed below.

Racism as endemic. Post-Apartheid South Africa became a country that promotes coexistence of multiple races and abandoned the previously imposed racial hierarchy. CRT suggest that this alone does not guarantee the end or removal of racism. Through CRT, the interpersonal prejudice and structural disparity may be interrogated. Soudien (2010) suggests that racism became covert with minimal harm, making it difficult to pinpoint but did not disappear.

Dismantling power-evasive ideologies.[27] Discourse analysis interrogates obscure ideas to avoid denial of racism and unmasks the link between power and race. Such a discourse confines racist individuals to the past? and exposes racist history that has no place in the present. Assuming that there is no longer racism obscures the opportunity to indulge in deeper analysis of a broader cultural pattern (Hook, 2013). South Africa is committed to non-racialism but the potential for non-racialism can also deny the existence of subtle racism. Therefore, Conradie (2016) suggests non-racialism should be challenged as the current defensive approach to raising topics of racism. All such power-evasive forms of non-racialism should therefore be questioned.

Social justice, experiential knowledge and interdisciplinary studies. These approaches are generated through discourse analysis to allow for advancement in social justice. While it promotes involvement of people who are perceived to be different, it also encourages reconsideration by the dominating group to understand group boundaries so that they do not take other groups for granted (Conradie 2016). For CRT to achieve this, research objectives should promote the meaning of race the same way it is acquired through daily practices. According to Steyn and McEwan (2013), interviews and focus groups should be conducted to collect data on past events through personal refection as well as sourced from archives (Hook 2013). Interdisciplinary research through CRT aims at gathering current knowledge about what formulates race as a social construct and its association with the construction of racism.

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[27] Power-evasive ideologies discourses serve to justify the ignorance of accumulated knowledge about the role of race in society (Conradie, 2016).

According to Modiri (2012), in South Africa there is a need to transform the country in a way that marginalization and racial exclusion becomes anathema to the constitutional and democratic ethos we claim for South African society. The CRT can engage in critical and radical thought in the complexity of racism. Modiri, for instance, used CRT to critique traditional approaches to race and racism that primarily looked at race-neutrality and colour-blind constitutionalism. Through CRT prevailing race concepts, oppression and injustice from a legal perspective were examined and Modiri (2012) has suggested that a transformative tool in CRT may be used to critique the post-apartheid era.

- Demonstrate that regardless of legal transformation to end White supremacy, White privilege and racism continue to manifest institutionally within society;
- Expose and examine how the law and the legal culture are implicated in strengthening the current power relations and social arrangements;
- Focus on injustice and the disadvantages faced by Black people to demonstrate how current legal discourses permits and contributes to facilitating it; and
- Disrupt the celebrated notion of a 'Rainbow Nation' in post-apartheid South Arica that exists via colour-blindness and a liberal economy by exposing ongoing racism, racial subordination, exploitation and suffering of Black people's daily experiences.

2.9. The Tradition of Resistance in Medical Education

The 1994 South African election marked the transition to democracy. Unsurprisingly, this brought many hope that the income and inequality would be reduced. The Reconstruction and Development Programme aimed at identifying and fighting poverty. Further to that the Constitution recognised healthcare, socio-economic aspects like sufficient food, water and income security based on democratic values of human dignity, freedom and equality (Shefer, Ratele & Kiguwa 2006).

Two decades later, South Africa is in a situation where it may have achieved a sustainable democracy, but it has also inherited many challenges - mostly centred

on the transformation from apartheid society. Racism defined aspects of the social relationship between different races. Yet, we are reminded on a daily basis of the legacy of our past as well as the ongoing manifestation of the unsustainable belief that one race is inherently superior to another (Shefer Ratele & Kiguwa 2006). According to Wilson (1999) it was pivotal for the apartheid government to maintain the apartheid machinery and it should be as pivotal for the new democracy to attempt to transform and reconstruct society.

In addition to abolishing apartheid, the introduction of policies that promote affirmative action in employment, education, sport and various area including the Broad-Based Black Economic Empowerment (BBBEE) programme was included to address the inequalities (Durrheim, Mtose & Brown 2011). Post-apartheid society contains uneven racial interactions where about 40% of 'Non-Whites' have never had contact with White people, as opposed to Whites who have casual and close contact with them through public and private institutions; namely, workplaces, schools, universities and churches that are no longer racially segregated due to the transformation agenda, theoretically and legally (Durrheim, Mtose & Brown 2011; Thackwell et al. 2016). Racial integration is an emerging reality and the majority of South Africans work and live alongside one another.

Racism still has a socio-geographic form in that promotes segregation within the historical limitations of the Group Areas Act. As such, residential segregation reinforces the original patterns of employment segregation (Christopher 2001). This causes individuals to be unable to relate to one another in the workplace. Essed (1991) has found that racism exists in post-apartheid South Africa when Non-White respondents narrate their racism experience for this present study which they view as ordinary, normal and unquestioned practice despite the fact that racist ideologies exist. Non-White people's stories of racism, discrimination, segregation, racial slurs are ongoing examples of racism. There are common themes that occurred during post-apartheid and apartheid era, like racism is pervasive and a way of life for Non-Whites in South Africa (Essed 1991; Durrheim, Mtose & Brown 2011; Thackwell et al. 2016).

Black Medical students' experiences between 1950-1990 at the University of Natal, Medical School have been documented by Noble (2004). In this study, the majority of the Medical School's Black graduates shared experiences of discrimination during clinical training at the exclusively Black teaching hospital. Black students were forced to develop tolerance for unethical racist treatment typical in the apartheid health care services at that time. For example, Black medical students were prohibited from conducting clinical practice at hospitals which were serving Coloured and White people; instead Black students had to learn and practise among their own racial group. Apartheid zoning also affected Black students who could not stay in a White area which was closer to the Medical School Buildings; instead they had to travel 15–20 kilometres from their homes (Noble 2004).

In the midst of all of these challenges the South African Students' Organization (SASO) was formed in 1968 as an exclusively Black, student-led, anti-apartheid organization to specifically address Black student concerns and issues at the height of the most oppressive years of apartheid (Noble 2004). In 1969, Steve Biko, a medical student studying at the Durban Medical School was elected as the first president of SASO. He argued that Blacks were 'politically, socially and economically discriminated against and identified themselves as such" (Noble 2004).

At its peak SASO played a major role in politicising Black students at the Durban Medical School campus, and before it left at the end of 1972, there were many underlying divisions and tensions that existed in the student body, which often undermined unified political action. What camaraderie there was started to fade away as tensions began to emerge 'around unequal racial privileges that Indians and Coloured students received over African students. As a result of student political activities, the Medical School suffered many years of political harassment by the State and security police. This was facilitated by a constant police and army presence at a vehicle storage garage for the armed services in a building on the same grounds as the residence (Noble 2004).

One of the worst consequences of South Africa's history of racial discrimination is the impact on the training of Black medical students. This is a subject that Perez and London in 2004 have explored in their research paper ‘Forty-five years apart - confronting the legacy of racial discrimination at the University of Cape Town’. Their research exposes the disparities that existed in the University of Cape Town’s Medical Sciences Faculty between White and Black students. The research projects set out to understand what happened at UCT during apartheid and to identify obstacles faced by Black staff and students, and women that both then and now continue to create barriers to their full participation in the Faculty (Perez & London 2004).

Although no legal statutes existed before 1948 for restricting the admission of Black students into 'White' universities, many universities, including UCT medical faculty adopted policies that effectively barred Blacks from study because it could lead to Black students examining White patients during their clinical practice. In the year 1923, UCT's Council stated that it will not be in the university’s interests to admit Black or Coloured students in any numbers, if at all. The intention behind this was to convince Black applicants that the University could not offer them appropriate facilities to complete medicine their training because of race restrictions imposed by hospital administrators (Black students were prohibited from completing their training at UCT due to local hospitals denying them access to White wards for the clinical practice phase of their training. Instead they were expected to travel overseas to complete training) (Phillips 1993).

According to de Villiers and de Villiers (1999) it was only in beginning of 1943 that Coloured and Indian students were allowed into the 'non-European' hospital wards in the then new Groote Schuur Hospital (only on condition that they had no contact in any way with White patients, even post-mortem). To make medical education more inclusive it is essential to understand how racial discrimination devalued medical education for Black student in the past (during apartheid) and accumulate lessons from those experiences which will help in ensuring that education follows a different path in the future.

2.9.1. Racism in post-apartheid South Africa

Education rights under section 29 of the South African Constitution states that everyone has the right to basic education, this includes adult education to further their education, which the state, through reasonable measures, must make progressively available and accessible (Constitution of the Republic of SA,1996). According to Chetty (2014), the liberation struggle cherished the idea of providing higher education for all but in reality, this idea does not favour Black students. Chetty (2014) indicates that a racialised social system has been maintained in South Africa because allocations of political, economic, social and psychological rewards to a specific group is based on race. The education system in Black townships does not reflect equity regardless of the Constitution and legislation which claims the removal of discrimination in schools. The quality of education has improved compared to that offered during apartheid but because of spatial apartheid the township schools are all Black.

Respect (or disrespect) for cultures, language and ways of social interaction plays a key role in shaping students' educational experience in South African educational institutions. A mix of legal barriers and social prejudice also occurs in present South Africa as reinforced for decades under apartheid; and still affects different aspects of South African society, including the healthcare sector (Baldwin- Ragavcn, De Gruchy & London 1999).

A study conducted by Gradin (2012) has explained the poverty trend in post-apartheid South Africa in terms of income by noting that there was a reduction in poverty among Blacks between 1993 and 2008. The reduction was mainly in relation to increased access in education and the ability to seek employment in skilled occupations to catch up with Whites. It demonstrated that the equal education and a less racially segregated market occurred after the end of apartheid and were the main reason for reduction in racial poverty gap between Blacks and Whites. Apart from an increase in education access, the study also suggested that the implementation of affirmative action was an additional factor contributing in the reduction in poverty amongst Blacks. The study concludes by indicating that people of African descent in SA face higher poverty and deprivation

rates than White people and such racial differentials were notably higher compared to the USA and Brazil due to inequalities in distribution of characteristics across races.

2.9.2. Racial discrimination in post-apartheid South African Health Care

It is important that measures are taken to transform the Emergency Medical Service into an institution that contributes to a democratic landscape. Much effort has gone into that process; for example, equal opportunity to good education and new opportunities which saw Black people studying further and creating a career. This study, as an examination of racial discrimination within the EMS, seeks to contribute to understand better the operation and influence of race within the EMS system. Hopefully, its recommendations advance the cause of anti–racism and contribute to ensuring that our EMS reflects the values underpinning this society, human dignity and equality (William et al. 2008). The legacy of apartheid has affected the South African health care system in various ways; namely, shortage of funds, immigration of healthcare and workers to mention a few.

London and Baldwin-Ragaven (2008) outline the current challenges faced by nursing practitioners and educators as human rights training becomes more essential in South Africa. The HPCSA is responsible for the incorporation of human rights learning outcomes in the accreditation of training institutions, thus the institutionalisation of human rights education for health professionals in South Africa is possible (HPCSA 2007). London and Baldwin-Ragaven (2008) state that educators and healthcare professionals are conflicted by challenges to ensure that not only do professional codes meet human rights standards but that what is being taught in training should actually be implemented in daily practice.

The health care professional's position makes them more effective to advocate patient's rights because they are on the front-line of receiving patients with various medical and trauma injuries. The World Health Organization (2005:21-42) defines the state of health as 'a state of complete…well-being and not merely the absence of disease'. Promotion of health and protection of human rights complement the bio-psycho-social approach. The South African Bill of Rights is a unique attempt to

break down the hierarchy social (?) divisions for human rights protection. The South African Constitution's (1996) Bill of Rights goes beyond the traditional human rights challenges by institutionalising entitlement of health, food, housing, education, an environment that is clean and health-promoting, and social security.

A study conducted by Likupe and Archibong (2013) in the British National Health Service explored how African nurses experienced racism from their White colleagues and the lack of opportunities for development in their workplace. The study also indicated that managers treated British nurses better and more favourably than Black African nurses. Such racism was reported as being covert. As a result, this caused some nurses to lose confidence in their clinical capabilities, some nurses who participated in the study believed that British nurses were jealous because their level of training was inferior as compared to their African counterparts. Black nurses are recruited from Africa with the highest qualifications; however, upon arrival in the work environment they are downgraded to the lowest nursing pay grade. The downgrading may be enforced by racism and discrimination because eventually this will ensure that they take instructions from nursing assistants. Black African nurses also stated that patients and relatives also showed racist attitude towards them (Likupe & Archibong 2013).

The SA Employment Equity Act 55 of 1998 (section 6) promotes the redress in the labour market and inequalities created by apartheid on previously disadvantaged groups; namely females and Africans, Indians and Coloureds. As indicated by the 2015 Provincial Equity Report (van der Heever & van der Merwe 2019) Black females are well presented in management positions within the South African Public Health Sector compared to the Private Health Sector. In this same study, it was discovered that race was directly linked to power which was used to marginalize Black nurses; this signified the intersection of race with gender. The study also explored how Black nurses were viewed as inferior but White nurses were seen as being competent and chosen for managerial positions; thus indicating an intersection of race and class. The power obtained with being a White manager gave way to marginalization of those with less power and this was evident through promotion practices which were questionable because it was seen as using power to oppress the rights of nurses.

The Constitution (1996) enriches other categories of health rights, which includes the right to equality (freedom from discrimination). Article 9, under the category of foundational rights, affects health and the right to Emergency Medical Care in Article 27.3. Here, sub-section 3 of Article 27 states that no person should be refused emergency medical treatment. Consequently, health professional implications in both public and private are clear, they outline that if a patient presents in an emergency, they should be provided with care, even if they do not come from a specific designated region or do not have insurance or money to pay to access private services.

2.10. Xenophobia in South Africa

For the purpose of this study, it was necessary to shed some light on the recent occurrence of xenophobic attacks in South Africa. This will allow the reader to understand what constitutes xenophobia and to draw a distinction between discriminatory social practices on the basis of race, gender and language, and xenophobia. In the wake of May 2008 South Africa experienced widespread violent attacks targeting foreigners which resulted in 62 deaths. Another attack in April 2015 created an outcry across Africa and the recall of a Nigerian ambassador (Classen 2017). Both qualitative and quantitative evidence suggested that these attacks were not primarily conducted by criminals although there was widespread participation in support of this violence (Classen 2014). These attacks violated human rights and national and regional consequences. According to Landau (2011), the level of hostility in intergroup relations are symptoms of deep social and political malaise.

There has been a steady undercurrent of xenophobia in South Africa's post-apartheid era, both in behaviour and attitude. Data from 1995 World Values Survey that sampled 18 countries indicated that South Africa was the most xenophobic nation (Classen 2017). Another survey conducted in 2006 indicated almost half of the South African sample wanted foreign nationals to be deported regardless of their legal status (South African Migration Project 2008). In this 2008 sample, those holding a favourable view towards immigrants were not more than

26%, regardless of their race or if immigrants were from Europe, North America or Africa.

Behavioural consequences of xenophobia are mostly experienced as daily discrimination for African migrants, especially nationals from West and Central African Countries (Dodson 2010). Immigrants are often attacked by vigilante groups within the community. These common yet disturbing attacks usually target immigrants who are shopkeepers (Charman & Piper 2012). The xenophobic attack and the violence in 2008 that resulted in the deaths of 62 people, also wounded 670 people and about 100 000 were displaced (Classen 2017). The majority of the victims were Mozambicans and Zimbabweans; however, within the number of dead people 21 were South African nationals who might have been mistaken as foreigners; or punished for not partaking in this attack; or who fell victim to police aggression (Monson & Arian 2012).

Researchers engaged in this area created extensive literature with six theories that attempted to explain South African xenophobia and its causes (Classen 2017). These are:

- **Resource competition.** The theory behind intergroup conflict is that violence and tension are rooted in competition for scarce resources. This arises when the economy is deteriorating and conflict and competition increase. Possible flashpoints in resource competition with African immigrants that occurs in terms of 'Jobs' and 'Government housing' has been identified by many studies of South African xenophobia (Human Sciences Research Council, 2008; Misago, 2012).
- **Poverty.** Economic deprivation or poverty is another hypothesis in social sciences that is said to trigger the violence toward out-groups (with the out-group coming from an impoverished background). Emotions of frustration and aggression manifest from poverty and the outburst of aggression is often displaced against the weak and innocent third party (Everatt 2010).
- **Relative deprivation.** To clarify the 'poverty starts conflict' argument, scholars have contended that frustration, which eventually causes aggressive behaviour is a result of expectations of welfare as much as actual deprivation, thus

making relative deprivation a contributing factor to the increase in xenophobia (Classen 2017).

- **Frustration with government.** A recurring theme in the literature has been the accumulation of frustration with government as the cause of South African xenophobia. The Human Science Research Council (2008) and Centre for the study of Violence and Reconciliation (2008) studies have emphasised that the lack of provision of government service and lack of interest from government in addressing their concerns resulted in frustration and aggression.
- **Mobilization.** Township community police meetings were often identified as the forum that encouraged community members to mobilise and participate in these attacks (Misago 2012). Therefore, xenophobic behaviours and attitudes may also originate from such social gatherings in the community.
- **Symbolic threat.** A symbolic threat to national and cultural identity is often perceived by communities to be from immigrants who adhere to different religious and cultural traditions (Huddy & Sears 1995). These threats have significantly contributed to xenophobia against immigrants. According to this theory, local people strongly hold on to their national identity due to the existence of a cultural difference between them and immigrants.

Although the occurrence of violence during xenophobia attacks may appear to be sudden, Classen's theories have exposed that there are multiple issues within South African society that contribute to acts of xenophobia. It is a complex and multi-faceted challenge which needs to be addressed at different levels.

2.11. Relevance of Work-integrated Training and Clinical Mentoring

Work-integrated training, or experiential learning, is a form of learning that occurs through experience. The process of transforming experience into knowledge is defined by experiential learning theory (ELT) which argues that 'learning is the ability to adapt to the world and results when there is an exchange between man and the environment' (Kolb, A & Kolb, D. 2005).

Work integrated learning is defined as clinical learning in the workplace where a juxtaposition of forces influencing the student's learning outcomes in the pre-

hospital setting (Edwards 2011). Work integrated learning is an important sphere of the Emergency Medical Care training where enrolled and HPCSA registered students are attached to different bases/stations or hospitals (Moodley 2016). It affords the student the opportunity to combine effective, psychomotor and cognitive skills to enable them to become competent independent practitioners upon completion of the course (Cooper 2005). Thus, student and EC providers require appropriate clinical guidance for the duration of the course.

As part of their BEMC degree curriculum Emergency Medical Care students register for Clinical Practice as a subject. To be competent in the subject they need to provide evidence that they:

- attended all clinical attachment shifts on the roster;
- filed their patient report forms;
- met and completed a minimum number of clinical skills as per the learner guide;
- submitted their portfolio of evidence; and
- completed reflection and their journal if requested to do so by the lecturer.

According to Mntambo (2009), work-integrated learning has a vital role to ensure students accumulate skills and knowledge. Lack of support and an insufficient amount of challenging cases can negatively contribute towards the student's readiness for real work cases. During work-integrated learning students are taught clinical skills, experience responsibility of professional practice and interpersonal skills that are useful socialisation skills when they become independent EC providers (Moodley 2016). The work-integrated learning experience plays a profound role in professional development, thus students should be guided and mentored constructively and effectively graduate as prepared and professional.

The World Health Organization (WHO) (2005) has maintained that work-integrated learning prepares the student to provide competent and quality emergency medical care towards their patients. Student EC providers are exposed to patients through their mentor, and will also rely on their work integrated learning. Edwards (2011) suggests that work-integrated learning

prepares the student for their occupation and creations of a professional identity through humanity, growth, dignity and wisdom by being exposed to the nature of work, professional identity and rules and regulations that they might encounter as registered independent practitioners. Structured work-integrated learning creates a link between theory and practice by affording students the opportunity to reflect on practice so as to learn from experiences in a pseudo-controlled environment. Feedback affords the students to interact and reflect on their interventions and improve their confidence and independent clinical decision making.

Moodley (2016) has concluded that EC students should be provided with a supportive environment that enables them to make clinical decisions and to experience various cases to prepare them for pre-hospital practice. In this work-integrated learning period, students should gain confidence, autonomy and become socialised into the prehospital professional setting which they will use. Placement into an area of work integrated learning should achieve the aim of education in a real-life practice setting (Houghton et al. 2013; Moodley 2016).

A mentor is an HPCSA registered professional who facilitates learning, assesses students and ensures their safety and that of the patient in clinical practice. Mentors are professionally liable for assessing students' capability to attain the required psychomotor, cognitive and effective skills (Moodley 2016). Another role is to ensure patient safety while ensuring mentorship of students. Clinical supervisors must validate student's competencies and failures in selected clinical procedures, physical finding and correct patient treatment which are determined by the student's curriculum. Moodley (2016), further describes students learn by observation of the mentor in the Emergency Medical Service (EMS) field in terms of the social norms and values of the profession.

Houghton et al. (2013), have also scrutinised factors that impact on student's implementation of clinical skills in the practice setting. Their findings show that supervision and support increased the student's confidence and sense of belonging. The relationship with staff members was also found to be a significant element in students' learning and socialization into the profession.

The working relationship between the EC students and mentors in practice settings has an influence on the learning experience of students. Supervision and support benefits the EC student and the EC mentor when expectations are agreed upon through effective communication about common clinical goals that improve patient care (Houghton et al. 2013). It is clear that clinical knowledge and performance is enhanced in circumstances where EC students are given necessary support during work integrated training. Likewise, effective mentors should be recognised and rewarded for their initiatives.

The role of an EC provider is challenging, dynamic and stressful as the nature of the work exposes individuals to unpredictable degrees of psychological trauma. These psychological stressors are compounded by multiple workplace environments (Moodley 2016). Mentoring may provide an effective means of offering greater support, education and professional development and improve clinical decision-making and independent practice. Unlike other healthcare professionals, Advanced Life Support (ALS) EC providers either work alone or in pairs but in some situations this practice may create challenges, for example, for a female ALS working night shift alone in a Primary Response Vehicle exposes her to danger while working in an uncontrolled environment (Moodley 2016).

Burgess, Goulston and Oates (2015) have suggested that role modelling by clinicians may provide assistance in developing medical student's professional competencies, attributes and values. Their study discovered that students identified both positive and negative behaviour and characteristics were portrayed by their clinical tutors in New Zealand. Therefore, for a clinical tutor to demonstrate excellence in their role modelling it requires excellent clinical care, personal characteristics and teaching skills. These findings, therefore, indicate the importance of clinical bedside tutors as role models which is seen to have an impact on faculty development and recruitment.

2.12. Gender-related Challenges in the Workplace

Gender is a term that commonly describes socially created and demarcated roles, activities, attributes and behaviour (Anker 1997; Butler 1993). Therefore, gender is currently not necessarily considered something we have or what we are born with. According to Ricardo and Barker (2008), how individuals develop is reflected by exposure to norms, opportunities and expectations which are dependent on gender and other social categories. For them gender is concerned with the attribution of social characteristics such as 'manly', 'womanly', 'masculine' and 'feminine' (Ricardo & Barker, 2008). Consequently, gender is now seen as a cognitive representation of experience which guides an individual's behaviours and is not looked at as a collection of personal characteristics but as a culturally-embedded life. Furthermore, according to Eckert and Maconnell-Ginet (2003) an individual's femininity/masculinity is a socially-constructed difference between women and men respectively, in terms of societal perception of power and prestige roles.

The current SA legislation views discrimination as being legal when it is implemented with the intention of redressing the past through affirmative action. Section 9(4) of the Bill of Rights (Constitution 1996) states that, 'No person can unfairly discriminate directly or indirectly against anyone on one or more grounds of gender, race, sex etc'. Therefore, sexual harassment can unreasonably interfere with the victim's work performance and create a hostile, intimidating and offensive work environment. According to Cortina (2002), sexual harassment is the most prevalent form of violence particularly perpetrated against women (Cortina, 2002). In 1995 the Department of Labour under the *South African Labour Relations Act*, defined sexual harassment as any persistent form of sexual conduct that is unwanted. According to the Act, if the recipient makes it clear that the behaviour is offensive then it will be considered as sexual harassment. In addition, the Act also states that the perpetrator should have knowledge that the conduct is unacceptable.

The *Protection from Harassment Act No .17 of 2011* affords an effective remedy for victims of harassment against such behaviour and also to introduce measures

for different organizations of the state to give full effect to the provisions of the Act. Therefore, the Act of 2011 defines sexual harassment as any unwelcome sexual attention from a person who reasonably knows that such attention is unwelcome; namely, unwelcome behaviour (explicit or implicit), suggestions, remarks of sexual nature that have the potential to offend, humiliate of intimate the related person in the circumstance, whereby a reasonable person having regard to all the circumstances would have anticipated that the related person would be offended, intimidated or humiliated. The Act also refers to expressed or implied promise of reward for agreeing to a sexually oriented request or expressed or implied threat for refusal with the sexual request.

Various forms of sexual harassment can be experienced by an individual. For example, a *quid pro quo* occurs when a person who holds a position of authority (an educator) makes decisions that affect a student's grades based on whether the student obeys his/her sexual demands (Fineran & Bennett 1999). A coercive context for sexual harassment occurs when an aggressive, frightening, or unpleasant environment caused by the harasser creates a hostile environment for the student (Fineran & Bennett 1999).

Cogin and Fish (2009) found that 95% of nursing students experienced sexual harassment during training. The intimate interaction of a healthcare practitioner's job is a significant factor that should be considered. The intimacy breaks societal rules where practitioners deal with body exposure, sexuality and touching − all of which involve some type of emotional and physical closeness that is rarely given to strangers (McGuire Dougherty & Atkinson 2006). The laws passed to protect the South African workforce like the *Protection from Harassment Act of 2011* addresses sexual harassment in South Africa (Gender Links for Equity and Justice 2012).

The code of good practice provides suitable measures to address sexual harassment and procedure of preventing it from recurring (South Africa. Code of Good Practice Labour Guide, 2015). The *Amended Sexual Offences Act 2007* was a reflection of the South African government's effort to deal with sexual crimes in the country. Therefore, rape of a male or female person by another male

or female is a criminal offence. The presence of these laws is meant to protect citizens and employees from sexual harassment and abuse in the workplace on a gender-neutral basis.

The *Employment Equity Act 1998* was introduced to eradicate sexual harassment in workplaces by encouraging equal opportunities and just treatment, and to achieve equality in the workplace. The Act states that no person may unfairly discriminate, directly or indirectly, against an employee in any employment policy or practice on the basis of sex, among others (South Africa. Department of Labour 1998). The *Labour Relations Act* 1995 also aims to eliminate sexual harassment in the workplace, by implementing the code of good practice (South Africa. Department of Labour 1995/6).

2.13. South Africa's Multi-lingual Society

In 1950, during the apartheid era, the *Group Areas Act 1950* (Union of South Africa, 1950) was established and lead to social and residential segregation. This was followed by the *Promotion of Bantu Self-Government Act* 1959 (Union of South Africa, 1959) which excluded non-White citizens from the political, economic and cultural domain. This 1959 Act used African languages as the main parameter to define linguistic identities of the Bantu population. Eight national units were defined by the Population Registration Act No.30 of 1950 namely; Venda, Tsonga, Tswana, Northern Sotho, Southern Sotho, Xhosa, Swazi and Zulu. Language was, therefore, used as a tool to separate Black people in the Union to prevent them from engaging intellectually and politically at a national level. In 1974 the apartheid regime decided to introduce Afrikaans as the medium of instruction in schools. On the 16th of June 1976, Black students who refused to be taught in Afrikaans (Brenzinger 2017) mobilised to protest in SOWETO township, Johannesburg.

Since 1996, however, all languages are viewed as having an equal status, meaning that no language has an advantage over the other. Post-apartheid South Africa now has eleven (11) official languages; namely, Tshivenda, Xitsonga, Setswana, Sepedi, Sesotho, isiXhosa, siSwazi, Zulu, English, Afrikaans and isiNdebele are recognised by the South African Constitution. The purpose was to

encourage all South Africans to merge into a non-racial society (Constitution 1996).

Language further serves as a form of 'communication' (Latin root 'communis', meaning common). For Cheney (2011), the word means that for effective communication to take place there has to be a common understanding of information exchanged. The quality of communication is determined by elements in the process of communication as further described by Keyton (2011): the 'Sender' is the communication initiator. 'Receiver' is the intended recipient of the message. 'Encodes' is where the sender should compose the message using words or gesture. 'Medium' is how the message is conveyed or carried. 'Decode' is meaningful interpretation of the information by the receiver. 'Noise' is any distortion of the message. 'Feedback' is a response that the receiver will transmit to the sender.

The association of language can be flexible and therefore enable differentiation between ethnonational groups (Matsuo 2005). Ethnonational groups[28] comprise people who share specific characteristics from birth (history, ancestors, religion, language or culture) inherited over generations.

2.14. Summary of the Chapter

This chapter reviews relevant literature related to the research question. It shares literature available in the subject matter and provides an in-depth description of what constitutes racism. It outlines the critical ethnographic methodology and the analytical framework of Critical Race Theory. The next chapter will focus on the research design and methods.

[28] Ethnonational group carry the same meaning as Ethnicity (Ozolins, 1996).

CHAPTER THREE: RESEARCH DESIGN AND METHODOLOGY

3.1. Introduction

As explored in the preceding chapter, this study aims to investigate and describe the discriminatory experiences of EMC students during their work-integrated training in the Western Cape. This chapter describes the research design used and also explains how this design is linked to the purpose of the study.

An in-depth discussion on the methodology of the study follows, describing the population and sample, ethical considerations and the setting in which the study took place. Included in the methodology is discussion on data collection procedure, which will be followed by an explanation of method and the rationale for data analysis.

3.2. Research Design

As qualitative research, this study aims at an in-depth understanding of human behaviour, attitudes and the reasons that govern human behaviour. Qualitative research design also makes it possible to understand the participant's behaviours, perceptions, attitudes and views regarding a topic (Landson-Billing 2003). The methodological lens of critical ethnography is used in this research project with a layer of autoethnography. Critical Race Theory provides the analytical frame to help make meaning from the data.

This study focused primarily on racial discrimination within the pre-hospital setting. This context focused on the relationship between Student and Emergency Care providers, EC providers and Patient, as well as Student and Patient. The aim of the study is to explore, through critical race theory, how discriminatory social practice manifests during clinical practice interactions between emergency medical care students and clinical mentors and how it was experienced or perceived by both the EC provider and the student.

To adequately and accurately interpret meaning from people's experiences and how these experiences have an influence on their well-being, a critical ethnographic approach was the most preferred method to conduct this research.

Critical Ethnography focuses on an entire cultural group (in this case: the pre-hospital emergency medical care community) and allows the researcher to describe and interpret the shared and learned patterns of values, behaviours and beliefs (Rudkin 2002).

Consistent with the paradigm of critical theory, the analytical framework suitable for this research is Critical Race Theory (CRT) because in this concept human beings are empowered to go beyond the constraints placed on them by race. Critical Race Theory enables the researcher to explore more of the meaning of social life, its historical problems and social struggles. It provides an understanding of the oppressive aspects of race and racism within the EMS (Conradie 2016). The CRT research motivates people to interact, become activists, and form networks thus collectively helps individuals to examine conditions of their existence (Creswell 2007).

Narrative research has a specific focus in the stories told by individuals (Clandinin & Connelly 2000). The project aims to document the everyday experiences of race and racism. According to Creswell (2007), a narrative approach enables the researcher to understand a written or spoken event which is chronologically connected since it focuses on gathering data through collecting stories, reporting experiences of individuals and then chronologically organizes the meaning of these experiences as discourse analysis.

3.3. Research Methodology

To enable participants to express their feelings and share their experiences and perceptions, a single open-ended question was posed to the participant.

Student participants were asked to: '**share your discriminatory experiences or perceptions during work-integrated learning/clinical practice as an Emergency Medical Care student?'**

Emergency Care provider participants were asked to: **'share your discriminatory experience or perceptions during clinical practice as an Emergency Care provider?'**

The researcher used a semi-structured interview approach because it was on a private one-on-one basis that allows for the freedom and willingness to share experiences openly without fear of judgment from colleagues for having their attitude change towards them. This approach was used because of the sensitivity of discussions around racial discrimination. This methodology did not include follow-up or additional questions but was guided by the replies from the participants (Boyce & Neale 2006).

Taylor (1998) suggested that storytelling is one of the most effective ways in challenging society's dominant mind-set because stories are able to create shared communal understanding. Most Critical Race Theory researchers often use the storytelling approach in contesting and engaging negative stereotyping. For this reason, this study did not limit the participants on the amount of time to share their experiences.

3.3.1. Critical Ethnography

The Critical Ethnographic approach employed in this study is a type of ethnographic research in which the emancipation of marginalized groups in society is advocated by some authors (Delgado & Stefancic 2000; Rudkin 2002). It also allowed for critique and potentially to bring change on the EMS front. Such an approach responds to the current circumstances whereby a system of power, privilege, prestige and higher authority serve to marginalize and discriminate individuals who are from different races, classes and genders. Critical Ethnography, therefore, allowed me to speak out against inequality and domination (Starr 2010). On the assumption that emergency care is a discipline in health care and that EMS is a microcosm of society, the discriminatory impact of power, privilege and prestige in emergency medical care and the EMS was examined.

Cultural Safety[29] was also used to expose pre-existing events and outcomes of power inequities to give voice to those marginalized by an economic, political and

[29] Cultural Safety refers to the ability to understand the relationship between minority status and health status to try and bring about change on nurse's attitude from those that continue to support

historical past. However, to gain insight into other beliefs, researchers and practitioners must acknowledge their own beliefs. As indicated by Carspecken (2013), it is worth noting that, the author himself, as a victim of racial discrimination, is aware of the potential impact of his own perspective on the data collection and interpretation process. Consequently, to avoid being biased there will be a reliance on reflectivity to maintain a constant state awareness about my bias.

3.3.2. Autoethnography

Autoethnography is a transformative research method which might lead to transformation of the researcher through self-discovery and self-awareness by exposing him/herself to the world (Starr 2010). Transformation also occurs for participants who also undergo the process of contemplation, reflexivity and introspection with the autoethnographer. The transformative trait of the autoethnographic research method occurs because it changes time, fosters empathy, requires vulnerability, embodies creativity, eliminates honour subjectivity and boundaries, and provides therapeutic benefits to both the researcher and the participants (Custer 2014; Starr 2010;).

Following Custer (2014), by using this research method, I allowed myself to undergo honest self-reflection and explore personal experiences. During the research process the researcher's personal experience became the central focus from which a new understanding developed for the holistic viewpoint of the study. This is a specific view of the world from the researcher's perspective to create a space where robust conversations and dialogue may lead to change (Starr 2010).

To promote more depth to data that was previously flat after statistical analysis alone, the author brought a combination of constructivist, quantitative and autoethnographic perspective into the discussion and analysis. Reflectivity in research went beyond a checking process but offered understanding and action transformation. Autoethnography is a dynamic process that allowed for the

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the current dominant practices and system of health care to those that are more supporting to the health of minority groups (Smye & Browne, 2002).

participants and myself to reflect on both of our experiences and this deep thinking enabled us to share a common understanding from our respective experiences. It also allowed me to immerse myself in the study to discover meaning of my own experiences thus creating room for self-transformation.

3.4. Participant Selection and Recruitment

The purposive sampling strategy was used for this study, provided they met the inclusion criteria. Data was collected from five qualified Emergency Care providers currently registered with HPCSA and practising within the South African EMS under the Western Cape EMS METRO. Data was also collected from 13 fourth-year Emergency Medical Care students registered with the Cape Peninsula University of Technology as well as the HPCSA. These were considered appropriate participants as they were actively practising within the pre-hospital setting and engaged in a clinical practice with more than three years clinical experience during work-integrated learning (Creswell 2007).

The coordinator of CPUT's fourth-year students in the Department of Emergency Medical Care was asked to spend five minutes briefing the students about the study, and if the student met the criteria, to invite participation in the study. Then, an appointment for the interview was made on the date and time convenient for both student and this researcher. Students were provided with an information sheet[30] to read and keep as well as a consent form[31] which they had to sign as proof that they had given their informed consent to participate in the study. Inclusion in the study required registration as a fourth-year EMC student at CPUT since they were viewed as the most experienced students with the most clinical exposure during work-integrated learning compared to other students at lower levels (First, Second and Third year). This would also allow them to share differences in experiences or perceptions of discriminatory behaviour in clinical practice which they had encountered over all four years.

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[30] ANNEXURE A: Research information sheet.

[31] ANNEXURE B: Consent to participate

Permission from the Western Cape EMS allowed for me to visit different METRO bases within the Cape Town Metropolitan area to recruit Emergency Care provider participants. I would arrive in the morning or afternoon during parade and ask permission from the base manager or shift leader to inform all crew members about the study. To be included in the study, EC providers had to be employed by the public EMS due to permission received from the Western Cape EMS. Participants who had worked with students during students' clinical attachments were specifically targeted. Once the EC provider agreed to participate in the study, they were provided with a research information sheet and a consent form to sign as proof that they have given consent. The author then asked for a private office with no surveillance cameras to commence with the interview.

On the set day of the interview the researcher issued the participant with the consent form and the research information letter. The researcher allowed some time for the participant to read and ask any questions prior to signing the consent form. Two copies of the consent form were given to the participant to sign, the researcher and participant both kept a copy (Kvale 1996).

As the study was primarily focused on racial discrimination there was no intention to deviate to other forms of discrimination; however, other forms of discrimination repeatedly emerged during data collection and triggered an analysis of them. Participation was opened up to all EC providers who met the inclusion criteria (Creswell 2007); namely, all fourth year BEMC students. Since the sample of participants for this study is not intended for generalisation to a population the number of participants was not relevant.

The study accommodated both women and men. However, gender distribution of the participants was insignificant because the focal point was race and, therefore, it was not used as a factor to determine inclusion or exclusion from the study. In addition, the age range for participants is between 23–50 years of age because this range is inclusive of 4th year BEMC students as well as Emergency Care providers currently practising in the chosen setting.

In the South African context, racial discrimination is determined in racial conflicts between White people and other 'races' which are not White, namely: Indians, Blacks and Coloureds (Williams et al. 2008) who were used for the sample. In this way, the study was diversified into participants representing different racial demographic profiles to explore racial discriminatory experiences between the races.

3.5. Data Collection

Since the focus was to understand racial the discriminatory experiences of students and emergency medical providers, verbal discussion was used to allow for clarifying questions and answers provided by the participant in face-to-face, one-on-one interviews. In this manner, participants were able to tell their story (Smith 2003). Focus was first placed on documentation of racial discrimination by participants within the pre-hospital setting to document and validate its existence but other forms of discrimination were frequently shared by participants which then prompted further analysis.

Interviews were held at a private research venue in the Department of EMS. Participants were asked to come in for the interview at a date and time convenient to them so as not to affect their learning schedule. Collectively, this encouraged the participants to be more open, free and comfortable so that they could share as much of their experiences as possible (Kvale 1996). For Emergency Medical Practitioners currently practising, interviews were also held at their work base-stations unless preferred otherwise by the practitioner. In that situation, another date, time and place were set for the interview that did not compromise service delivery if the participants were on duty. Interviews were recorded for later transcription.

3.6. Data Analysis

The audio recordings were transcribed by the researcher. Where participant's voices are presented, the page number of the transcript is indicated for ease of cross-referencing. An analysis of the narratives enabled the development of categories, structures, and relationships (Loftland & Loftland 1995). Through the use of CRT to break down the data concrete descriptions were derived to classify

into patterns and then themes which addressed CRT categories. Using mind mapping, complex data was then sorted into visually organised data. The use of mind-mapping easily represented ideas linked around a central theme and only served as a visual guide in navigating through the data (Sheppard & Crowe 2011).

The categories that were organised and summarised brought meaning to the data. Phrases, topics and concepts were used to group the data. Every segment that was meaningful was coded with a highlight (colour) and data was read line-by-line. Marking every meaningful segment that is transcribed data and categorising is called 'coding'. Categorising and Coding depended on what was meaningful to the research topic and what would assist in responding to the research question (Creswell 2007).

3.7. Reliability of the Study

According to Bryman and Cramer (2011), 'valid', 'reliable' and 'representation' are terms usually associated with quantitative research, whereas qualitative studies are generally concerned with understanding the meaning behind the issue rather than validity and reliability in addressing a discourse. Although these terms do not usually form part of a qualitative study since its focus is not to measure, Ritchie and Lewis (2003) have suggested that the terms may be used in a qualitative study but they have to be redefined.

This present study is a qualitative investigation that focused on discriminatory social practice during clinical practice in the emergency medical care experienced by 13 fourth year BEMC students and five Emergency Care providers, making a total of 18 purposively sampled participants. The aim was to document the existence of discriminatory practices during clinical practice in emergency medical care through their own accounts and from their lived experiences or perspectives rather than archive external validation, meaning that the aim was not to generalise the findings to the EMS population of the Western Cape.

The other concern which may be raised is whether the collected data is reliable. The aim of the study was to document discriminatory experiences during clinical practice in emergency medical care education and not principally to verify if the

accounts were honest and truthful and, therefore, this reliability is assumed. It is in the nature of a qualitative study that while participants are requested to narrate their lived experiences or perceptions, it is possible that some participants may omit aspects or cannot accurately recall their stories.

During the data analysis process, categories were organised and summarised so that they brought meaning to the transcribed data. Topics and phrases were used to group the data. The data was read line-by-line and every segment that was meaningful was coded. Coding meant marking every meaningful data segment that was transcribed and categorised. Coding and categorising depended on what is seen as meaningful to the research topic and thus helpful to answer the research question. Mind Mapping software (FreeMind® mind-mapping software, 'open-source') was used to organise the complex data into similar categories central to the themes (Sheppard & Crowe 2011). The author did manual coding because the data was manageable through mind mapping. Mind mapping allows the author to systemically and logically differentiate (highlight using different colours and group similar phrases together) to provide thick descriptions of the topic. The total of 18 participants was manageable and the study was also self-funded. I transcribed all the recordings as I wanted to re-familiarise myself with the data to ease the analysis and sorting of data (Loftland & Loftland 1995).

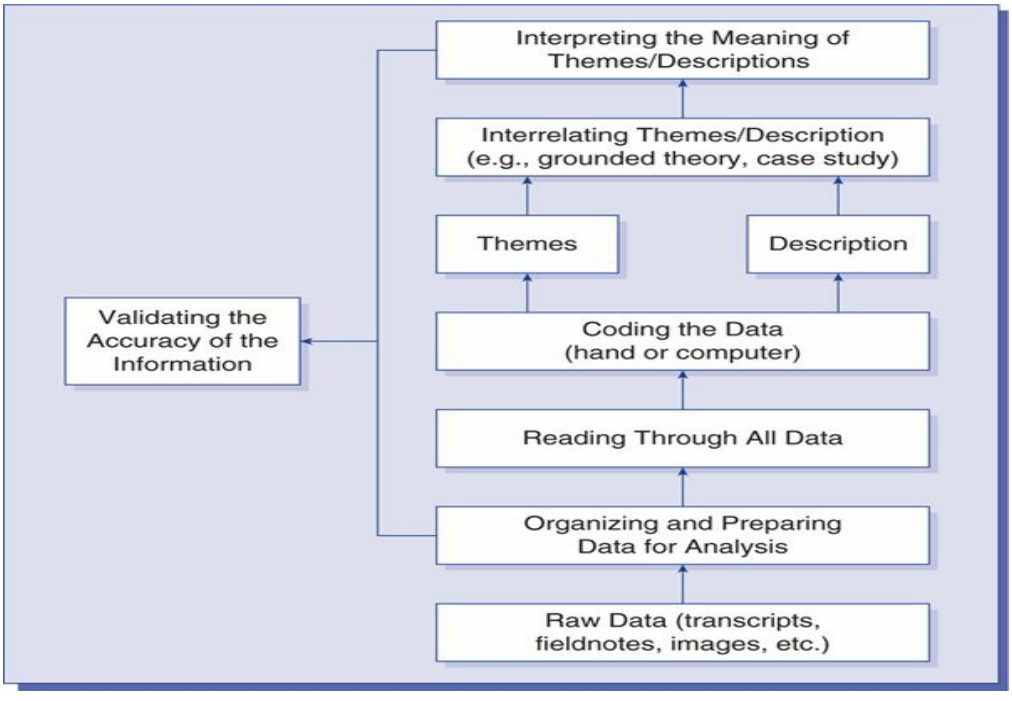

Figure 1: Data analysis (Source: Creswell 2014).

Creswell's (2014) systematic approach to validate the accuracy of the data analysis was adopted in which themes were developed from the emerging information collected from participants (Figure 1). It is also worth repeating, that as this is a critical ethnographic study, the author's previous experience of discriminatory practices during clinical practice may be filtered into the interpretation of findings.

3.8. Limitations

The study was limited to fourth year BEMC students registered at CPUT and Emergency Care providers working at the public EMS in Western Cape Province and registered with the HPCSA. Data saturation was reached after interviewing 13 BEMC students and five EC providers from the EMS. The primary focus was on clinical practice experiences and perceptions that occur within the pre-hospital setting during work-integrated learning. Whilst participants also shared their other hospital experiences, that data was not included in the study as those incidences occurred within the hospital setting, the study mainly focused on pre-hospital experiences and perception of discriminatory practices. The author also acknowledges that because of his race (Black) and the sensitivity around discussing race issues with participants during data collection, there is a possibility that participants of a different racial identity may have felt uncomfortable to share some of their experiences or perceptions on racial discrimination.

3.9. Ethical Considerations

The research must have ethical guidelines because it uses human participants. A research information sheet was provided which explained to the participants what the study was about and the reasons the study was being done (Orb &d Eisenhauer 2000). It also provided information regarding the advantages and disadvantages that might be related to the study. Those participating in the study were provided with sufficient information with regard to any possible risk that may be involved, or any anticipated expectations and benefits (Mach & Woodsong 2005).

All means were tried to avoid making the participant feel vulnerable or intimidated, and at no point was the participant's opinion influenced by the researcher. Mach and Woodsong (2005) also suggest that a copy of the written information letter and consent form should be given to the participants and the researcher should also read the research information to the participants verbally at this stage. Participants were also informed that they may choose to discontinue with the study at any given time, and they were assured that they will suffer no reprisals for doing so.

Confidentiality was assured by the researcher as the topic of discrimination is sensitive, and also because participants would want to feel protected in such a way that this information would not end up being used against them in anyway. The researcher reassured the participants to gain the trust of the participants. Participants were then informed they would be given a unique number (code) to ensure confidentiality, and that the interview was to be transcribed by only the researcher (Orb & Eisenhauer 2000).

Each interview was allocated a number to ensure that the participant's identity was protected and only the code was used to mark and identify the report. Permission from participants was sought to use a recording device for the interviews. The audio recording was then transferred from the recording device and stored in a laptop computer (Boyce & Neale 2006). Both the recording device and the laptop computer had access control. A compact disk was used to back-up the audio files and they were stored in a locked safe. Transcription was done by the researcher as the first level of analysis and thus ensured confidentiality as nobody heard the recordings except for the researcher.

As researcher I was aware that the topic of discrimination is very sensitive and it may cause some of the participants to be emotionally affected by the interview processes. Recalling experiences required they re-live the discriminatory incident, and it might bring bad memories in such a way that it affects them emotionally (McNeilly 1996). Therefore, participants could be referred to the Student Counselling Services on campus should there have been a need. In addition,

participation in the research through dialogue with the researcher may benefit participants because racist discourse is not innate but can be developed, transmitted and assimilated. This occurs through communication writing and speaking (Vaz, Valentin & Castro 2015).

Permission granted by the Head of the Department of Emergency Medical Sciences to invite fourth year BEMC students as participants for this study also permitted use the department's research venue to conduct the interviews. The Health and Wellness Sciences Research Ethics Committee provided institutional ethical clearance for the study to be conducted. Further permission to use the EC providers from EMS stations was granted by the EMS Provincial Government and the Western Cape Department of Health. EMS employees also granted consent at a personal level by signing the consent form. Owing to the scope of a Master's study and the small sample the study, the author only used EC providers from the public EMS because this single approval from Western Cape government provided access to a large pool of potential participants with different demographics and from different geophysical locations that could be recruited for the study.

3.10. Summary of the Chapter

This qualitative study recruits a total of 18 voluntary participants, 13 fourth-year EMC students from CPUT and five EC providers (from Western Cape EMS) for interviews. The interviews take place in a private research venue at CPUT and a private office at the METRO base station for students and EC providers respectively. Participants are not limited by time. Findings are presented in the form of a descriptive narration. In the chapter that follows Mind Mapping software is employed to sort and arrange the data into similar phrases. Ethical approval is granted by the Health and Wellness Sciences Research Ethics Committee and the site permission for recruiting EC providers is granted by the Western Cape Government. The following chapter provides the analysis of the data gathered from the participants.

CHAPTER FOUR: DATA ANALYSIS AND FINDINGS

4.1. Introduction

Chapter 3 has presented the methodology guiding the structure of this study. This chapter demonstrates the data collection method and how the data is analysed in relation to the research question and sub-questions. The aim of the data analysis is to bring about meaning to the transcribed text through narrative analysis (Creswell 2014).

Data were collected by means of 18 recorded semi-structured individual interviews which were transcribed, verbatim, for analysis. Interviews lasted approximately 20 to 65 minutes. The study's results outline the lived experiences and perceptions of both Emergency Medical Care students and Emergency Care providers during work integrated learning to understand and examine the core problems of social discriminatory practices within the EMS and the potential of harm it may bring. This section describes the data analysis in relation to the questions/knowledge gaps below.

4.2. Research Question

How do social discriminatory practices manifest within the pre-hospital environment during BEMC work-integrated learning in clinical practice at a South African University?

4.2.1. Sub-Questions

a. How do final year emergency medical care students at a University perceive or experience racial discrimination during work integrated learning?

b. How do professional Emergency Care providers (latent mentors) perceive and experience racial discrimination in the emergency medical service?

c. How can critical ethnography give voice and reflexivity to victims of racial discrimination experiences during work integrated learning in clinical practice during the BEMC degree at a SA university?

Critical Ethnographic methodology and the analytical frame of CRT was used to allow the incorporation of 'story-telling' and personal narratives. The rationale is to constructively explore discriminatory practices experienced by emergency care providers and emergency medical care students that reveals the significance behind these perceptions of discriminatory practices within the pre-hospital setting and gives hope by re-telling the details behind their experiences.

The qualitative data was obtained from fourth year BEMC students and Emergency Care providers charged with the responsibility of mentorship.[32] Participants were selected in accordance with the study's inclusion criteria. One-on-one private interviews were conducted (by the author) and recorded data was transcribed (with page numbers of the transcription indicated next to any direct quote from the transcription). A narrative approach allowed the author to understand the spoken events which were chronologically connected (Creswell 2007).

4.3. Data Analysis

4.3.1. Qualitative data and mind mapping

An 'open coding' process was used to arrange the data in a logical format for an analysis of content meaning (Henning 2004; Yin 2009). The three different stages of working through the data in open coding enabled an iterative approach to the written information (Figure 2).

The first stage involved going thought the date line-by-line which allowed the author to orientate himself with the data and get a general picture of what the participants reported. The second stage outlined how the author moved back and forth to group the data into themes for data reduction and cross-checking. Stage three involved grouping the themes together to find common and uncommon 'denominators' from the reports by participants. This resulted in the emergence of thick descriptions of the phenomena under study.

To validate the open coding by grouping of themes and subthemes FreeMind®

[32] Note that mentors are *de facto* ex-students of clinical practice at some point in their studies.

mind-mapping software (open-source) was used to enable navigation through all the derived themes as well as to view all key data on one platform. This provided more access to the data to group and regroup themes, and to spot reoccurrences of incidents/themes/phenomena.

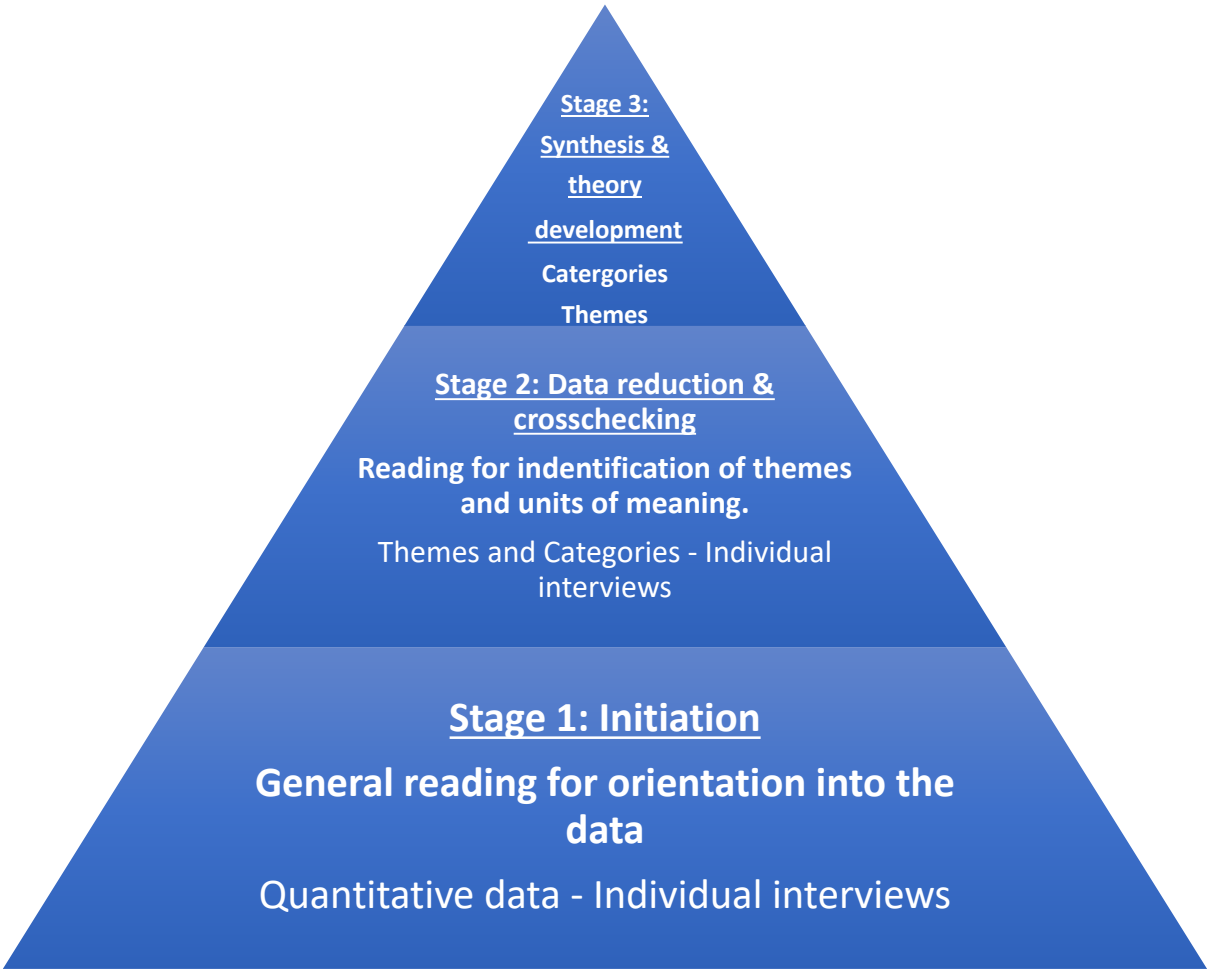

Figure 2: Open Coding process (Source: Corbin & Strauss 2007).

The analytic procedure is guided by the evidence collected and the aim of the study, thus allowing a detailed and clear analysis (Yin 1994). The objective was to search for any recurrent patterns in the data that could be developed into subthemes and then main themes which would then be reported in the results. A step-by-step guide by Braun and Clarke (2006) was used for thematic analysis.

4.3.2. Thematic analysis

The five steps taken for thematic analysis were:

- **Familiarization with the data**

  All the audio recordings of all the participants are listened to followed by a transcription of the data by the researcher. The transcripts are then read to familiarize the researcher with the data.

- **Initial codes generation**

  Transcripts, are read line by line per participant to highlight data in the text that describes discriminatory practices (as defined in Chapter 2: section 2.2) during work integrated learning.

- **Searching and generating subthemes and themes**

  Similar phrases grouped together within the text and categorised into specific subthemes. The wording or name of the subtheme had to be in line with grouped phrases. Similar subthemes that emerged were then grouped under major themes.

- **Reviewing themes**

  All the emerging major themes were verified to correlate with the subthemes and subthemes are correlated with grouped phrases.

- **Defining and naming themes**

  Themes are named and described as per the data collected and discussed with the support of relevant literature review.

4.4. Themes Subthemes and Samples from the Data

According to Vaismoradi et al. (2016), a theme is used as a concept, attribute, element and descriptor. It represents recurrent phrases as they appear in the data analysis that allow the research question to be answered. Themes may also have sub-themes which subdivide the data and develop patterns from the participant's information as reported.

Themes require interpretation because they refer to a more implicit and abstract level. Explicit content of the text is known as 'a Category': a simple description of the participant's accounts (Gray & Densten 1998). A theme emerges when the author raises the participants' experience or perspective (from interview data) to

an abstract level (such as in relation to CRT) and re-conceptualises it to discover the underlying meaning of the participant's words as reported during data collection. In other words, the data is a textual (concrete) representation whereas the themes are theoretical (abstract) representations.

The three main themes developed and derived through the open coding process from the transcriptions are listed below:

1. **Uncovering a Paramedic's gender constraints.**
2. **Being my 'Race' within the institution.**
3. **Language discordance in a linguistically-diverse clinical setting.**

Table 1 below shows an overview of the three major themes and seven subthemes that emerged from the data analysis.

Table 1: Themes and subthemes

MAIN THEMES	SUBTHEMES
1. Uncovering a Paramedic's Gender Constraints.	1a. Sexual harassment. 1b.Gender inequality and patriarchy.
2. Being my 'Race' within the Institution.	2a. A discourse between racism and preference. 2b. Perception of race within the EMS industry. 2c. Conceptualization of racism and privilege in EMS.
3. Language discordance in linguistically-diverse clinical setting.	3a. EMS and language dynamics 3b. Language barrier during work-integrated learning and patient care.

The following abbreviations indirectly represent the codes for data drawn from the participants' interviews:

- **P -** Participant code number
- **Page -** reference page for cross-checking transcripts and accountability
- **Category -** content of the participant's transcript;
- **Sample 1 -** EMC Students (4th year EMC Students registered at CPUT)
- **Sample 2 -** EC providers (EC providers working at WCG EMS)

4.4.1. Theme 1: Uncovering a Paramedic's [33] Gender Constraints

Historically, the Emergency Care profession has been dominated by male providers. Critical Theory assumptions are helpful here as it posits that knowledge is historically constructed. The introduction of female practitioners into the profession is a step in the direction of gender equality in the workspace. The pre-hospital setting is an uncontrolled environment which further exposes female EC providers to various challenges. Chapter 2 described gender and outlined different forms that constitute gender discrimination. Through data analysis a multitude of variables were uncovered that revealed female practitioners' exposure to sexual harassment and gender inequality.

THEMES	SUBTHEMES
1. Uncovering a Paramedic's Gender Constraints	1a. Sexual harassment 1b.Gender inequality and patriarchy

4.4.1.1. *Subtheme 1a: Sexual Harassment*

Sexual harassment is discriminatory as it interferes with the student's right to equal education (South Africa. *Protection from Harassment Act 17 of 2011*.) The textual representations which substantiate the sub-theme of sexual harassment follow in the next section.

[33] 'Paramedic' is a protected term in terms of the *Health Professions Act 56 of 1974* as it refers to cadres registered on the Paramedic register. Emergency Care Practitioner (ECP) is also protected to mean a BETM or BTech EMC graduate registered on the ECP register. 'Emergency Care Provider' is a term used to encompass all cadres, irrespective of the registration category.

Samples from EMC Students for subtheme 1a

> I've had a crew member told me that White women are always bitchy.... And when I didn't respond or act to it he tried to make me feel uncomfortable so he would speak about vividly grossly sexual things with his partner to try and get me uncomfortable and I got so mad I had to leave halfway through the shift because I couldn't take it anymore. I asked him to drop me off at the base because I wasn't willing to expose myself to this any longer because it was ridiculous (P 8, page 3).

Participant 8 as White female experienced a 'hostile work environment' in a type of sexual harassment during clinical attachment, where she was insulted by a practitioner, who called her a "bitch" and made vividly vulgar utterances and created an aggressive, frightening, or unpleasant environment. This occurrence is considered *quid pro quo* harassment which occurs when the practitioner, as the person who has authority, made a decision that negatively affected the student's learning experience because the participant (P8) had refused to obey his sexual demands (Fineran & Bennett 1999).

> With that free hand he tried to grope me, which was very inappropriate and I was like, what are you doing? … and he kept having discriminatory remarks, and he was just speaking to me in a…very sexual behaviour towards me though, it is not appropriate at all (P 5, page 37-38).

Participant 5 above as White female experienced sexual harassment perpetrated by the patient, where the harasser used grossly offensive sexual language towards the student thus creating a hostile environment. Therefore, the intimate interactions of a (student or) practitioner's job are a significant factor that should be considered in the analysis of risk and vulnerability.

Sample from EC Provider for subtheme 1a

> He said to me that both him and the patient were going to rape me. So there! People…they think because it is just said, it is not as … a bad, but it is equally as bad for me because I pictured them physically raping me and killing my partner… so my imagination was there. Even though it didn't happen, it went there and the

> fact that his hands were in my panty... that showed me that he wasn't afraid to do whatever he needed to (P 18, Page 167).

Participant 18 above, a Coloured woman, experienced sexual harassment and even threats of gang-rape (where gang refers to the patient and person accompanying the patient) during their clinical practice. These threats were made by the person accompanying the patient as an escort. Conventionally, one person is allowed to escort the patient to the hospital and they usually go with the patient in the ambulance. Participant 18 felt as if she *had* been raped by the escort because not only did he say it but he went as far as inserting his hands into her underwear.

This action shows how deliberate and determined the escort was to follow through on the treat. Our legal reform as per the *Sexual Offences and Related Matters Amendment Act 32* (South Africa. 2007) includes the insertion of a digit (or object) into the vagina (or anus) of a non-consenting person (gender-neutral), as constituting a crime of rape. In this context, the argument can be made that the offence experienced by Participant 18 constitutes 'attempted rape' and not merely the threat of rape.

4.4.1.2. Subtheme 1b: Gender inequality and patriarchy

During clinical practice in the pre-hospital setting, participants experienced gender inequality and manifestations of patriarchy during their activities in the provision of care.

Samples from EMC Students on subtheme 1b

> Probably as well it is difficult for woman to gain respect especially within the public sector they struggle… because I'm small so they undermine my capabilities a lot…. I think there is a stigma (and stereotype) that paramedics have to be this big strong people that can lift people and carry them for kilometres at a time… when I get there I'm like this big [gesturing to mean petite]. I'm a girl and I look 12 and no one takes me seriously (P 2, Page 4 and 7-8).

Participant 2 as a White female felt disrespected because of her physical build, she does not comprehend why her body size is assumed to reflect her intellectual capabilities, safe to say that that there is a demographic stereotype in relation to physical characteristics. She also acknowledges that there is an assumption that a paramedic needs to look in a specific way, stereotyping the emergency medical care identity and stigmatising[34] all those that are 'other'. The 'othering'[35] of people in organisations is offensive, as it leads to social exclusion and marginalization of citizens. This theme primarily encompasses social stereotypes or perceptions of a 'Paramedic' but the mechanism intersects with that of sexism[36] and racism.

> I think it was a pregnancy-related issue or gynaecological issue, so she felt more comfortable to speaking to female about it, I do not think if it was some other type of pathology she would have as much of an issue because she did let the doctor engage to an extent and when it came to that she specifically wanted to speak to me a female, and then with regards to the skills of the urinary catheter she preferred the female practitioner as a…patient preference... or privacy issue (P 3, Page 19).

Participant 3 experienced a situation whereby a patient who had a gynaecological issue would verbally engage with the doctor (male doctor) in-charge but did not allow the doctor to physical perform a procedure on her in pursuit of treatment. She preferred a female practitioner to physically perform a skill on her, such as introduction of a catheter into her urethra, [as] such a skill would require a patient's genitals to be exposed. It remains unclear if in this case the patient discriminated against the doctor on the basis of gender or if it was the patient's personal preference.

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[34] Stigma is a strong social process that underestimate people or a group based on perception or real differences such as gender, sexual orientation, age, class, ethnicity, race or behavior (Ogden & Nyblade 2005).

[35] The concept of 'Othering' is treating people from another group differently from the other group which is usually inferior to the group you belong to (Matthies 2013)

[36] Sexism is described as discrimination or prejudice based on gender or sex, or a belief that men are superior to woman (Mikolajczak & Pietrzak 2015).

> There were African practitioners working with me and they said to the control centre we have a White female student with us, we are refusing to enter the zone, the area, because of the hostility and I think that in future to try and be a practitioner in a situation where the community might perceive us differently based on our race or our gender is of concern (P 5, page 36).

Participant 5, a White female was working with a non-White crew when she overheard them informing the control centre that they would not be able to enter the zone because they have a White female student. Participant 5 described the area as being hostile, meaning that there was some concern for her safety and if the situation would be friendly enough for them to proceed with their work. In the participant's view, however, it is unclear if the decision taken by the non-White practitioner was based on her race, gender or because she is a student.

Sample EC Provider on subtheme 1b

> [an African male EC Provider said to me] "You do not tell me what to do. You can be the paramedic[37] but I'm older than you, I'm male and I'm African" (P18, Page 164).

> I [Coloured female ECP] do not think that there is a specific way to be seen as a paramedic, people are surprised when I work with somebody else and it is a paramedic call and then they are like, are you the paramedic? And I'm like, yes. So, I do not know, maybe I'm too nice, maybe I'm not so arrogant about my qualification, maybe it could be me that's making them think that I'm not the paramedic (P 18, Page 165).

The participant's interpretation stems from the fact that she is younger than the African male EC provider and she cannot instruct him to do specific things during clinical practice even though she is more qualified than him. The male EC provider referred to (by participant 18) values age and ethnic group hierarchy over clinical competency and the leadership of a more qualified practitioner. There is also an undertone of gender discrimination because he says he is 'male' which begs the

[37] Within the Western Cape EMS a Paramedic title is given to a person who has an Advanced Life Support qualification.

question whether he would take clinical instruction from a younger male practitioner. Participant 18 feels undermined because she is not expected worthy as a Paramedic in this situation. She is unsure how to portray herself to be acknowledged as a Paramedic. She displays self-doubt and looks inward to explain this conduct towards her.

4.4.2. Theme 2: Being my 'Race' within the Institution

In the wake of apartheid, South Africa became known as 'the rainbow nation' to reflect the country's multicultural diversity since it is a multi-ethnic society with various languages, races and cultures. However, despite political and social transformation, racism appears to remain within South African society. Racial discrimination is the second main theme derived from the data of participants whereby incidents of racism perpetuated by students, patients and Emergency Care providers were reported. Race or racism was either experienced or witnessed by participants and it was apparent to the author that the feeling of being discriminated against on the basis of race was experienced and perceived by both so-called White and non-White students and EC providers. Interestingly, it seems the power to offend and be offended may be race-neutral in the EMC context.

THEMES	SUBTHEMES
2. Being my 'Race' within the Institution	2a. A discourse between racism and preference. 2b. Perception of Race within the EMS industry. 2c. Conceptualization of Racism and Privilege in EMS

4.4.2.1. Subtheme 2a: A discourse between racism and preference

To accurately understand how the nature of racism is portrayed and how it is received within the pre-hospital environment it is important to outline what it is and it is not. Focus will be placed on whether the patient's preference to be treated by

a specific practitioner can be quantified as racism. Participants reported racism as being portrayed by patients, therefore it was of significance for the author to adequately analyse if the act of patient preference can be considered to be racial discrimination.

Samples from EMC Students for Subtheme 2a

> One thing you take notice of is that Black people associate with Black people and White people associate with White people and so forth, the CCAs will be on their own and then the Coloured will be on their own, so already there is segregation in the class (P10, Page 90).

Participant 10, a Black male, indicated that there is a subconscious grouping that divides the class into multiple groups which is predetermined by race or class, even though the class is treated as one group of individuals but within the class, members do not see themselves as 'one'.

> If I had to compare all those shifts, I feel that Black people would treat me nicer compared to your Coloured and White people. This is based on… I would go and work in Khayelitsha which is my favourite base and I would go and work there because I know that it is Black dominated, and I feel good going there because I know, number one: they would never racially discriminate me (P10, Page 93).

Another sample from participant 10 also indicates a feeling of comfort associated with working with a crew of the same race or ethnic group and who share similar background. The participant above does not have a fear of being racially discriminated in such contexts. This resonates with my own experiences as a student. I also looked forward to working with Black EC providers because that made me feel comfortable to be around them to the extent that I would voluntarily choose to work additional shifts with Black EC providers.

> When I am with someone of my own race, even like asking questions, I feel comfortable asking the practitioner questions as compared to when I am with a practitioner of a different race (P9, Page 79).

For participant 9, It appears that there is more room to transfer knowledge when the student is working with an EC practitioner of the same race as him, this creates room for the student to learn as the student is in a non-threatening and enabling space.

> I felt much more comfortable when working with someone of my own race because they allow and encourage me to do things (P9, Page 77).

Participant 9 as a Black student also felt that work-integrated learning was more productive because he was afforded an opportunity to practice his skills when the EC provider was of the same race as him. As a senior student I was afforded the opportunity to perform advanced skill during clinical practice when working with Black EC providers as they trusted my clinical judgement and competency. Unfortunately, this rarely happened when I was working with a White EC provider and I able to personally confirm the following observation related by this EMC student:

> I have had cases where a person would say “I don’t want to be treated by this person”’ or when you get to a scene, they would say it to you that they are fine they don’t want to be treated by you, you must bring a person of a certain colour to come and treat them (P12, Page 121).

Participant 12’s experience as a Black student, shows that there were some cases whereby the (White) patient would refuse to be treated by him and asked him to call his White colleague to take over treatment.

> There isn’t a lot of people of my race in this field, therefore people will think that first of all you don’t know what you are doing, and secondly that you are not sure of why you are here (P9, Page 81).

Participant 9 was also made to feel that she does not belong in the EMS industry because she is Black and that she was an intruder and not was supposed to be in the industry.

> There are four groups in our class at the moment. The one set mostly speaks Afrikaans, then the other set has a lot of CCAs and then the other set .. it is Coloureds (they tend to stick together more), and then the other which comprises mostly Black students, which also sticks together (P11, Page 112).

For another participant the internal division within the class is unofficially classified on the basis of language, race and previous qualification (CCA). In such circumstances, the full value of shared diversity is unlikely to be realised.

Sample from EC Provider for subtheme 2a

> Look, I get along with most people and I don't have a problem with the colour of their skin but I do find that when I deal with people from my own colour or race and Black people…I do feel that I don't have to explain myself…you know… that there is no barrier (P14, 141).

As a Coloured EC provider, Participant 14 feels much comfortable working with practitioners of the same race. There is a sense of belonging when with Coloured EC providers compared to when he is with EC White providers. This is because he did not feel the need to explain himself to be accepted by the group. The regular act of having to unnecessarily account to others can be seen to undermine one's autonomy.

4.4.2.2. Subtheme 2b: Perception of race within the EMS industry

Since South Africa is a multiracial and multicultural country, the Emergency Medical Service, dispatches Emergency Care providers and students to various emergency medical situations where both can be exposed to patients from different racial/ethnic groupings which they have to treat and manage.

Both students and Emergency Care provider participants reported how they perceived racial discrimination within the pre-hospital setting. Incidents of racial discrimination have been manifested between students of different races, between students and their mentors (qualified EC providers supervising the student during clinical attachment), between student and the patient being treated by the student,

between EC providers and the patients and racial discrimination has also been witnessed between Emergency Care providers of differing races.

In earlier versions of analysis, this study has noted[38] the tendency to refer to the term 'opposing race'. Such a dyadic contrast may have reference to a Black/White dichotomy with its roots steeped in apartheid-style adversarial constructions of race relations. The challenge with such a dichotomy is that it does not consider other people of colour and does not credit White people who champion equality. Further, it also does not explain xenophobia between fellow Africans or a reverence for White European foreigners over Black African foreigners.[39]

Samples from EMC Students for Subtheme 2b:

> There is just too much discrimination within the EMS. I believe that Black people have not been fully accepted in this industry. Most White people still believe that it is their industry and they are the only ones who deserves to be ALS. This is what is causing most of the discrimination within the EMS (P1, Page 2).

Participant 1 as a Black male, feels alienated and unwanted by White people in the EMS. He indicates that White people believe that they should be the only ones who should progress within the EMS industry. What is the historical significance of such an observation? This can be explained as professional entitlement on the basis of race. South Africa, under apartheid, used the mechanism of job reservation to promote White privilege in professions and management. This historical practice has resulted in the need, post-apartheid, for employment equity legislation that outlaws job reservation and promotes affirmative action. Notwithstanding the intention for affirmative action to widen access to opportunities, its backlash has been to stigmatise Black appointments as a procedural requirement rather than one of merit. In emergency medical care, such

[38] Such observations are the result of Reflexivity and self-critique.

[39] Hence, I desist from using 'opposing race' although, at the time of the analysis it seemed sufficiently explanatory.

stigma is indefensible as all graduates must pass HPCSA accredited programmes and hold professional registration.

> Then you will get those ones who will make those comments about your colour or whatsoever or the way that they are looking at you or when you get closer to them, when you are trying to do something you will obviously see that this one is not comfortable with you (P12, Page 120).

The patient community too, hold views that promote racial stereotypes and historically racist norms. Participant 12 a Black male student explains that some patients will say negative remarks about your race and through their body language he could see that the patient was not comfortable with him examining them or performing medical skills.

> The one point that I was trying to highlight is that during class time … is that when you are supposed to do something, say for instance they give you the responsibility of checking the jump bag, they tend to look down on Black people, especially if you are not that intelligent like them, especially if you are not getting your 80% and 90%, if you are just an average student, they consider you as someone who is useless (P10, Page 90).

Black students and EC providers felt that they were constantly undermined by their fellow White classmates and colleagues respectively. Black and Coloured participants felt that for them to be accepted for their clinical competence within an acceptable standard for White people, they had to prove themselves before they would be well received by them. However, as Black people they did not encounter the same treatment when working with people of their own race. Black students were further classified by their own White classmates on the basis of academic performance, average (50%–70%) Black students were regarded as incompetent and were not taken seriously with any task that could potentially affect the class. White students were more receiving or accommodating of Black students who averaged +80%.

> So now if you are Black, you are considered as a minority and considering the course [is] one of the White dominated courses or − Coloured dominated but there are a few Black people in class… so now one thing we took notice of is that there will already be segregation within the class (P10, Page 90).

There was a majority of White students in participant 10's class, making them the dominant group. Black students as the minority, were marginalized. The White EMC students from first year to fourth year were always the majority and I personally recall several cases whereby being a minority affected us. For example, it was very easy for the dominant White group (who mostly had private transport) to easily agree to some external class activities that would take place far from campus residences. This arrangement did not consider the minority Black group in terms using public transport. Such a lack of consideration for others had the potential to exclude minorities from educational opportunities, to place them at risk and to falsely position them as non-compliant.

> At the time I was annoyed, I was really annoyed because I was there to help him and he was just seeing that I was White, which really irritated me at the time because he was also swearing at me about my mother, and my parents and ...[sighs] (P4, Page 26).

Participant 4, a White female, indicated that in her attempt to help a patient of Colour, the patient saw her as nothing but a White female that he could swear at. What didn't make sense to her is why would someone be this verbally aggressive when all she was trying to do was help. Without condoning the verbal abuse by the patient, the participant seemed unaware that Black racism is rooted in White oppression and a repressive apartheid state that imprisoned activists, relocated and fragmented communities on the basis of race, denied access to public spaces and racialised every aspect of education, health care, and economic opportunity. It is evident that even though South Africa has been a democratic country for the past 25 years under a Black government, racism still exists within our society.

It would appear, therefore, that both White and Black emergency care providers have racialised identities that play out in the experiences described above. In both

cases, the clinical competency of the care-giver (Black or White), has the potential to be seriously undermined to the detriment of patient safety and practitioner efficacy.

Samples from EC Providers for Subtheme 2b:

> I think that the big thing with the company that I worked for was the fact that most of the paramedics were so-called White and here I am, a Coloured paramedic, coming in into a White-male dominated industry and I am working for a company that is so-called White owned, and I am coming into this company and I am trying to be treated equal to them (P14, Page 139).

As a minority within a White male-dominant company, participant 14 (a Coloured male) felt that even though he had the same qualification (Advanced Life Support level) as some of his White counterparts, he was not treated in the same manner.

> I had no issues with regards to non-White and I now classify Xhosa (Black), and Coloured yes, those are the most two majority that I have worked with. I have no challenges with regard to that and I think that we felt that there was common ground because I think that most of them respected me and I respected them for studying further and they respected me for my previous qualification (CCA). But it was always a challenge when I needed to work with a White practitioner, I felt that I always needed to prove myself that my previous qualification was legitimate (P13, Page 125).

I have also personally seen such learned behaviour by qualified emergency care providers manifest itself into the prehospital environment. In this case Black and Coloured emergency care providers felt that they had to prove themselves to be respected by their White counterparts within the EMS as *bona fide* Emergency Care Practitioners holding a Degree in Emergency Medical Care. There was an assumption that Black or Coloured practitioners carry a lower qualification which results in them being undermined by their White colleagues.

> The fact that I'm female, the fact that I'm Coloured plays a big role in how people approach me or accept me as an ECP (Emergency Care Provider), because I'm

> never the ECP, I'm always the intern or the Basic Life Support, even in the way that sometimes doctors and nurses speak to me. they do not know me, they automatically assume that I cannot be the highest qualified (P18, Page 160).

Participants were judged on the basis of race on different occasions and because of their race, a lower level of performance or qualification was expected from them without being given the opportunity to share their credentials. In retrospect, participants felt that because they were classified as being Coloured and female certain people in the pre-hospital and hospital setting assume that they are carrying the lowest qualification or that they are not employed and only students.

> [W]e have a White paramedic on our shift, two Coloureds and one Black paramedic; but whenever there is opportunities, courses and stuff, the White paramedic gets chosen first. Like even now…for the Acting office job … I asked long before everybody else, and she got in (P18, Page 161).

As also indicated by Participant 18 (a female Coloured ECP) she made herself available for an opportunity to be assigned an Acting job which was available before anyone could take advantage of such; however, the opportunity was given to the White paramedic instead. She further explored her dissatisfaction about the (White paramedic) being frequently selected to go on courses and given other opportunities which they were hardly offered. This participant also clarified that within her shift there was one White, two Coloured and one Black paramedic that all with the same credentials, hence this unfair conduct fuelled her frustration. The EMS hierarchy, it seems, can be complicit in unfairly transacting opportunities and therefore are counterproductive to the developmental agenda, which seems to indicate the need for redress.

4.4.2.3. Subtheme 2c: Conceptualization of racism and privilege in EMS

The Constitution binds the state to progressively work towards a realisation of the right to health. This comes with equal access to health without any form of racial discrimination (Coovadia 2009). As I attempted to document the existence of racial discrimination within the EMS I drew a correlation between racism and

privilege in the EMS. This recalls Essed's (1997) mantra: 'Everyday racism is racism, but not all racism is everyday racism'. which suggests that at some point the perpetrator's pervasive racist action becomes subconscious or involuntary, although unfortunately, it also becomes a normal experience or a way of life for the victim. This behaviour unfortunately has the potential of placing the perpetrator in a privileged position if such action goes unnoticed with no formal methods for redress or accountability. This also means it has been accepted as the status quo within that environment and society.

Samples from EMC Students for subtheme 2c

> It is possible that he had some sort of resentment for me because I'm White, I'm not certain… uhm… obviously White people in this country have a history of exploiting other races and oppressing other races (P4, Page 27).

Participant 4 above (White male student), believes that the patient resented him because of his colour. He also makes an attempt to justify the patient's behaviour by pointing out White people have a history of taking advantage of other races which, in his view, could have informed the patient's resentment.

> A lot of people still assume that because you are White, you are privileged. It is a fair assumption because most of the White people in the country are privileged but I mean even if I was to be poor like, like incredibly poor, I think that I would probably be more offended because I'd say I'm not privileged, it wouldn't matter because I think the people just see White and assume privilege (P4, Page 28).

Participant 4 (White male) continues to draw a correlation between White people and privilege. He accepts the assumption made by majority of Black and Coloured people that view White people as being privileged and agrees that it is a fair assumption. In the same breath, he indicates that if you are a poor White person and people assume that you are privileged it may come across as being offensive.

> When I was working mostly in Khayelitsha, when you are working with a paramedic and they see a Coloured or a White student with the paramedic, they sort of like, people are more reluctant to speak to you as a student, but there is

> something that I have realised, they call you doctor or something like that where there is actually someone of a higher qualification than you but they avoid him almost because of their skin colour (P11, Page 106).

While on shift in a predominantly Black and poor community during her work-integrated learning, Participant 11 above noticed that because she is White, the Black patients would often assume she is a doctor and would be drawn to her rather than to the Black or Coloured qualified Emergency Care provider that she would be working with at the time. In an attempt to analyse such data it also should be acknowledged that students usually wear a different uniform to EC providers they work with. However, it is noteworthy that in this context Black students who wear the same uniform as the White students during their work-integrated learning were not identified by the patient as 'doctors' during this study.

> And with older patients maybe they cannot read and maybe they don't know who is who in the environment that we are working in and they probably think that this guy knows more because of their skin colour (P11, Page 107)

Participant 11 also indicated that maybe because of his race (White) older patients in predominantly Black communities assumed he is more knowledgeable and referred to him as 'doctor'. It should be noted that older patients were born during the apartheid era, and appear to associate intellectual ability and skill with race. Sadly, I can relate to the participant's experience because there was one incident where an elderly White male in his 60s preferred to be treated by one of the White junior paramedics that I was mentoring at the time because the patient assumed he was the most qualified one amongst the three of us (two Black EC Providers and one White EC provider on internship).

Samples from EC Providers for subtheme 2c

> They tend to treat the one better than the other one especially the patients that are not smelling so nice, they tend to treat them differently, they tend to put them aside, when they have to open a folder, they have to go sit on the corner but for the ones that are nicely dressed, they normally get to be put on a bed, like they

> get VIP treatment… . Sometimes we tend to put people in different brackets (P15, Page 143).

Participant 15 describes how patients are admitted and offered medical treatment on the basis of class and those that appear a better class are provided with adequate medical treatment. As an operational EC provider, I personally witnessed a lot of such incidents during motor vehicle accidents when a tendency to offer optimal care to the patient with medical aid was obviously better compared to those that did not have medical aid regardless of their injuries. Such unethical conduct can only be pervasive if there are perverse incentives associated with certain patient typologies. In this way, health care organisations may be complicit in creating a toxic organisational culture that undermines independence of practice.

> If I was White or Black they would have respected me more and if I was male even more…. it is a cultural thing, because most people see Coloureds as people who don't get anywhere in life (P18, Page 163).

Participant 18 described key issues from her experience as a female Coloured Emergency Care provider. She felt disrespected because of her race and believed that if she was Black or White, she would have been afforded some level of acceptable respect within the industry. She also triggers the author to view race from a cultural perspective as she indicates that there is a thinking that has been adopted by society which makes them believe that Coloured people do not succeed in life or do not amount to anything in life on the basis of cultural practices.

4.4.3. Theme 3: Language Discordance in Linguistically Diverse Clinical Setting

South Africa is a multicultural, multi-lingual and diverse country with eleven official languages. All languages are equal before the law. In the Western Cape Province there are three predominately spoken languages namely; Afrikaans, English and isiXhosa. To examine whether the concept of language has an impact on EMC students during their working integrated learning, this study looked at language as

a fundamental basis for the transfer of knowledge and skill between qualified EC providers and students.

MAIN THEME	SUBTHEME
3. Language discordance in linguistically diverse clinical setting	3a. EMS and Language Dynamics 3b. Language Barrier during Work-Integrated Learning and Patient Care

4.4.3.1. Subtheme 3a: EMS and language dynamics

The EMS's pre-hospital environment exposes the student and Emergency Care providers to different language dynamics. These dynamics range from having to communicate with a patient using any of the 11 official languages in South Africa to the crews deciding on which language to use in their workplace or in their respective emergency vehicle. The dynamics are made more complex by the periodic introduction of a student into the emergency vehicle for the purpose of work-integrated learning. The introduction of a student might impact how the crew communicates in the ambulance: Do they accommodate the student or does the student have to adjust to the language spoken by the crew? The Intersectionality present here is that of language, race and power granted by one's standing in the EMS profession. Arguably, students, who constitute the future workforce, are at the lower rungs of the EMS society.

Samples from EMC Students for subtheme 3a

> When they are working with a student they will go like…"argh it's a student"… and they start speaking in Afrikaans and then you will know that this shift is going to be a very long one. But as soon as the practitioner that you are working with starts asking "What is your name? What year are you doing?" Then you will know that this is going to be a nice trip (P10. Page 94).

> It does negatively affect you because now, firstly the day becomes the longest day ever, you find that you are amongst people who are speaking a language that you do

> not understand, so you don't even know what is happening and you cannot hear what the nurses are saying and sometimes…the doctors even (P12, Page 119).

Upon arrival in the ambulance base to join a new crew participant 10 states that once the crew realises that they are working with a student, some EC providers are not as welcoming and they will continue speaking Afrikaans (a language that he does not understand). This experience for both participants (Black) 10 and 12 makes them believe that such an encounter at the beginning of a shift already sets the tone for the rest of the day/night and in this case it feels as if the shift becomes less tolerable when they are not received and welcomed in a language that they understand.

> One thing that triggers a lot of things is that if you do not speak their language, it becomes very difficult. Because now you have a crew which is Coloured and they will speak Afrikaans and maybe I don't have an Afrikaans background, and maybe they start communicating with you in Afrikaans (P10, Page 93).

Participant 10 as a Black male student saw the language barrier as a trigger for how the crew will accommodate him during the shift as not being able to speak the crew's language put her in a bad light with them.

> The other day I went into an ambulance and I spoke to a paramedic and they were Coloured and I told them that I do not understand Afrikaans, and they said no this is how we talk in this ambulance and there is no way that we are going to speak in English. I am telling you…the whole night they spoke in Afrikaans, they were giving me orders in Afrikaans and I was just thinking maybe this is what they want me to do and if I do the wrong thing, but it was a long night I must say (P8, Page 66).

Participant 8, as a Black female, felt disconnected by the crew (EC providers) because of the language barrier when the crew made it clear that they would not change their language to accommodate her. During clinical practice she was also given instructions in Afrikaans and she constantly feared that she might make a mistake that would negatively affect the patient's prognosis.

> Yes it puts me in a disadvantaged position because the moment they see me they think that I am from South Africa by just looking at me and the moment I open my mouth, my accent tells that I am not from South Africa and that just changes everything else: the way they are going to talk to me, the way they are going to relay information. Right now I can understand a bit of Xhosa but when they see a Black person speaking to them in English they look at me like, I am full of myself, you know like … how come you are Black and you cannot speak Xhosa? So, to them it's like you are full of yourself (P8, Page 65-66).

Participant 8 above, a Black female foreign student studying in South Africa, indicates that most Black people she meets during her clinical attachment perceive her as a Xhosa-speaking but once she starts speaking English she is made to feel she is 'full of herself' (better than them) or too proud to speak Xhosa even though it is not her first language. She also indicates that being a foreign student puts her in a disadvantageous position because once she starts speaking, people are quick to judge her through the accent that she is not from South Africa and immediately undermine her.

> There was definitely a language barrier and I was the only English speaker amongst them, and they sort of, because I was an English speaker…uhm…I wasn't allowed to sit with them, they deliberately told me that I couldn't sit with them…uhm... and they would not speak to me unless I asked them repeatedly (P4, Page 23).

The participant 4, a White female, was excluded from the ethno-national group, which in this case was a Xhosa-speaking group. Owing to an inability to speak the local language (Xhosa) she was vulnerable to discrimination on that basis and was treated as an outsider by these Xhosa speakers. As both the student and the EC provider shared their experiences it became clear that the experience had a negative effect and she felt trapped in an environment that she could not do much to change. The above samples describe xenophobia with language being the unique characteristic that identifies a person as different.

> I feel that there should be a standard because when we are at university, we get taught in English so I feel like when you are working in that environment, you are

> supposed to also communicate in English because that is how we mostly understand each other. So, if that's the standard, then there won't be any problems. Then maybe when it comes to a patient, who maybe does not speak or understand English, then they can communicate to the patient in the language they understand and interpret their communication with the patient, then there will be a way forward (P9, Page 83).

The language of communication at the University where students are enrolled is English, but the language of communication between crews during work is poorly defined. The only time the EC providers are obliged to change their language might be during patient care because they have to communicate with the patient using a language that he or she understands so that they can be provided with consent to treat the patient. Another time is when the patient to refuses care after they have been advised of the consequences as stated in the 'National Patient's Right Charter' (HPCSA, 2008). This leaves the students with limited room to enforce change that will benefit or accommodate them during their clinical attachment.

> I think that the problem is, being English spoken and coming to a place and working where Afrikaans is predominantly the language that is spoken. I think that when someone kind of gives you an instruction or speaks to you, there is a bit of a delay, in first processing what they are saying, translating and then operating. That can become a problem because they want something done quickly and you are still trying to process what they said (P7, Page 54).

Participant 7 as a Black male student describes the delay in translation and interpretation that occurs when two people speak different languages. He explains how that can be a challenge during an emergency medical care situation because it will delay any execution of the treatment plan is the commands are in a language he does not understand. The context for this uncertainty is that there is no identified *lingua franca*[40] in the country.

[40] This refers to a chosen language of the state for the purpose of administration and practicality, such as in Nigeria.

> The only time that I felt a bit left out as a student, was when maybe just the language barrier between the crew and myself. I am a Coloured male from Cape Town and I speak English or Afrikaans and it is a multiracial environment so you have crews from everywhere, and they feel comfortable speaking their own language and not always accommodative to the student on board (P16, Page 146).

Participant 16 (a qualified EC provider) recalled when he was still a student and indicated that crew were not open to accommodating a student and instead stick to the language they are comfortable with regardless of the student's presence or their ability to understand that specific language.

> I am actually Coloured, but what I experience most of the time is that if I cannot speak your language [Black people's language e.g. Xhosa]. Your whole perception changes and your whole attitude towards me also changes… at the end of the day I feel a little bit negative also because of the fact that I am Black, I have the hair, I have this beautiful skin, everywhere I go it is like "Oh African queen" but yet I cannot speak the language (P17, Page 151-152).

The above participant's transcript during the analysis uncovers the fact that even though she is Coloured, her skin and hair are Black, and she is not fair skinned like most Coloured people. She was, however, not Black enough to be accepted by the Black work crew because she couldn't speak any African languages but only English and Afrikaans. She also reported that the first impression of her appearance to Black people is mostly positive and she recalls being called an 'African Queen', but this was always negated by Black attitudes and perceptions of her once it was realised she cannot speak Xhosa or other African languages. This case highlights the arbitrary nature of racism based on discrimination of unique characteristics.

4.4.3.2. *Subtheme 3b: Language barrier during work-integrated learning and patient care*

As described in Chapter 2, the apartheid system controlled the movement of Black people by using a pass system that granted them permission to enter urban areas. It is also a system that dictated where the person could live, attend school and work. This further divided Black people according to their spoken language, for example, the majority of Tsonga, Venda, Pedi speakers were mainly located in the Transvaal Province (currently known as Limpopo) whereas Xhosa speaking people lived in the Transkei (currently known as the Eastern Cape Province).

Post-apartheid policies and legislation promoted freedom and equality amongst all people living within South Africa. This allowed an opportunity for the majority of people to move freely and relocate within South Africa in search of better opportunities. As people gradually learnt to co-exist and live together, language started to become a barrier because two people from different backgrounds working together might speak different home languages. This also filters down to EC providers working within the pre-hospital setting as they come across patients who speak different languages which creates a barrier between them and the patient. The difference in the languages spoken by the student and the EC provider may also pose a barrier between the two. Hence, socio-cultural competence is needed.

Samples from EMC Students for subtheme 3b

> During patient care, it will depend on the patient. If the patient is a Coloured person, then they will speak Afrikaans, and obviously I will not benefit from that (P10, Page 95).

The difference in language between the EC provider and patient forms a barrier to health care; through language the student examines the patient, addresses the patient's concerns or advises the patient on his/her well-being.

> So if the crew is people who both speak Afrikaans, then the shift is not comfortable because they will like … go to an area and when they treat a

> patient, they will speak Afrikaans and then you get left behind of what is actually happening (P9, Page 77).

The participant is clear that the barrier created by language makes it impractical for experiential learning to take place, yet it does. Participants reported that they were not benefiting in a situation when they got left behind on what was happening with the patient because the language used did not afford them the opportunity to participate or understand what was happening.

> And it becomes a very big problem especially if I want to do a case study and they have written [it] in Afrikaans (P8, Page 65).

Writing up a case study forms part of clinical practice and it is an important aspect of work-integrated learning. Participant 8 further indicates that when the patient report form is written in Afrikaans it is difficult for her to extract information and use it for her case study.

> The Xhosa speaking students that were there, uhm…were allowed to perform skills because, they spoke in Xhosa and they would ask questions and if I spoke in English they wouldn't acknowledge me (P4, Page 31).

Participant 4, as a White female student working with a crew that spoke Xhosa indicates that she was denied the opportunity to perform a skill during clinical practice. Instead the EC providers availed that opportunity to Xhosa-speaking students who were also on shift. The difference in spoken languages made her believe that if she could speak Xhosa the EC provider may have afforded her the opportunity to perform the skill but because of language barrier she lost a learning opportunity.

As an autoethnographer, I can relate to the experience of participant 4 as a third year EMC student working in the same emergency vehicle with a fellow second-year White student (from the same University) under a White EC provider. We got dispatched to an emergency and during medical care of the patient there was an opportunity for me to perform a specific skill which was one of the requirements on

the third-year skills sheet; however, as I was about to make use of that opportunity the White EC provider instructed the White student to do that skill although I immediately pointed out it was not part of the skill requirement for second year students (I was familiar with the second year programme since we were both from the same University and Department). He then indicated that I would get a chance to do the skill on the next call. This was a missed opportunity because during work-integrated learning in the EMS we never know which cases we would be dispatched to. I felt that the practitioner took an incorrect decision, despite being correctly informed by me, and the only reasonable explanation is that he based the decision on race and not merit by affording the learning opportunity to a person of his own race.

> I had a case where, I think for an entire shift, they would treat the patient and I would try to get involved and I was excluded [be]cause I didn't know what was going on and the patient also speak their language and I had no idea what they were saying. It was a little discouraging for most of the shift [as] I wasn't able to actually engage with the patient or actually treat the patient (so as far as my treatment went with the patient) which is what you kind of aim to do on your shifts. It would be just "oh the patient needs this, do that" and you wouldn't know why, [nor would] you know [what] was actually wrong with the patient (P3, Page 15).

Participant 3 as a Black male felt that entire work-integrated learning shift was counter-productive because not only could he not understand what the patient was saying but also the EC providers, speaking in the same language did not bother translating the case to him or to get him involved by informing him of the patient's medical case enough so that he could have participated in clinical decisions and management of the patient. He made several attempts to get engaged but the EC provider's use of language created a constant barrier that the student could not break.

Samples from EC Providers for subtheme 3b

This subtheme was only applicable to students because no EC provider participating in the study encountered language barriers when communicating with the student or patient during clinical practice. It was also unclear if the EC providers' understanding and experience of language barrier were the same or different to students. This finding, however, does not totally exclude the possibility of the EC provider experiencing language barriers when communicating with the patient or their colleagues within the EMS. As a qualified EC provider myself, there have been multiple cases whereby the patient and I could not find a common language and I had to rely on a chaperone (patient escort) to translate.

My own personal advantage is that as a qualified BTech in EMC I am registered as an Emergency Care Practitioner which is the highest registration category in the EMS profession as per the HPCSA. By default, that makes me the highest qualified person at the scene most of the time and with that comes the privilege of having authority to manage the scene and operations around the patient if the patient is under my care and/or I have a team working under my supervision. So, I would be able to immediately intervene and rule out the language barriers to make sure that everyone working around the patient understands what is happening so that they can all equally contribute to the patient's prognosis.

The language barrier challenge appears to have the potential to affect the student's educational opportunities, and therefore their learning during clinical attachment. Participants were overwhelmed by feelings of helplessness towards the situation (EC provider speaking in a language not understood) when it happens.

4.5. Summary of the Chapter

It could be assumed that work-integrated experience is probably the most exciting part of the student training phase as they get a unique opportunity to feel the pressure as they practise what was learnt in class on real patients and meet different people in the process. However, for EMC students, that opportunity is frequently missing as they have to learn how to deal with discrimination. This chapter presents the findings in data reported by the participants and is given my own interpretation, where applicable, by using the autoethnographic approach of sharing personal experiences of racial discrimination.

Different themes and subthemes also emerge from that data through critical ethnography. Findings are grouped together with the sub-themes to create categories which assist with the discussion. The findings suggest that participants experienced discrimination on the basis of race, gender and language. These findings are analysed and discussed in the next chapter.

CHAPTER FIVE: DISCUSSION OF FINDINGS

5.1. Introduction

The main objective of this study is to document the existence of social discriminatory practices during clinical practice in Emergency Medical Care. Participants' experiences vary according to a multitude of factors; namely, their gender, race and spoken language. Overall participants did experience some form of discrimination during working integrated learning. This chapter will interpret key themes through contextualising them with a Critical Race Theory (CRT) lens as a lens to understand how discrimination manifests during work-place learning in the pre-hospital setting and also how students and Emergency Care providers navigate this tense atmosphere of discrimination. The five tenets of CRT will be considered as a framework namely; an approach to racism as endemic, dismantling of prevailing ideologies, commitment to social justice, experiential knowledge of research subjects and lastly interdisciplinary work, were applicable to use them in order to derive meaning from the participant's experiences and textual representations of Chapter 4.

5.2. Uncovering a Paramedic's Gender Constraints

A conceptual difference exists between the terms' gender' and 'sex'. Gender refers to the social or cultural constructs associated with being male or female whilst sex refers to the physiological, physical differentiations, the reproductive system, height and masculinity/femininity of an individual (Ricardo & Barker 2008). Biological sex provides the foundation onto which gender can build (Anker 1997). The process of gendering is therefore a social attribute which stems from biological sex (Eckert & Maconnell-Ginnet 2003; Kite, Deaux & Haines 2008).

5.2.1. Sexual harassment

Sexual harassment can occur in a patriarchal system model where the harassment can be explained in a societal context. This model explains that sexual harassment occurs due to male dominance over women (Cogin & Fish 2009). Participant 16's sample shows the treatment of a patient who sexually harassed and assaulted the caregivers. The patient's actions were experienced as grossly violating and violently intrusive towards the practitioner. The patient,

therefore, violated the EC provider's rights according to South African legislation (see Chapter 2).

Participant 5 and Participant 18 both experienced sexual harassment which later escalated into sexual assault. Both incidences were perpetrated by patients and those accompanying them. Moffet (2006) explains the occurrence of sexual violence is due to South Africans experiencing a masculinity crisis where they use sexual violence to keep women in subordinate positions. According to McGuire, Dougherty & Atkinson (2006), the healthcare profession has an intimacy that brings the patient emotionally and physically closer to the practitioner. Further, patients were seen trying to negotiate power, as a form of control by being close to nurses (McGuire, Dougherty & Atkinson 2006).

Nielsen et al. (2017) states that sexual harassment is taboo in the health care sector. A study by Cogin and Fish in 2009 has found an increased prevalence of reported sexual harassment incidents (76%) in the nursing profession. Such sexual harassment not only involved nurses but it had also been reported by student nurses where 95% of the nursing students experienced sexual harassment during their training (Cogin & Fish 2009). The findings of this study corroborate this experience in emergency medical care services whereby both students and practitioners experienced sexual harassment during their clinical practice. This could potentially be viewed as a generational experience of abuse which entrenches it as 'normal'.

Sexual harassment can also occur due to the organizational model which facilitates sexual harassment in a hierarchal system where individuals in higher positions abuse their power for their own sexual gratification (Cogin & Fish 2009). This can be seen through the experience of Participant 2, where a paramedic, who was entrusted with the role of facilitating clinical practice for the participant, used his position of relative authority to sexually harass the female subordinate.

From a CRT perspective the experience of sexual harassment often results in victims becoming emotionally overloaded and if this becomes overwhelming, it is likely to result in increased absenteeism and leaving the workplace (Nielsen et al.

2017). This consequence was also reflected by Participant 2 who left the shift early due to the insurmountable sexual pressure placed on her by the EC provider on shift. Not only is this kind of action a human rights violation with harmful consequences but the clinical practice training purpose is also thwarted and therefore wholly counter-productive to the intent of such professional education. This concept can be best understood using the *quid pro quo* principle as indicated in Chapter 2, The EC provider as a person with authority over the student made sexual remarks in the presence of the student in an attempt to get her interested in what he was saying or implying. This eventually forced the student leave the shift early and therefore, she also lost an opportunity to learn on that day.

5.2.2. Gender inequality and patriarchy

Historically, until the 18th century, little or no attention was paid to social inequality because social values were influenced by religion (Anker 1997). Inequality was viewed as an unchangeable fact as it was then believed that inequality could be changed (Anker 1997; Kite, Deaux & Haines 2008). In the 19th century this view was displaced by a scientific explanation. According to Butler (1993), scholars formulated theories for gender inequality; the theories were derived from a male-oriented intellectual stance. Women were viewed as the cause of the societal problems and the solutions to those problems were that the women needed to be more like men to address the problem (Reskin & Biely 2005; Ricardo & Barker 2008).

Participant 5 felt racially discriminated against when EC providers refused to enter an area which they believed would be hostile to her as a White female student. Therefore, it can be seen that a need to balance employment rights in rendering care to the patient and ethical duties within the community is essential. The role players in this instance viewed it ethically justifiable if EMS personnel were refused entry into an area if it compromised their safety. It remains unclear if EC providers working with Participant 5 would have proceeded to go into a hostile area if they were working with either with a Black female student, or a Black male student, or a White male student or with no student, but from the transcript it appears that judgment was made on the basis of safety for the student rather than discrimination or bias. In any event, the case demonstrates

Intersectionality: the interests of the patient vs. the interests of the practitioners; violence against the EMS vs. victims in the community; racially motivated violence vs. intimidation and common opportunistic crime.

The safety of the crew remains a priority when entering any emergency situation. Recent multiple attacks in the Western Cape Metropolitan EMS made Paramedics more vigilant when attending to incidents in the pre-hospital setting. A newsletter from the Emergency Care Professional Board published by the HPCSA in 2018, acknowledged the increase of criminal attacks on EMS professionals at work and noted that within the country there were eight incidents of attack on EMS personnel from January - June 2018. It also encouraged EMS professionals to stop and think about any potential hazard that may be attached to an incident by bearing in mind the location and the time.

Gender can negatively affect both men and women in certain situations. For example, a man can be disadvantaged by being excluded from a gynaecological examination where a female chaperone must be present (Butler 1990). This can negatively impact a male student's clinical practice exposure and experience. In the same way, women firefighters were once not able to fit their firefighter gear (Women in fire service, 2003) and similarly, in terms of Participant 2's experience, women were perceived as being weak and physically incompetent to work in the EMS. This data on gender inequality experienced by these participants could be attributed to 'gender stereotyping' (Kite, Deaux & Haines 2008). Gender stereotyping results in a division of labour, which is also referred to as 'sex segregation' (Anker 1997), which has resulted in occupations being labelled as 'men's work' or 'women's work'. The sexual division can also be reflected on equipment and processes used primarily by one biological sex or another (Cortina, 2002). The experiences of Participants 2 and 18 can therefore be explained as a perception of a sexual division of labour due to in the constraints put on their gender by the co-worker in the profession.

Gender stereotyping is also a preconceived view of attributes, characteristics that are possessed by men and women (Anker 1997; Eckert & Maconnell-Ginnet, 2003; Kite Deaux & Haines 2008; UNHR, 2014). According to the South

African Human Rights Commission (SAHRC), South African women have been marginalized and regarded as unequal to men in social and power relations (SAHRC 2017). Culture and society often define women's roles to be those of looking after the children, family, relatives and the household, whilst the men are regarded as bread-winners. Social stereotyping is when inferences about sex, personality and traits are made based on an individual's biological sex; for example, men are seen to specialise best in marketing careers, whilst women are seen to be better at specialising in domestic work (Reskin & Bieby 2005; Ricardo & Barke 2008).

Participant 3 witnessed an incident where a female patient refused a male practitioner to perform an examination on her as she preferred a female practitioner for that specific procedure to be done. During clinical attachment, students are exposed to both male and female patients and as they are undergoing work-integrated training they are expected to offer patient care under the supervision of their mentors without discriminating the patient on the basis of gender. In view of patient rights in the National Patient Rights Charter by the HPCSA (2008), patients have the right to refuse care being provided by the practitioner provided that they are of sound judgment and their condition had been explained to them, making them aware of the consequences. Patients also have the right to be referred to alternative practitioners.

According to a study conducted by Johnson et al. (2005), 66.6% of patients had no gender bias in relation to selecting an obstetrician-gynecologist and 80.8% felt that gender did not play any significant role in quality of care. The same study also indicated that patient's preference/satisfaction levels were not based on gender but rather on the Obstetrician-gynecologist's reputation, sense of compassion and experience.

5.3. Being my 'Race' within the Institution

Critical Race Theory has been considered in an attempt to contextualise the researcher and participant's dialogue. The author, being a victim of racial discrimination himself, has declared his bias to ensure his experience is not based on race victimisation alone. It is hoped that the use of critical reasoning

and argumentation (Naidoo 2011) will help remove preconceived ideas that might obscure the author's thinking.

5.3.1. A discourse between racism and preference

In general, patients are aware and sensitive to interpersonal dynamics but due to the discriminatory history within society, stigmas in healthcare mainly affected Black people. A study by (Cooper & Powe 2004) on racial stigma suggests that people cope with the constant threat of discrimination or bias by consciously avoiding interaction with people who carry the potential to victimise them.

As acknowledged by Participant 11, students would group themselves on the basis of race. In this case, the patient may prefer healthcare provider-patient racial concordance. The patient's refusal to be treated by a healthcare provider may be racially motivated due to the belief that medical treatment provided by a Black healthcare provider is of poor quality. Previously, this notion was racially motivated during legally sanctioned segregation by majority of White healthcare providers and the general public in the United States (Byrd & Clayton 2001).

According to the Health Professions Council of South Africa (2008), the patient has the right of choice to health services. This gives the patient freedom to choose a specific health care provider to offer them a service or treatment at a facility of their choice. The right is only granted provided it does not contradict the ethical standards applicable to the health care provider or facility. The patient also has the right to refuse treatment provided they qualify to make such a decision and that the decline for treatment does not affect others. The patient's rights are supported in their preference. What often remains unclear is whether the patient's refusal of care is based on the assigned healthcare provider's racial identity or some other reason.

This practice poses a dilemma between medicine and ethics since satisfying the patient's preference may be viewed as supporting racial discrimination and would be against the Bill of Rights as stated in the South African constitution. Healthcare providers may also view this as racial discrimination, if they are being told which patients to treat on the basis of the patient's race.

As described by Kimani (2012) in Chapter 2 there are three policies which could be considered to accommodate the patient's preference; through accommodation, the limits of accommodation, and beyond accommodation. An improvement in the patient–provider relationship across all racial and ethnic groups within the healthcare system could be eliminated by a long-term strategic approach. In Chapter 2 the literature suggests that patient's preference to a specific practitioner goes beyond the healthcare provider's race as patient-provider concordance contributes to the patient's overall health outcome; however, it classifies a preference that is solely based on race as racial discrimination.

There seems to be more room to learn and share knowledge between student and mentor and patient and healthcare provider when the two parties involved are from the same race. As reported by one participant, a culture of racial disparity exists amongst students in the same class as racial grouping. There is also a perceived level of comfort that a student has when he works under supervision of someone of his own race. The racial disparity overflows to the prehospital environment and is eventually evident between practitioner and patient.

In a study conducted by Perez and London (2004), an incident in 1942 (the year that Black students were admitted into the medical faculty in the University of Cape Town) was reported that when the Black students, upon admission, were notified in writing by the then Cape Hospital Board that non-European medical students were not allowed in European Wards and were not allowed to perform any medical examination on White patients at the Groote Schuur Hospital. This history no doubt influences responses to current acts of racially-based clinical preferences.

5.3.2. Perception of race within the EMS industry

Perception is an ability to see or to be aware of something either by witnessing it or hearing about it. Perception may also be a way in which a situation is interpreted, understood or regarded (McDonald 2012). The interpretation and understanding of racism may be subjective depending on one's previous experience of racial encounters with people 'opposite' their race (or in opposition to their race). It was therefore evident during data collection that perceptions of race amongst practitioners and students of different racial background had conflicting views.

In the past, the opportunity to access such training was limited for the Black majority as indicated in Chapter 2. This could perhaps explain what the participant (P9, Page 81) refers to about the EMS not having enough Black people qualified at an Advanced Life Support level. Lack of awareness about such courses or training could have also contributed to the current minimal number of Black paramedics in the profession, bearing in mind that the majority of Black people were previously concentrated in the homelands which isolated them from opportunities and institutions mainly located in urban and suburban areas where Whites resided. In the past, urban areas were reserved for White people in terms of the segregation laws. The policy was consolidated when the National Party came to power in 1948 and its policy of apartheid ensured political exclusion, social separation, racial injustice and economic marginalization (Coovadia 2009).

The HPCSA, as the post-apartheid regulator, may not have done enough to widen access and improve racial equity among its accredited training providers. The apartheid system was based on a racial hierarchy which classified South Africans as European (White), Asian (Indian), Coloured, or Bantu (Black) and White people were placed at the top of this hierarchy. In the past, therefore, this could directly affect access to education of higher learning and hence, there were fewer Black graduates. In addition, such classification further determined where the person could work, where they were allowed to live, which school they could go to, resources allocated to their education, if they could vote, access to healthcare and if they could marry. Millions of Black South Africans were

forcefully removed to areas of land centred on rural labour and denied citizenship to allow freedom of access to urban areas with a pass which would provide permission to enter the restricted areas and work (SAHO 2016).

Participant 1 and 14 mention that White people believe or feel as if the EMS industry 'belongs' to them. Since the fundamental basis that ensured White people had previously been the majority in the EMS due to the past unfair advantage in access to education and training facilities, one can see how this domination arose in the EMS. Does this dominance equate to a misinformed sense of ownership (and cultural hegemony) that excludes the marginalised from the environment and pave a way for those that feel entitled to rule?

Karlberg (2005), deconstructs the dominance of power and clarifies elements of an alternative discourse of power. The study exposes the distinctions of 'power over' which are shown in issues of control, social conflict and coercion. The focus is more on power as a domination paradigm, whereas power was conceptualised as a simple behavioural term. Within a social or political system, power can be exercised in a more subtle way and may often mobilise bias that prevents some people or groups from advancing their own interest within society. In the EMS there are some practitioners and students who have come to the conclusion that White people feel that they have ownership of this profession and the lack of Black paramedics in the field trained at an Advanced Life Support level justifies the White cultural majority.

By applying Critical Race Theory, a correlation between majority, dominance and power was constructed to see if there is a relationship between each of them. This could assist in understanding why a certain group within a population dominated by one race would feel marginalized. Perceptions of race within the EMS appears to be a persistent notion in one form or the other lingering over from the apartheid era despite the cultural evolvement since. With any substantial effort of its redress in the EMS, therefore, it might be significant to recall this history of unequal racial distribution within the institution itself. In essence, the political majority is not the same as the cultural majority. On the premise that clinical practice interactions are operations in cultural exchange,

clinical practice, as a platform for social action, also enables discriminatory social practice. This begs the question: Can clinical practice enable and facilitate non-discriminatory social practice?

Reich (1981:17-75), described racism as being harmful to disadvantaged groups within a White population in terms of two principles. Firstly, racism undermines people's capacity in challenging different forms of inequality and power because it divides popular political and social movements. Those who are presumed as the elite have often strategically used race to protect their class interests. The sole objective of emergency care providers is to offer clinical care to the patient, irrespective of their race in a multiracial country; however, racial tension between providers may have the potential to transgress cross over to patient management which may have the potential for clinical judgment to be based on race.

Participant 18 was frequently denied the opportunity to go on courses for her own professional growth and was also not afforded the opportunity to act as a base manager despite being available. Instead those opportunities were mostly awarded to the White EC provider who carried the same qualification. The station manager's idea of what constitutes giving someone the opportunity to act on the job or go on courses is not known. This is immaterial to the argument; however, he frequently provides these opportunities to only one White paramedic on shift rather than to the other three (two Coloured and one Black, all female paramedics). This constitutes unfair treatment and is experienced as prejudice. The discrimination is not considered acceptable and it is through these discriminatory behaviours that the Emergency Care providers become frustrated because even though they carry the same qualification as the White paramedic their capabilities are still viewed as being inadequate due to their race. To be fair, White participants also reported the experience of discrimination on the basis of rape.

Racism experienced or perceived in the modern day era is no longer overt or institutionalised as it was during times of apartheid, segregation or slavery. Modern day racism is covert and systemically embedded in economic and political structures that do not promote equal opportunity but provide interest and

incentives on the basis race (Bobo, Kluegel & Smith 1997). In so doing the interests of the dominant group are preserved within society and it creates a biased environment that undermines the disadvantaged who will never be part of the group because of their skin colour. It also removes the opportunity for one to progress within a corporate world based on abilities or merit because there is already a preconceived idea of capabilities falsely correlated to their race.

5.3.3. Conceptualization of racism and privilege in EMS

On 27 April 1994, the first democratic election for the Republic of South Africa brought in a government which prioritised national unity under a Constitution that had a strong and explicit anti-racist stance. However, despite the essential political and social transformation, racism would remain part of South Africa in many aspects of society and organisational structures (Stevens 1998).

To conceptualise the idea of racism and privilege within the Emergency Medical Service it is essential to demonstrate a clear understanding of both racism and privilege respectively as in Chapter 2. This allows for an interpretation of this phenomenon collectively from a CRT point of view. Participant 4 is a White participant who accepted the resentment he received from Black people because his view is that in South Africa, White people have a history of exploiting and oppressing other races. It is clear in this instance, that the perpetrator's racial acts are being justified based on the country's racial history, and it also confirms that individuals show and receive racist behaviour in different ways.

The concept of racism is an exceptionally complex one. It goes beyond a simple conviction used by a group or an individual to justify discrimination against other people from the outside. Racism is internal and may be used to direct the opinion of the individual or group about himself or others, eventually the person's behaviour is directly influenced by their race (Connolly 1998). It is apparent that Participant 4, as a White male does not see this notion as racist. Greene and Blitz (2012) suggest that the majority of White people see racial equity as being colour-blind. This appears not to be possible and actually allows for stress and insults of micro-aggressive racism to be invisible to White people. When one fails to acknowledge race, it results in minimisation, denial or rationalisation of social

injustice and individual experiences of discrimination (Bonilla-Silva 2003; Monnat 2010).

Participants also experienced challenges as women in a male-dominanted environment. Some participants stated that if they were male, society/colleagues would have respected them or treated them better. The participants often experience different forms of discrimination all at once but are still expected to exercise their duties as paramedics. In 1998, Steven defined racism as an unsupported belief that among humans there are biological hierarchies in the form of different races and attempts to justify the political, economic and social exploitation of certain social groups by others. He further described it as a phenomenon that is socially pervasive and obscures imbalanced social relations.

Therefore, employers and supervisors have a responsibility to support and guide cultural competencies of their subordinates and their abilities to respond to a wide range of human experience while maintaining their objectivity. When working with racially and culturally diverse clients, an essential feature of supervision is the mentor's ability to raise and guide analyses of race, ethnicity, and culture (Estrada, Wiggins Frame & Braun-Williams 2003). There is no good reason to suggest otherwise for supervisors or mentors in emergency medical care.

The data provided by Participant 18 reveals she experienced three levels of racism; namely, individual, cultural and institutional. 'Individual racism' is a personal belief that one race is inferior compared to another race, and the view is mainly derived from observing physical differences between racial groups. 'Institutional racism' is systematically embedded into the law, practices and conventions when that reflects racial inequality or its practice results in racial inequality. 'Cultural racism' occurs when one racial group views another group's culture as lesser or views them as having no culture at all. Individual and cultural racism is portrayed by a person at an individual and personal level, but with institutional racism it is reflected through the practices and policies of an institution (Connolly 1998). What then is the complicity of the EMS organisation?

Within a racist-orientated society, individuals will express some form of racialization[41] within their discourses. The process of racialization is vital in identifying the difference between 'self' and 'other'. With reference to the context as described in the transcripts, Participant 18[42], as a Coloured female, is negatively perceived as 'other' as she was identified as Black and White (making her feel inferior because of race). This indicates that despite constitutional changes, South Africans remain divided on the basis of race with a constant but covert undertone of racial discrimination. With a CRT convergence lens, the author uncovers Participant 18's experience through Intersectionality (as described in Chapter 2). Conceptualising the relationship between systems of oppression in Feminist theory is predominantly done through Intersectionality which constructs our multiple identities and our social location in the hierarchy of privilege and power (Carastathis 2014).

Critical Race Theory allows an examination of the difference afforded the White student to be called a 'doctor' by a Black patient. As indicated by Participant 11, patients are usually reluctant to speak to a student but if the patient assumes that Participant 11 is a doctor based on her race then the patient will be more engaging with her and enable her to have a more clinical discussion with the patient. This added advantage in her clinical experience puts her in a position of relative privilege because her fellow Black or Coloured students are denied such an advantage.

In the deployment of Critical Race Theory a broader appreciation of privilege is required to understand if Participant 11's statement that White people are privileged is a fair assumption to make. Mcintosh (1988: 38) has stated that White people are carefully taught not to recognise White privilege in the same way that most men do. She describes White privilege as 'an invisible package of assets that were not earned' and which they remain oblivious about. She further declares that her schooling did not teach her to see herself as an oppressor, or a person who is unfairly advantaged or a participant in a culture that is damaged.

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[41] Racialization is the process of attributing racial identity to a person or group (Fassin, 2011).

[42] Participant 18 holds a Bachelor's Degree in Emergency Medical Care and is one of the few registered Emergency Care Practitioners within the organisation.

The sense of White privilege that White people carry with them appears to give them an unfair advantage within society over other racial groups. In the context of EMS it can be seen when patients are more open to talk to the White student and also assumes the White student is the doctor. This is evidence of White advantage (to engage more with the patient at a clinical level) and may boost their confidence and self-esteem which can positively contribute towards the student's clinical practice. The patient has unwittingly given the student the high status in the presence of two other qualified Emergency Care providers supervising the student and it would appear in this case to be a matter of respect for White privilege, which as Mcintosh (1988) indicates, is 'unearned power' which is not offered on the basis of merit or intelligence but because of race.

5.4 Language Discordance in Diverse Clinical Settings

South African institutions of higher learning are largely made up of diverse student groups who speak various languages. An Increasing number of students are also in the Faculty of Health Sciences to acquire medical or allied knowledge and training. According to Keeton et al. (2017) clinical practice is the fundamental element of Health Science programmes as it ensures students acquire knowledge and skills transfer in linguistically diverse clinical settings.

Therefore, EMS teams operate in multicultural environments where there is frequent language discord between EC providers and patients. Communication in the EMS is often spontaneous, due to with increased content and informal delivery. As such communication plays a critical role in ensuring organised and systemic flow of information among members of the clinical teams. Practitioners, as mentors have a dual purpose during clinical practice; as clinician and caregiver to the patient and equally they have to afford students learning opportunities during their clinical practice attachments

5.4.1 EMS and language dynamics

Language, as the most vital form of communication, enables two or more individuals to interact (Keyton 2011). When students are randomly placed at different base stations for their clinical attachment, they usually work with a different practitioner at each and would work with that specific crew for the rest of the shift. The pre-hospital setting is an uncontrolled environment that poses different challenges to emergency care providers as they try to manage the scene and make it conducive to conduct clinical care for the patient. At the same time the environment is transformed into a learning space to promote work-integrated training for EMC students during their clinical attachment. In this case, the personal dynamic slightly changes with the introduction of a student as part of a crew in an Ambulance or Primary Response Vehicle. The qualified Emergency Care provider remains in charge and the student is set to work under their supervision; an arrangement that makes the Emergency Care provider the power broker. As the power broker by default they may, therefore, subconsciously set the tone for the entire shift in and around ambulance operations.

With reference to Participant 10 and 12's experiences, therefore, it is indicated that if the EC provider is welcoming towards the student and shows interest by allowing introductions to take place and acknowledges the student's progression or level of study the student can look forward to the shift with a positive mind-set. The EC provider, therefore, plays a critical role in how the student will view their work-integrated learning environment. What these participants have also highlighted is the correlation between language barrier and productivity of the shift. Both predicted an unproductive shift on their arrival at the base station based on language barriers between them (student) and the EC provider. I would submit, therefore, that deliberately speaking to someone in a language they do not know is a communication stopper. The motive may well be to marginalise or to protect a perceived status and power. What is certain, however, is that dignity violations are likely to be on both sides.

Students find themselves interjecting a crew which in most cases is accustomed to working together without a student on-board the vehicle. The participants

reported that it becomes difficult to be part of the crew if the crew continue speaking in a language that does not accommodate the student, and in some cases, they would tell the student that they will not switch language because that was not 'how things work' in their ambulance.

As indicated in Chapter 2, participants often experience a 'communication process barrier' (Keyton, 2011). In one case, there was an 'Encoding Barrier' (the words used by the EC provider) for messages in Afrikaans, a language that the student did not understand. As a result, the student was unable decode the message into meaningful information, and no feedback could be sent to the EC provider. Therefore, there was no communication between the two. The language barrier, therefore, excluded the student from engaging in any form of communication with the crew even though a student presence in the team had been acknowledged.

This intentional exclusion of an EMC student by an EC provider and subsequent lack of consideration made the student feel discriminated against on the basis of language. This behaviour would be something beyond the student's control and does not form part of their training; however, the only way to overcome that imbalance would be for the student to speak Afrikaans. This then becomes an unfair disadvantage because it discriminates, only those students privileged enough to have Afrikaans as their first or second language could have a productive shift and academically engage with the crew to learn as much as possible on the shift.

From such experiences, language is viewed as the key factor to isolate others from the ethnic group. In 1996, Ozolins also suggested that a possible relationship between ethnicity[43] and language in a different historical context. As described in Chapter 2 the concept of language as a boundary marker for ethnonational groups is a critical aspect to understand the dilemma of Participant 17, a Coloured EC provider with dark physical features. She was considered

[43] Ethnicity the fact or state of belonging to a social group that has common national or cultural tradition (Oxford University, 2007)

Black, but then discriminated against by Black people because she could not speak African languages. This is similar to the discrimination against Participant 8, a Black foreign student, discriminated against by Black people because she could not speak Xhosa.

5.4.2 Language barrier during work-integrated learning and patient care

Participants also reported the existence of a language barrier within the EMS and also when EMC students engage with their mentors[44] and patients during work-integrated learning and patient care. Participant reported occasions whereby the EC providers (e.g. Afrikaans speaking crew) during the shift would speak to each other in Afrikaans the entire shift and if they happen to be dispatched to an Afrikaans-speaking patient they would continue speaking to the patient in Afrikaans and would not bother explaining/translating the patient's condition or symptoms to the student. This conduct, therefore, totally excluded the students from participating in patient care and as a result they were unable to clinical engage in patient management. Students viewed this as a vital loss of a learning opportunity in their curriculum.

The EMC Students further indicated that while mentors did not feel compelled to translate information to accommodate the student, by contrast EC providers were happy to offer an opportunity to a student who spoke the same language as them. Participants considered this approach discriminatory because only some students could therefore benefit from the clinical attachment shift.

Using a language that the patient understands contributes positively to the patient's prognosis and benefits the clinical outcome. However, if the student on scene does not understand the spoken language they might not immediately understand what is happening with the patient. In the context of experiential learning as described in Chapter 2, perhaps the most appropriate method of approach would be for the EC provider to accommodate the student by sharing

[44] Mentors in the context are qualified Emergency Care providers supervising EMC students during clinical attachment.

with them the clinical presentation of the patient so that they also could be in a position to learn from that particular case and suggest a treatment plan as per their curriculum.

5.5 Summary of the Chapter

The study's objective is to document the lived experiences and perceptions of both Emergency Medical Care students and Emergency Care providers during work integrated learning. The core problem reflects discriminatory social practices within the EMS and the potential of harm it causes. This study supports the argument that discriminatory practices exist within the pre-hospital setting which require sufficient documentation of its existence.

The discussion of the findings concludes that discrimination is experienced by both EMC students and EC providers during clinical practice in Emergency Medical Care. The analysis includes Critical Race Theory and incorporates specific findings in the literature. In the chapter that follows, the author makes recommendations to different stakeholders.

CHAPTER SIX: CONCLUSIONS AND RECOMMENDATIONS

6.1. Introduction

This study has clearly documented the existence of discriminatory social practices during clinical practice in emergency medical care. Experiences and perceptions of discrimination were reported by both EC providers and EMC students. The data uncover discrimination on the basis of gender, race and language between EC providers, between EC providers and students, and between patients and EMC students. From a critical ethnographic approach, the focus was initially on researching the existence of racial discrimination within the EMS during clinical practice. It was evident during data collection that participants experienced discrimination mainly based on their race, spoken language and gender.

6.2. Summary of Discussion

A total of 18 participants were purposively recruited for this study, 13 fourth year BEMC students registered at CPUT and five EC providers working at the EMS in the Western Cape Province. Participants provided sufficient data to answer the research question and sub-questions as posed.

Research Question

How do social discriminatory practices manifest within the pre-hospital environment during BEMC work-integrated learning in clinical practice at a South African University?

Sub-Questions

SQ.1. How do final year emergency medical care students at a University perceive or experience racial discrimination during work integrated learning?

SQ.2. How do professional Emergency Medical Care providers (latent mentors) perceive and experience racial discrimination in the emergency medical service?

SQ.3. How can critical ethnography give voice and reflexivity to victims of racial

discrimination experiences during work integrated learning in clinical practice during the BEMC degree at a SA university?

Recruitment of new participants stopped when the data reached saturation. Semi-structured interviews held with participants lasted between 20–65 minutes and were digitally recorded and transcribed into a Microsoft Word document. Narrative analysis was used and from this analysis three main themes emerged.

The distinctive factors of South African history that contribute to the current problems include racial, gender and language discrimination. These are challenges deeply rooted within society and also embedded in the EMS industry, starting from when participants are EMC students until they are qualified and working within the EMS. This behaviour has had a negative impact on EMC student's experiential learning. Students' perceptions on work-integrated learning is viewed as hostile and counter-productive. How much EMC students learn during this time is determined by the EC provider they are working with on that shift, as well as by the student's behaviour and the interaction between both in relation to a patient-care scenario.

The opportunity to learn was subconsciously influenced by race, gender and spoken language, but it can also be determined by the nature of the call they were dispatched to, the capacity and nurturing nature of the mentor they are working with, the learning capabilities and capacity of the student, the trustworthiness of the relationship between the mentor and the student, as well as the student's confidence in clinically engaging with the patient and taking the opportunity to learn.

Female EMC students are often denied the opportunity to learn because they appear to be more vulnerable and susceptible to sexual harassment and violence. Unfortunately, even as EC providers they continue to be at risk for sexually harassment. Incidence of sexual harassment and gender discrimination were also portrayed by patients during clinical practice with no respite from such risk of harm.

Adequate patient care relies on effective communication between the practitioner and the patient, but during work-integrated learning there also has to be effective communication between the student and the mentor. Language should not affect the transfer of knowledge from qualified EC provider to EMC student during work-integrated learning. Racial discrimination currently experienced by students and EC providers appears to be subtle and covert. In this form racist behaviours go unnoticed with no direct recourse. Hence victims and perpetrators of racism continue as if everything is normal.

The EMC students experienced consistent racism during their work-integrated learning from their first year of study to fourth year. The EC providers also indicated that racism occurred within their work environment more frequently but was rarely reported. This is better understood as everyday racism, as mentioned by Essed in Chapter 2. Not only is racism a process that sustains unequal power relationships but it also creates a set of outcomes wherein the injustice resides and festers. It is through this notion that one can understand why we cannot easily differentiate between racism and everyday racism (Clair & Denis 2015).

6.3. Recommendations

Themes are derived to substantiate the existence of racial discrimination as well as discrimination on the basis of gender and language. The data collected from participants correlate with the existing literature (Chetty 2014; London and Baldwin-Ragaven 2008; London & Perez 2004; Harrel 2000; Modiri 2012).The following recommendations are made to improve the student's work-integrated learning experience during clinical practice, but also for EC providers to find an elevated discourse on the practice of discrimination in the work environment.

6.3.1. Opportunity for students to address discriminatory practices

Discrimination is a sensitive topic that the majority of people would avoid talking about or formally raise within an organisation. It is for this reason that the university should create an environment whereby students are able to share their discriminatory experiences without fear of being victimised or misquoted, and this can be done in various forms. Addressing discriminatory practice requires a well-structured approach to disrupt if not totally eradicate discrimination.

As students are in need of a discrimination-free environment, it is recommended that the university should adopt a strategy designed by the Anti-Harassment Interdepartmental Team (2018) that is built with the aim of addressing and preventing workplace harassment and discrimination. The following aspects should be included; commitment and accountability, transparency, policy, reporting, training and development, continuation of work on anti-discrimination and anti-harrassment; areas for further review. These are further described as follows:

- **Commitment and accountability.** The Department of Emergency Medical Sciences needs to demonstrate a greater commitment to improving work-integrated learning environment for students and accountability measures to transform it into one that promotes a safe environment free of discrimination.
- **Transparency.** There should be a trustworthy relationship between students, faculty members and stakeholders to build an effective and transparent discrimination and harassment prevention programme.
- **Policy.** The Faculty of Health and Wellness, in partnership with stakeholders as well students (consulted for their input) should develop policies that will be applicable to guide all EMC students and mentors. Policies should enforce freedom from sexual harassment and racial discrimination in the clinical practice environment; these policies should be readily available and accessible at the university and all base stations involved in clinical attachment.
- **Reporting.** A reporting structure should be created to allow for investigation processes to be initiated. In addition, a student-centred reporting structure should be provided to protect them from victimization. This should be seen as a structure that will build and maintain trust between Faculty members, students and stakeholders. Clinical practice documentation should also have room for students to assess their mentor, thus providing the Faculty members with contextual evidence of how they were treated by the mentor.

- **Training and Development.** Both students and mentors should be trained on addressing and preventing discrimination during work-integrated learning.
- **Continuation of Work on Anti-Discrimination and Anti-Harassment**

For the promotion of an effective and lasting system, further work should be done to improve the way discrimination issues are dealt with by the Faculty.

- **Areas for Further Review and Consideration**

The university and stakeholders need to review all policies and agreements and open them up for consideration by the students and mentors.

Having a well-structured strategy and approach, as suggested above, to address discriminatory practices may well encourage students collectively to report incidences of discrimination.

6.3.2. A productive and conducive work-integrated learning environment

An environment that provides students with sustainable opportunities to practise theoretical knowledge acquired in class and on a patient during work-integrated learning will require partnership with stakeholders.[45] Since the Department of Emergency Medical Sciences works closely with all stakeholders' in the provision of facilities for clinical attachment, a memorandum of agreement (MoA) is recommended that will outline all predetermined learning objectives and expectations from all parties involved.

To ensure easy implementation of such an agreement, the MoA should not be made at a provincial level but at a station level so that all involved understand what is expected of them. Close monitoring of the agreement would make it possible for any amendments to be made, if necessary and without delay. The MoA should be discussed, reviewed and updated annually since it is critical that feedback from both EMC students and EC providers contributes to this revised

[45] Stakeholders are different EMS base stations where EMC students are placed for their clinical attachments.

agreement as they are core players who are set to implement and benefit from the document.

Work-integrated learning experience should be outlined with clear goals, and learning outcomes should be measurable and this document should be made available to EC provider currently engaged with work-integrated learning (it is already available to students in the form of a clinical practice learner guide). Owing to the nature of pre-hospital settings often it might not be possible to measure the set learning outcomes because it is an uncontrolled environment; however, the overall working environment and sharing of knowledge between the student and the mentor should not be influenced by discrimination or bias. The focal point should remain education and the desire to create an environment where learning can take place.

The institution should create feasible opportunities for students to reflect on their experiences, on what they are learning and how they are learning. This can be done through a journal writing system whereby the student will be able to document their experience during the shift. This would enable faculty members and clinical coordinators to review such journals and discuss issues with stakeholders. In addition, this would allow stakeholders an opportunity to learn about student's experiences and perceptions about work-integrated learning during their clinical attachment.

Such a reflection will trigger appropriate discussions which are solution-driven to improve the student's clinical practice experience. As some programmes such as the Field Internship Student Data Acquisition Project (FISDAP) are already in place in some institutions, the sharing of findings (reflections and journal) captured on these programmes should be further encouraged to address student challenges during work-integrated learning. It is therefore recommended that amendments to the memorandum of agreement (MOA) with the clinical platform must continually take place.

Any amendments done should be added to the MOA during the scheduled review with all stakeholders (all EMS base station involved in student's clinical

placement). It is significant to do this at an EMS base station level because the challenges differ from one station to the next. For example, if during the review of journal at one specific station, a crew has been repeatedly reported to be racist; it does not mean that all stations or all crew members are racist. Consequently, the faculty members and representative from the base station would be able to narrow down the problem and come up with the most appropriate solution for redress.

This adds a sense of discipline and responsibility from the student while the EC provider's primary job remains that of providing care to the patient and secondly to mentor a student. An acceptable level of respect for the EC providers' primary job will promote a good working relationship between the two, and enable the EC provider to identify a teaching moment during clinical practice and afford the opportunity to the student.

6.3.3. Identifying and training clinical mentors at CPUT

Since EMC students work under the supervision of EC providers as mentors, clinical mentors assume an active role through closely working with EMC students by providing them with the necessary support, training and guidance. Not all EC providers working with students understand the concept of teaching or transferring knowledge to students during clinical practice. The clinical mentor's role and responsibility is poorly defined; it is mainly limited to what the level of study the student is and which skills they should perform during their attachment. This is a grey area of responsibility for both the student and mentor in terms of trying to navigate some sort of balance that would eventually satisfy both of them.

As described by Ragins and Kram (2007), not all EC providers should be labelled as mentors; some could be viewed as unofficial mentors by their engagement in a short mentoring episode. The researchers further define a mentor as a person that engages with the mentored person as a partner through reciprocal activities such as planning, questioning, problem-solving and reflecting. Such an individual's mentor plays a very important role in the undergraduates' path of advancing their career.

Since the majority of EC providers are never trained on how to conduct themselves as clinical mentors or trained in mentorship guidance, there is room for student mistreatment and discrimination. The CPUT should take a more active role in identifying and training clinical mentors to be responsible for supervising students during their clinical attachment. Such training should not only focus on a set of skills that students need to complete per level of training but, since both are vulnerable, should also bring an awareness of different forms of discrimination that can be experienced by both the student and the mentors.

Since a large number of practitioners might need to be trained, training could be twofold: Firstly, via video-based training accessible by phone for all potential clinical mentors working with students; and secondly, followed by a more detailed training for shift leaders, base managers and station managers so that they can also be in a position to assist and understand in detail for what is expected from colleagues as mentors and from students.

6.3.4. The promotion of anti-discriminatory training by HPCSA

As the body responsible for regulating and monitoring EC providers' clinical practice and quality assurance for the Higher Education Institution offering EMC programmes, the HPCSA should introduce and implement an anti-discrimination training programme specifically for EC providers and EMC students registered with the Council. Such training should be part of the EMC curriculum and available to qualified EC providers as part of a Continuous Professional Development course. Currently, there is lack of attention to human rights and ant-discrimination training within the EMS which are important issues to discuss in increasingly racially integrated communities. Failure to do so is presently impacting student experience during work-integrated learning as described in this study but more importantly this has the potential to further harm clinical practice as experienced by the author.

There are also some departments within government that have identified the need for constructive training and awareness in discrimination. The Department of Justice and Constitutional Development has outlined The National Action Plan to

Combat Racism, Racial Discrimination, Xenophobia and Related Intolerance (South Africa 2019) to combat unfair discrimination and inequality in South Africa. Given this country's history human rights should be practised as an enabling framework, and that framework could well be introduced by the HPCSA for implementation by EC providers and EMC students but it should remain the HPCSA's responsibility to oversee the implementation.

6.4. Recommendations for Further Study

This study forms a foundation to conduct wider studies that raise and examine broader issues in relation to discriminatory practices within the EMS. A combination of quantitative and qualitative methods in this topic is recommended. Such further studies should advance disciplinary actions that could arise from experiences that may have contributed to discriminatory practices in the EMS.

Future research is also recommended during work-integrated learning to identify best practices for engaging mentors and patients to formally dismantle discrimination in clinical practice. These practices can then be shared, learned and implemented to promote an inclusive and conducive experiential learning for EMC students.

Both EMC students and EC providers indicate discriminatory practices between students; between EC providers; EC providers and students; between EC provider and patients and between students and patient. What is not known is if patients feel discriminated by paramedics or EC providers on the basis of race, gender and language within the pre-hospital setting. Therefore, further research is recommended to uncover the experience from the patient's perspective. The study of race issues within the EMS in an attempt to transform the pre-hospital patient care and student experiential learning in South Africa will remain a vital contribution to the health care sector.

6.5. Conclusion

This study provides tentative evidence to support the existence of discriminatory practices during clinical practice in work-integrated learning as experienced by students and EC providers. The impact of racial discrimination is explored (as experienced by students as victims or perpetrators and EC providers as victims or perpetrators) through Critical Race Theory. Racism experienced by participants is described as covert racism (rather than overt) which makes it difficult to address currently within the working environment.

Gender and language are also reported as barriers that affected student's learning opportunities and were reported to discriminate against EMC students during work-integrated learning thereby impacting on the student's clinical practice and exposure. Collectively these experiences had an impact on the viability of students being able to extract knowledge from the mentor or the mentor creating an educative environment for the student. It may be true to say that the current *modus operandi* of some mentors represents 'tormentor-ship' rather than mentorship.

In retrospect, the research exposes great potential for work-integrated learning to be improved for the students to gain knowledge and clinical competency. The student-mentor role needs to be better defined with expectations clearly outlined for both parties. The EMC students need to be equipped with the appropriate structures within the University system that will enable redress for racial, gender and language discrimination.

The cognitive dissonance that is created by unfair discrimination by health care practitioners is currently not objective and fair. The purpose of this study, however, is to scholarly and practically address this dissonance to advance the professional interests of the EMS profession. Therefore, a comprehensive mentorship programme should be created; to consider objective and subjective criteria for mentors and student selection, to achieve expectations validated by educational theory and formal assessment, and to perform and effectively

measure the mentoring relationship/programme. These deliberate measures are necessary to respond to the counterproductive experience of discriminatory social practice during clinical practice. Dissidents of the structurally embedded practice of unfair discrimination should ask the question: If clinical practice does not intend such discriminatory social practice, then why does it occur?

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ANNEXURE A: REQUEST TO PARTICIPATE IN A RESEARCH STUDY

Dear Sir or Madam

I, *Tshepo Nelson Maake*, the undersigned am a Masters of Emergency Medical Care scholar from Cape Peninsula University of Technology currently conducting research project in partial fulfilment Masters of Emergency Medical Care postgraduate degree.

The title of my study is ***"A critical ethnographic study of discriminatory social practice during clinical practice in emergency medical care".***

I feel by virtue of your experience that you may be a valuable source of information for this study. Upon agreement of participating in this study you will be required to take part in a one on one, face to face confidential interview with the researcher at a time and date convenient for you. The interview will be recorded using a recording device, and the only people who will have access to this data will be the researcher, the researcher's supervisor and the co-supervisor as the data will be password protected. The researcher will record and transcribe the interview himself. Your identity will remain anonymous as no names will be recorded during this study.

Participating in this study is total voluntary and should you wish to withdraw from the study at any given point, you should feel free to do so and be assured that there won't be any consequences for this. Should you be interested, a copy of the final research report can be made available to you. After participating in the study there will not be any form of direct benefit or cost due to you.

Possible risk of participating in the study:

- Participant might have to relive past discriminatory experience.
- Emotional outburst during the interview e.g. crying
- Feeling of anger during and after the interview
- Frustrated by the main question and follow up questions that the researcher will be asking the participant

Candidates who are interested in participating in this are required to sign the consent form. If you have any questions regarding the study, feel free to contact me or my supervisors on the following contact details:

Supervisors : Dr Navindhra Naidoo (B Tech EMC, HD Ed, MPH, PhD)
Tell Number : 021 959 6534
E-mail address: naidoon@cput.ac.za

Co-Supervisor : Dr B.T. Millar (B.A., Hons., M.A., M.A., PhD)
Tell Number : 021 976 5176
E-mail address: MillarB@cput.ac.za

Author : Mr. Tshepo Maake (NDip EMC, BTech EMC)
Cell Number : 082 956-4343
E-mail address: tnmaake@yahoo.com

Yours faithfully,

ANNEXURE B: CONSENT TO PARTICIPATE

I ……..,hereby confirm that I have
Full Name and Surname
understood the information written and explained to me with regard to the research project entitled, ***"A critical ethnographic study of discriminatory social practice during clinical practice in emergency medical care".*** I understand that my participation in the interview process is voluntary and that I am free to withdraw at any point without any consequences.

Signed at (place) ……..... on (date) ……..…… 201....

…… ……..

Signature of participant

ANNEXURE C: INTERVIEW GUIDE

Time of interview : _____

Date : _____

Place : _____

Interviewer : _____

Interviewee : _____

Welcome and introduction	-	2 minutes
Opening question and discussion	-	15-45 minutes (unlimited if necessary)
Interview Question for students	-	**"share your discriminatory experiences or perceptions during work-integrated learning/clinical practice as an Emergency Medical Care student?"**
Interview question for EC providers	-	**"share your discriminatory experience or perceptions during clinical practice as an Emergency Care provider?**,
Closure	-	2 minutes

Notes (Hand written during the interview)

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Follow up **prompts** that may be used "whenever necessary":

- "Why do you think this is the case?"
- "What causes this?"
- How did you deal with it?
- "Why do you think this is the case?"
- "Can you perhaps elaborate more on that"

ANNEXURE D: LETTER TO THE HOD OF DEPARTMENT OF EMC

5025 Embelia close
Kosmosdal
Centurion
0157

Department of Emergency Medical Care
Symphony Way (off Modderdam Road)
PO Box 1906
Bellville
7535

Dear Mr Christopher

My name is Tshepo Nelson Maake and I am a registered Masters of Emergency Medical Care student at the Cape Peninsula University of Technology for the academic year of 2016. As part of my MTech EMC research project, I would like to invite CPUT EMC fourth year BEMC and BTech EMC students to participate in an interview sharing their racial discriminatory experiences or perception during work-integrated learning/ clinical placement as Emergency Medical Care students. Please find here in attached Information form concerning my research study.

I would greatly appreciate you granting me permission to use one of the classroom in within the Department of Emergency Medical Sciences for interviews and also to utilize the fourth year BEMC and BTech EMC students in my study should ethical clearance be granted. Please indicate your consent by signing the consent form attached below. Your assistance with this matter is greatly appreciated.

Yours sincerely

Mr Tshepo Nelson Maake
Emergency Care Practitioner

ANNEXURE E: CONSENT FORM FOR HOD OF DEPARTMENT OF EMC

I,_____(Name of HOD) hereby grant permission, to _____(Name of person requesting permission) to use fourth year BEMC and BTech EMC students for the purpose of my Masters of Emergency Medical Care study

Signed : _____ (*Signature of HOD*)

Name : _____

(Please Print)

Date : _____(*dd/mm/yyyy*)

Other persons to contact for consent:

Name : _____

Position : _____

Telephone NO : _____

Email address : _____

ANNEXURE F: LETTER TO THE WESTERN CAPE DEPARTMENT OF HEALTH

Dear Sir or Madam

NB: Site Permission and permission to utilise Metro's Emergency Care Provider as participants

I, *Tshepo Nelson Maake*, the undersigned am a Masters of Emergency Medical Care scholar from Cape Peninsula University of Technology currently conducting research project in partial fulfilment Masters of Emergency Medical Care postgraduate degree.

The title of my study is ***"A critical ethnographic study of discriminatory social practice during clinical practice in emergency medical care".***

With informed judgment and operational experience within the Western Cape EMS, the Metro EMS is an organization which has Emergency Care Providers with optimal exposure to various clinical incident and also have a unique opportunity of working with students as mentors during their work integrated learning. I feel by virtue of their (EC Providers) experience that they will be a valuable source of information for this study.

Upon their agreement of participating in this study they will be required to take part in a one on one, face to face confidential interview with the researcher at a time and date convenient for them. The interview will be recorded using a recording device, and the only people who will have access to this data will be the researcher, the researcher's supervisor and the co-supervisor as the data will be password protected. The researcher will record and transcribe the interview himself. Their identity will remain anonymous as no names will be recorded during this study.

Participating in this study is total voluntary and should they wish to withdraw from the study at any given point, they should feel free to do so and be assured that there won't be any consequences for this. Should they be interested, a copy of the

final research report can be made available to them or the department. After participating in the study there will not be any form of direct benefit or cost due to them.

Possible risk of participating in the study:

- Participant might have to re-live past discriminatory experience.
- Emotional outburst during the interview e.g. crying
- Feeling of anger during or after the interview.
- Frustrated by the main question or follow up questions that the researcher will be asking the participant.

Candidates who are interested in participating in this are required to sign the consent form. If they have any questions regarding the study, the department or participant should feel free to contact me or my supervisors on the following contact details:

Supervisors : Dr Navindhra Naidoo (B Tech EMC, HD Ed, MPH, PhD)
Tell Number : 021 959 6534
E-mail address: naidoon@cput.ac.za

Co-Supervisor : Dr B.T. Millar (B.A., Hons., M.A., M.A., PhD)
Tell Number : 021 976 5176
E-mail address: MillarB@cput.ac.za

Author : Mr. Tshepo Maake (NDip EMC, BTech EMC)
Cell Number : 082 956-4343
E-mail address: tnmaake@yahoo.com

Yours faithfully,

ANNEXURE G: SITE APPROVAL FROM WESTERN CAPE DEPARTMENT OF HEALTH

DIRECTORATE: **EMERGENCY MEDICAL SERVICES**
ENQUIRIES: **Dr Shaheem de Vries**
• shaheem.devries@pgwc.gov.za
☏: +27 21 932 1966

Attention: Mr Tshepo Maake

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH – 'ACRITICAL ETHNOGRAPHIC STUDY OF DISCRIMINATORY SOCIAL PRACTICE DURING CLINICAL PRACTICE IN EMERGENCY CARE

Dear Mr Maake,

Your request on the above matter refers.

Thank you for the request to conduct research within the Western Cape Government Emergency Medical Service. Following the amendments as recommended by the DRC, I am satisfied as to both the relevance, suitability and impact of your chosen field of research.

I am therefore pleased to inform you that such approval is hereby granted.

I wish you well in your endeavor and trust that you will keep this office and its department informed of your findings when these become available. I am so looking forward to the insights that your research will afford us.

Yours sincerely

Dr Shaheem de Vries
Head: Emergency Medical Services
Western Cape Government Health

Date: 11th September 2017

ANNEXURE H: CPUT HWS - RESEARCH ETHICS COMMITTEE ETHICS CLEARANCE

Cape Peninsula University of Technology

HEALTH AND WELLNESS SCIENCES RESEARCH ETHICS COMMITTEE (HWS-REC)
Registration Number NHREC: REC- 230408-014

P.O. Box 1906 • Bellville 7535 South Africa
Symphony Road Bellville 7535
Tel: +27 21 959 6917
Email: simonsy@cput.ac.za

03 April 2020
REC Approval Reference No:
CPUT/HW-REC 2016/H28 (renewal)

Faculty of Health and Wellness Sciences – Emergency Medical Sciences

Dear Mr Tshepo Nelson Maake,

Re: APPLICATION TO THE HW-REC FOR ETHICS CLEARANCE

Approval was granted by the Health and Wellness Sciences-REC to Mr Maake for ethical clearance on 15 September 2016. This approval is for research activities related to student research at the Cape Peninsula University of Technology within the Department of Emergency Medical Sciences.

Title: A critical ethnographic study of racial discriminatory social practice during clinical practice in emergency medical care

Supervisor: Dr N Naidoo
Co-supervisor: Dr BT Millar

Comment:

Approval will not extend beyond 29 January 2021. An extension should be applied for 6 weeks before this expiry date should data collection and use/analysis of data, information and/or samples for this study continue beyond this date.

The investigator(s) should understand the ethical conditions under which they are authorized to carry out this study and they should be compliant to these conditions. It is required that the investigator(s) complete an **annual progress report** that should be submitted to the HWS-REC in December of that particular year, for the HWS-REC to be kept informed of the progress and of any problems you may have encountered.

Kind Regards,

M. le Roes-Hill

Dr Marilize Le Roes-Hill
Deputy Chairperson – Research Ethics Committee
Faculty of Health and Wellness Sciences