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B L A C K D O C T O R S

An Investigation into Aspects of the
Training and Career of Students and
Graduates from the Medical School of
the University of Natal.

PART I: THE STUDENT

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GENERAL INTRODUCTION.

Concern for, and interest in, the education of medical practitioners, their subsequent careers, and the problems and difficulties which they face in practice, has been growing steadily. This is particularly so during the last decade and more, as a quick perusal of the bibliography at the end of this report will reveal. Social scientists, particularly sociologists, have played a part in the increasing volume of research. In addition to a host of scientific papers, several large-scale studies have been made. Robert Merton, Reader and Kendall edited a study on *The Student Physician* published in 1957. The best work of its kind was published in 1961 by Howard Becker in collaboration with Hughes, Geer and Strauss. Like the book by Merton et al., this was also a study undertaken in the United States, and is entitled *Boys in White: Student Culture in Medical School*. Knight (1973) produced a book *Medical Student: Doctor in the Making*. Studies, too, of the patients with whom the doctors and nurses work, as well as of the institutions (hospitals) involved, have increasingly thrown light on some of the social situations and settings within which medical practice is carried out. For example, there have been studies such as Erving Goffman's study *Asylums: Essays on the Social Structure of Mental Patients and other Institutions*, (1961) and Sudnow who studied the treatment of death within a hospital in *Passing On: The Social Organization of Dying* (1967). Medical Schools have begun to introduce medical sociology into their syllabus, and to appoint sociologists to their staff. For instance, Glaser, (1965) the author of *The Awareness of Dying*, is or was an associate research sociologist at the University of California Medical Centre, whilst Strauss (a co-author of *Boys in White*) was, and may still be, Professor of Sociology at the same establishment.

This spirit of self-consciousness and scrutiny by medical schools and teachers of medicine has sometimes even led to large-scale studies on an official basis. In the United Kingdom, the *Royal Commission on Medical Education* sat from 1965 to 1968, while in the United States a commission sponsored by the Carnegie Corporation likewise involved itself in questions about medical training and practice.

Questions such as the following have been asked and are being asked, in Europe and America: What type of graduates are the medical schools turning out? How far are the graduates prepared for the problems that they will face in practice? To what extent do the types of doctors produced by universities meet the medical needs of the community? Examined

dispassionately, how do the medical students react and interact during their training? What do they think about their training? Who are the medical students? Similarly, who teaches them, and what do the staff think and feel about the students? Looking back in retrospect, what are the views of graduates on their training? These and similar questions have increasingly been in the minds of those responsible for the education of doctors. Not only in Europe and America, but also in South Africa medical schools are being influenced by the climate of questioning and research into medical education.

In the Republic of South Africa, the University of Natal offers for Black students ¹⁾ a six-year course leading to the degrees of M.B., Ch.B. (Bachelor of Medicine and Bachelor of Surgery), which together with a one-year post-graduate internship at a recognised hospital leads to the general qualification for registered medical practitioners. A Matriculation Certificate, or its equivalent, is needed for admission to the Medical School. As with all Medical Schools in South Africa, intake is limited, and only the best candidates stand a chance of being admitted.

It was in 1947 that the government of the then Union of South Africa approved the establishment by the University of a medical school for Black students. This was a time when the University was allowed to have relatively large numbers of Black students in the various faculties. The first students, totalling 35 in number, were admitted in 1951. By 1974 there were 593 students in the Faculty of Medicine. The Medical School uses King Edward VIII Hospital for teaching purposes. This is a very large hospital for Black patients, with never less than 5,000 patients, staff and visitors a day (to quote one estimate).

A history of the early years of the Medical School has been published by Gordon (1960) in the *South African Medical Journal*. This medical school is the only one at present catering solely for Black medical students, although small numbers of Black students (mainly Indian and Coloured) are given permits from time to time to study at the (White) medical schools at the University of Cape Town and the University of the Witwatersrand. The

1) i.e. African, Indian (Asian) and Coloured (African or Indian and White hybrid) students.

government will not allow White medical students to study at the University of Natal, even though in faculties other than medicine it is a 'White' university.

The Medical School of the University of Natal has not been insulated from the currents of questioning and investigation which have been outlined above. So it is, that in the latter part of the 1960's, the Institute for Social Research at the University of Natal was approached by the authorities of the Medical School with a view to the possibility of undertaking a multi-faceted evaluative study of the Medical School and its products. The proposed study was to be sociological, and was intended primarily for the guidance of the Medical School. It was decided to investigate the students, staff, and graduates of the school. In addition, the research was also to provide some indication of the attitudes and beliefs towards ill-health and modern medicine of urban African and Indian populations - that is the populations to whom the graduates would minister.

Probably the most effective approach to a study of medical students and medical practitioners would be in terms of participant observation. This means sharing with the subjects their daily life, and observing what they do and say. Becker and his colleagues used this approach to great effect in *Boys in White* (1961). After lengthy discussions it was decided that it would not be practical to use this approach for the present study. Structural constraints inherent in present-day South African society prevent Whites from effectively undertaking participant observation of Black medical students, while finance and problems of a sufficient number of suitable Black research workers made participant observation by Black social scientists unfeasible. As far as the graduates themselves are concerned, they are so scattered geographically over Southern Africa and beyond that any participant observation of a representative sample was impossible. Hence, the basic research approach adopted was that of the survey technique. Details of the research methods used for different parts of the study are provided at appropriate points in the text.

After formulation, sponsors for the research were sought. The South African Human Sciences Research Council agreed to finance the project with a larger grant spread over three years. Fieldwork commenced in 1969, and was finished in 1972.

The report on the research is being issued in several parts. It is hoped after the last one to prepare and issue a co-ordinated integrated report. The reports are intended primarily for the benefit of the Medical School at the University of Natal. Nonetheless, the findings should be of interest to a wider audience. Obviously some of the results are culture-bound, specific to the local South African scene, but others are likely to be broadly relevant for medical education and for social scientists.

PART I:MEDICAL STUDENTS AT THE MEDICAL SCHOOL OF THE
UNIVERSITY OF NATAL1. *Introduction.*

The present report is the first one in a series dealing with the various aspects of the research undertaken into the Medical School at the University of Natal - students, staff, and graduates - as well as the populations to whom these graduates minister.

Between August and October 1969, staff from the Institute for Social Research undertook interviewing of a sample of medical students at the University of Natal. This followed exploratory focussed group interviews with students, as well as a pilot study. A non-proportionally stratified sample was drawn from the 1969 class lists of the Medical School; Appendix A provides details. A random sample of 101 respondents was obtained, of whom 16 were preliminary year students,¹⁾ 21 were first years, 23 second years, 13 third years, 11 fourth years, 9 fifth years, and 8 sixth year students. The 101 respondents represented a universe of 413 students, and details of sampling fractions and the weighting procedure adopted for tabulation are given in Appendix A. This part of the report describes the sample results without using significance tests. Appendix B provides details of the interview schedule which was applied by trained interviewers to the sample cases.

1) Preliminary students were those who have not, in the opinion of the Medical School, obtained sufficiently high marks in mathematics, the sciences and English in a Matriculation Examination, to allow them to proceed directly to first year. Experience at the Medical School has been that the students coming from school, (particularly African students), in many cases did not have a sufficiently high level of education to be able to cope adequately with first year medical studies. Therefore this preliminary year was introduced to meet the needs of the majority of students who need some form of bridge between school and university. This means many students have seven years of medical school education. The hopes of the Medical School are that rising standards of Black school education will allow the preliminary year to be dropped, and moves are afoot to this end.

2. *Characteristics and Background of the Students interviewed:*

The average age of the medical students in our sample was $22\frac{1}{2}$ years, with a tendency for the African students to be some 3 years older than the Indian or Coloured students. Over four-fifths were male, with most of the female students being Indian rather than African or Coloured. Two-fifths of the students were oppidani living at home with parents or relatives. Race was a major factor here, with two-thirds of the Indians being oppidanis. Almost three-tenths of the Coloureds were oppidanis, against only nine per cent of the African students.

The main home language of the Indian students was English (51 per cent) or Gujerati (27 per cent). Bearing in mind the language distribution of Indians in South Africa, this quite clearly shows a definite economic selection from the wealthier Indians. Working-class Indians such as Tamil, Telegu and Urdu-speaking, are notably absent from the ranks of the Indian medical students, despite the fact that they form a large proportion of the Indian population of the country. The African students had one-third speaking Zulu, and this reflects the tendency of the Medical School to draw more heavily from Natal in which it is situated. Another third spoke either Tswana, Tongo, or Pedi (which are related languages).

The majority of students are from cities. In total, one-third of the students were from Durban, 14 per cent from Johannesburg, 9 per cent from Pietermaritzburg and 6 per cent from Pretoria. Thus almost two-thirds were from these four cities. The Africans came mainly from Johannesburg or Pretoria, and the Indians very largely from Durban and Pietermaritzburg. The Coloureds tended to come from three main cities - Johannesburg, Durban and Cape Town. Very few of the students were from rural areas in terms of their home background. A fifth of the Africans, and one-tenth of the Indians and Coloureds came from rural areas. In terms of provinces, the students cover all the provinces except the Free State, but as one would expect it is mainly the Provinces of Natal and Transvaal which supply the majority (almost nine-tenths) of students.

As far as religious affiliation is concerned, amongst Africans most of the students had parents who belonged to a recognised 'White' Christian denomination. Two-thirds were from major Protestant denominations, one-eighth from the Roman Catholic Church, and one-tenth from minor Western sects. Only 8 per cent of the students had parents belonging to Bantu separatist churches, 3 per cent stated they had parents whose religion was the traditional ancestor worship, and 2 per cent had parents who were stated to be agnostic or atheistic. Thus it would seem that in so far as religious

affiliation is an indication of westernisation and modernisation, most of the parents of the African students were westernised, with only an insignificant proportion being traditional in their religious affiliation.

Amongst the Indians, where there is a strong religious tradition which has had very little inroad made by Christianity, 72 per cent of the Indian students had parents who were Hindu, and 19 per cent Muslim. Only 6 per cent were Christians, and the remaining small proportion were agnostics.

The Coloureds are too small a number of students to analyse on this point.

The religious affiliations of the students themselves correlated highly with those of their parents, and this is a typical pattern. The Phi-Coefficient was 0.74 between parental and student religion.

The occupational background of the fathers of the students was investigated. Whereas the bulk of the Indian and African population in South Africa are manual workers, the students to a large extent came from either white-collar homes or homes where there was a skilled manual or a supervisory manual background. Economic factors alone would militate against students coming from semi-skilled or unskilled backgrounds, and this is what our findings show. Only 11 per cent of the African students and 8 per cent of the Indian students came from homes where the father was semi-skilled or unskilled.

Relative to the educational level of the general population of Africans and Indians, the fathers of students at the Medical School were fairly well educated. The mean educational level of the fathers of African students was Standard 7, of Indian students Standard 6, and of Coloured students Standard 8. The educational level of the mothers was a little lower than this.

In terms of the family sizes from which the students came, they tended to come from families with an average of $5\frac{1}{2}$ children. There was a wide spread from being the eldest down to being the youngest child in the family. However, it is interesting to note that almost three-fifths of the African students had been either the eldest or an elder child, in contrast to only a third of the Indians. Conversely, only a quarter of the Africans had been the youngest or one of the younger children of the family, as against the best part of half of the Indian students. There seems to be a selective factor operating here which varies with the race of the student. However, this does not seem of particular importance. The

siblings of students tended to be largely white-collar workers, again showing that the students are not drawn from a complete cross-section of the African or Indian population.

Looking at the academic record of the students we had selected to represent a cross-section of the Medical School and interviewed, seven-tenths had not repeated any year. Of the remainder, one-quarter had repeated one year, and 5 per cent had repeated two years. Less than half a per cent had repeated three of the years of study. There was no significant difference in the distribution of African and Indian students according to repeating. A scrutiny of the subjects that they repeated showed second year was the year where most students tended to come down. This accords with the view of students, to be discussed later, that second year was the most difficult year at the Medical School. Of those interviewed, the greatest single proportion had failed Physiology - one-quarter of the students. It should be noted that Physiology is a second-year subject. Fifteen per cent had failed all their second-year subjects, while a further 11 per cent had failed both Anatomy and Physiology. This meant half of the students surveyed had failed one or more second-year subjects. Other subjects were failed by less than one-tenth of the students interviewed.

These results are not overall failure rates as they omit students excluded from the Medical School, or those who voluntarily left. Even allowing for sampling errors, the figures for failure of second-year subjects are serious enough to warrant attention by the Board of the Faculty of Medicine. This matter will be gone into later in this part of the report when student records are analysed in Section 16.

3. *The Choice of Medicine as a Career.*

Table I below gives the percentage distribution of reasons supplied by the sample of 101 students for choosing medicine as a career. It should be noted that the table represents the percentage of *students* giving *each* reason. There is a moderate association between race and type of reason mentioned. (ϕ corrected = 0.38)¹).

1)

$$\phi \text{ corrected} = \frac{\chi^2}{\sqrt{N \text{ Min } (r-1, c-1)}}$$

This is derived from Cramer's V. See Blalock (1972, 297).

Table 1.

*Reasons given by a Sample of 101 Students for Selecting Medicine as a Career,
University of Natal Medical School, 1968:*

Reasons Given for Selecting Medicine as a Career	Percentage of Cases			
	African students	Indian students	Coloured students	All Students in sample
I always wished to become a Doctor	22	47	21	35
Medicine offers the opportunity of service to humanity/my people	22	32	40	29
For people of my race there are limited opportunities available for alternative careers	10	8	17	9
Medicine offers me financial security	28	11	29	19
A career in medicine provides prestige and status	14	3	10	7
I was inspired by a doctor's example	2	3	-	2
Bursaries and loans are available for medical training	3	-	-	1
The country needs more doctors	18	3	-	8
It was my parents' wish that I take up medicine	-	12	7	7
Other varied reasons not mentioned frequently	7	9	17	9
NUMBER OF SAMPLE CASES RESPONDING	54	36	11	101

NOTE: The figures in the columns are not mutually exclusive, and therefore are not additive, as on occasions students mentioned more than one reason. The figures are the per cent of students giving a particular reason.

Those students mentioning the financial security afforded by medicine as a reason for choosing medicine as a career amounted to 28 per cent of the Africans, 11 per cent of the Indians and 29 per cent of the Coloureds. Conversely, 22 per cent of the Africans, 32 per cent of the Indians, and 40 per cent of the Coloureds mentioned the opportunity for service afforded by medicine. This altruistic element also emerged in response to other interview questions, and will be reported further on below.

The students were asked whether they had considered taking up any other job than practising medicine. From the sample it is estimated that 37% of the Africans, 52% of the Indians and 38% of the Coloureds, or 45% of all students, had never considered a career other than medicine. This shows that an important percentage of students were completely single-minded in their approach to medicine ¹⁾ (whatever their reasons for choosing it). The higher proportion amongst Indians is possibly a reflection of their higher financial status on average, which makes their chance of training in medicine more realistic. The most frequently mentioned occupation seen as an alternative to medicine was teaching. Nineteen per cent of the Africans, 18% of the Indians and 17% of the Coloureds referred to it. Apart from being an occupation widely available to Blacks, teaching involves 'working with people', as does medicine. This suggests that at least quite a number of those who took medicine as a career, were motivated towards working with people. Findings to be presented shortly in fact show this.

Counting only jobs mentioned by 5 per cent or more of the students, apart from teaching, alternative occupations students had considered varied with the race of students. Amongst Africans, in second place was law (mentioned by 11%), then civil engineering (7%) and pharmacy (5%). Amongst Indian students, in second place was civil engineering (reported by 17%), and pure science (5%). Finally with Coloureds, pharmacy tied with teaching, mentioned by 17% of the students, and law followed, reported by 10%. Students were interviewed about what they liked best of all about the prospect of becoming a medical practitioner. Mentioned most frequently was 'being able to

1) The Student Adviser at the University of Natal has verbally reported to the author that this single-mindedness is in his experience typical of White medical students.

help others', with a second similar reason of 'being able to deal with patients'. Taken together, 71% of the students gave one or other of these aspects as being best liked about a future medical career. Further details are given in Table 2 below:

Table 2

Aspects of a Future Career in Medicine which appealed to Medical Students, 1969.

ASPECT LIKED	PERCENTAGE MENTIONING THE ASPECT AS		
	BEST LIKED	SECOND BEST LIKED.	THIRD BEST ASPECT
Being able to help others	51	18	13
Being able to deal with patients	20	17	8
Medicine is highly respected profession	—*	8	8
Doing work involving scientific methods and/or research	9	20	19
Being my own boss	—*	—*	18
Challenging and stimulating nature of the work	8	19	21
Being in a secure, lucrative profession	6	10	8
Other aspects mentioned each by less than 5% of students	6	8	5
TOTAL	100	100	100

* Mentioned by less than 5%.

Aspects mentioned by few students, but which we may note, are that medicine is a highly respected profession, and provides interesting and intelligent colleagues.

The aspects liked best varied slightly according to race. The phi-coefficient varied from 0,21 for the first aspect of medicine mentioned, increasing slightly to 0,27 for the second-mentioned aspect, to 0,31 for the aspect mentioned third as being liked, by race. Broadly then most of the students, regardless of race, showed much the same profile, with altruistic idealism being the most marked, and financial rewards being mentioned by a small minority. This is similar to the findings of Becker et al. (1961) in their study of Kansas University Medical students.

4. *Financial Aspects of a Medical Education:*

It was stated by an official of the Medical School that the position in regard to financing medical students at the University of Natal is that the Assistant Registrar for the Faculty of Medicine is able, from sources made available by various bodies and well-wishers, to assist any deserving medical student in dire financial straits who applies for financial help.

The Blacks are, as a population, far poorer than the White group, and it is known that a proportion of medical students at the University of Natal Medical School have difficulty in financing their education. The students were asked as to what form of finance they used. The method of financing varies between races (a phi-coefficient of 0,78 was obtained). This is partly as a result of the different socio-economic level of the races, and partly because of the varying availability, by race, of grants and loans for students. Looking at the total picture, only 3% of the Africans, as against 38% of the Indians and 52% of the Coloureds, received financial aid which they did not feel obliged or were not required, to repay. This clearly shows the disadvantaged position of the Africans when it comes to financing a medical education. Two per cent of the Africans used some of their savings and earnings to meet part of their costs, as against 12% of the Indians. Four per cent of the students, (2% of the Africans, 6% of the Indians and none of the Coloureds) relied on vacation jobs to help them financially.

It should be mentioned here that the State Loan Bursary (part of which is an outright bursary, and part of which must be repaid subsequently to graduating) is available only to Africans. Ninety-five per cent of our sample of Africans received this State Loan Bursary, while two-fifths of them relied on it entirely.

Overall, a not insubstantial number of young Black doctors start their careers with substantial amounts of money which they must, or feel they

should, repay.

Because the majority of the African students and also Indian students had to repay some or all of the finance received for their education at Medical School, we would expect that they have financial worries. In reply to questions, 45% of the Africans as against 17% of the Indians and 40% of the few Coloureds, agreed that they had 'serious financial worries'. There is a moderate link between financial worries and father's occupation - the percentage of students expressing anxiety tends to increase as one goes down the occupational scale. This is what one would expect. Thus for example, 14% of children from professional and high administrative, and independent commercial and managerial homes, mentioned serious financial problems, as against 69% of those whose father was unskilled. An important area of concern of the student is the whole question of finance. In particular, the burden which has to be shouldered by those who have money which must be repaid, and find that they drop out from Medical School, is a tremendous one; and many students have the fear that they will not 'make the grade' to become a doctor, and yet will still have this financial millstone around their necks, thus having to fall back on a far less well-paid job than doctoring to pay it off.

During the pilot study we became aware that there was quite a considerable degree of dissatisfaction amongst certain students as to the manner in which they received their bursary money. Forty-four per cent were not in receipt of money paid through the Medical School, and a further 23% who were in receipt of monies through the School had no criticisms. The remaining 33% of the students voiced one or more criticisms of the scheme used for payment of money by the Medical School. Forty-eight per cent of those who voiced criticism felt that the students had to wait 'very long' for their money, which was inconvenient. This seems to point to the need for communication with the students, so that they appreciate the reasons for what in their eyes is an undue delay. Thirty-eight per cent felt that the staff concerned with the payment of grants and bursaries had an unpleasant manner, and stated that when students came to receive money they had to account for how they had spent the previous part of the bursary - and this was resented as being something which was their own business. Sometimes students felt they were not treated like adults. This points to possible changes needed in the public relations angle of paying out of bursaries and loans. About one-quarter of those who voiced criticism criticised the fact that they did not always get the amount of money they had applied for. This particular criticism suggests there would be some value in trying to indicate to the

students the reasons why they do not always get what they had hoped for. The only other criticism mentioned by an important number of students was that there should be direct contact between the donor and recipient, without the Medical School intervening. This was mentioned by 12% of those who voiced criticisms. In practice this suggestion may not always be possible. (Note: All these percentages cannot be added together as some students voice more than one criticism).

The main suggestion made about the payment of loans and bursaries was that fees should be deducted from the bursary/loan, and the remainder be paid out automatically on a monthly or quarterly basis to the person direct, or through the post, without any need to go and be interviewed when the money was paid out. This was mentioned by two-fifths of those who made suggestions.

The comments and suggestions students have made in relation to the disbursement of money through the administration of medical schools suggest that there are problems in the area of adequate communication and possibly to some extent in interpersonal relations between the administrative staff and the students. It is clear from the tenor of many replies that the students wished for financial independence, and to be able to handle their affairs in whatever way they deemed best. Probably some of them (at least unconsciously) resent having to rely on bursaries and loans to finance their way through medical school. If the staff concerned are aware of these problems, an attempt can be made to investigate to what extent alternative ways of handling finance are possible.

5. Attitude Towards the Medical School and the University of Natal.

About one-fifth of the students had attended another university previously prior to coming to the Medical School. They were asked to comment on how they found the University of Natal compared. They mentioned a variety of factors, but there was no clear pattern, except that there was very much of a balance between the positive and negative attitudes towards the University of Natal in contrast to their previous university. The spread seems fairly normal and gives no rise for concern. We would expect to find mixed feelings, and this is in fact what occurred.

One indication of student morale and satisfaction is how the students see their particular institution comparing with others in the country. Questioned about the Medical School of the University of Natal, 17 per cent thought it was better than others in the Republic, while a further 40 per cent thought it was about the same. Two-fifths of

the students felt that they were not in a position to judge and therefore could not arrive at a firm conclusion. It is encouraging that only 3 of the 101 students interviewed thought that the Medical School compared unfavourably with others in the country. They mentioned what they regarded as inadequate equipment in the laboratories, and also poor recreational facilities.

There were no major differences in the responses of students according to their race. We should note, however, that the proportion who thought that the Medical School was about the same as others in the country tended to increase steadily with year of study. Thus, whereas only one-tenth of the preliminary students thought that it was much the same as others in the country, three-fifths of the fifth and sixth year students thought this. The reasons for this view were the common syllabus imposed by the South African Medical and Dental Council, and an exchange system of external examiners.

The Medical School is legally and administratively an integral part of the University of Natal, but it has its own campus which is geographically separated from the main Durban campus at Howard College (being about 3 kilometres away). This separation is inevitable as the result of the need to tie the Medical School to a teaching hospital (in this case the adjacent large King Edward VIII Hospital for Black patients). It was postulated that because of this isolation, and also perhaps because of racial differences, the medical students may not feel that they are a full integral part of the University, the rest of which consists almost entirely of White students. Questioned on the point, four-fifths felt that they were not an integral part of the University. The Africans were rather less pessimistic in this regard, with only two-thirds taking this standpoint, as against nine-tenths of the Indian and four-fifths of the Coloured students. The proportion holding this negative view tends to increase with year of study. Thus for example only 40 per cent of the students in preliminary year as against 69 per cent of those in first year, and 90 per cent or more of those from second year onwards felt that they were not an integral part of the University. This suggests a process of disenchantment from about the second year of study onwards. The main reason given was the physical separation of the Medical School campus from the Howard College campus, and the resulting minimum contact with Howard College students. Other reasons given also expressed in various ways a feeling of isolation.

6. *Students' Views of Education in the University of Natal Medical School.*

A major section of the interview related to the attitudes and perspective of students in relation to their medical studies, and also their patterns of work. In the syllabus which was in operation in 1969, there was an overwhelming consensus amongst students that the fourth year of study, which represents the start of clinical studies, was the easiest year. The major reason given for this attitude was that there were no exams written during that year. The only other year mentioned by an important number of students was the preliminary year, which was seen as very easy, on the ground that it was largely a repetition of work up to Matric standard.

There was even greater consensus amongst students as to which was the most difficult year of study, given the 1969 syllabus. Over nine-tenths of the students mentioned the second year as the most difficult year. The reasons for this were that there was too much work during the year, or that the syllabus was too wide and too detailed. In particular, physiology and the practicals related thereto seemed to be the aspects regarded as the most difficult. There was no significant variation in the views according to the race of students. Questioned further, students regarded the second year as the most difficult not because the work in itself was of much above average difficulty, but rather because the volume of work to be handled was considerable, especially in physiology.

Suggestions made for improving the second year were that there should be a better distribution of the work load over a longer period of time (50% of the students); or the same work should be better arranged during the year (11%); and smaller and more frequent tutorial groups be held, especially in physiology (6%). It is interesting to note that more of the Africans wanted a better distribution of work load over a longer period of time (59% of the Africans) than did the Indians (47%) or Coloureds (36%). It is notable that only 5% of the students thought the solution to the problem of second year lay with the students working harder.

The students were asked about the ways in which they thought the most difficult year academically at the Medical School affected academic performance. Apart from the obvious comment that poor marks and/or failure resulted from the difficulty of the work (a quarter mentioned this), the most frequently mentioned reaction was one of fear of failure in second year, with discouragement and in some cases defeatism, which led to poor marks. About one-third of the African and Coloured students and a sixth of the Indian students mentioned this - or a quarter of all students interviewed. In all, half thus mentioned poor marks as a result of the difficult year.

A minority of round about one quarter of the students said that the difficulty of second year made the students work harder. The most common feature of behaviour mentioned as being the result of the difficulty of second year was mentioned by a third of the students, who said the difficulty made them forego sports and social activities, and entertainment, in order to devote more time to studying. About one-fifth mentioned tension and insecurity resulting from the apparently overwhelming challenge of the second year, while one in seven mentioned moodiness, frustration and withdrawal, or heavy drinking and womanising. We were not able to observe to what extent these reported changes occurred. It is notable that less than a tenth felt that no difference had been made to their behaviour by the academic problems presented by second year studies.

Two-thirds of the students regarded the clinical years as the most important phase of their life as medical students, with nearly all the remainder mentioning second or third year. (Fourth to sixth years are the years of clinical studies).

Those voting for clinical years almost to a man gave as a reason that this was a phase in their training where one came into contact with patients, and began to feel like a doctor and began to see and to understand theory in practice. Conversely, those who mentioned second or third year as being very important pointed out that it was at this stage that a lot of theory was learnt which subsequently they would put into practice in clinical years.

An opportunity was given to the students to express criticisms and make suggestions about each of the various years of study, as organised in 1969. In regard to preliminary year, there was a wide scatter of opinions, and we can conclude that there was no clear-cut criticism or suggestion in regard to it. It should be noted that only about one-tenth wanted it abolished, which suggested that most of the students - in fact nearly all - saw it as being valuable. This should be borne in mind when the Medical School considers in the future the desirability or otherwise of retaining preliminary year of study.

In regard to first year there was also a wide scatter of opinion, and many had nothing to suggest or criticise. Approximately 14% felt that first year should emphasize some subjects relating to medicine - they were a bit frustrated by a course full of what they saw as irrelevant subjects. Also, not being taught at the Medical School before second year produced feelings of isolation for preliminary and first year students. (Preliminary and first year students are taught at Wentworth, some 10 km. from the School).

The main suggestions and criticisms were made in relation to second year, which we have already picked out as being regarded by most students as the most difficult year. Of those who made suggestions, over one-third felt that second year physiology should be re-organised, with a better distribution of the load, and perhaps with some extension of the subject into later years as well. One-sixth wanted more tutorials than tests during the second year, while a tenth of those making comments felt that more time should be devoted to bio-chemistry. Thus it will be seen that physiology is picked out as the course which seems to give them the main trouble in second year.

Nothing of importance emerged from students' responses to the third year course, but in fourth year almost two-fifths of those who made replies (only about 13% of all students - many had not yet reached fourth year by the time of the interview) said they would like to have an examination during this year. The fifth year of study was a year which produced comments from the small number of senior students who had progressed that far. Over a quarter wanted an elective period of study at the end of the fifth year, while about one-quarter felt that there was too much work, and more time should be made available for ward work. One way in which this could be achieved was by moving subjects such as public health, preventative medicine, ophthalmology and obstetrics into fourth year. There was a suggestion by some that ears, nose and throat examinations should be written during this year.

Lastly, suggestions from the most senior students were made in regard to the final (sixth) year of study. About equal proportions wanted no change on the one hand, and on the other hand, seminars and surgery ending in August to allow more time for ward rounds and swotting for the final examination.

Reviewing these comments and criticisms, what emerges is that it is mainly second year which warrants attention by the Board of the Faculty. It should seriously consider whether there is some merit in the suggestion of the students that there be re-arrangement of the work load with perhaps an easing of the burden presented mainly by physiology.

During the interview, questions were asked about changes which the students would like to see made to the examination system. Nothing really of importance emerged except that about one-fifth felt the results should be based more on the year's work than on the examination itself.

In regard to experiencing a set-back with an examination, about two-fifths of the students said that they had experienced such a set-back. The reasons for this experience varied widely, as did in fact the comments

they made in regard to the actions which they took subsequently after the set-backs. However, it should be pointed out that only one-fifth of those concerned said that they had sought help or guidance from the teaching staff after the set-back. This does not suggest close student-teacher contacts. Three quarters of those who had sought help from the staff found it satisfactory.

7. *Ideas about the Type of Student who has a chance of doing well at Medical School.*

As research workers we were curious to find out what views the students had of the type of person who would score well at Medical School. In regard to work habits, over four-fifths thought a hard worker would do well, whereas it is interesting to note that 14% saw somebody who was only an average worker as being capable of doing well. There was little difference in the views by race or year of study.

It is intriguing to note that while 54% of the students said that an analytical questioning mind would do well at Medical School, over a third felt somebody with a photographic memory could do well. (Fifty-six per cent of the Africans as against 24% of the Indians mentioned this latter point). This is rather disturbing, and suggests that African students see the demand of the school in a different light from the Indians, and try to meet the challenges of the work in a different way. There was some trend according to year of study, with increasing emphasis up to third year on memory, and then from fourth year onwards there was an abrupt swing towards stressing the analytical approach. This suggests that the advent of clinical years produces a change in the ideas of the students and that until fourth year they see in many instances the role of the student as being a learner by rote of facts and theory, but that once they get into the clinical years and start attempting to apply their knowledge, the students get a deeper awareness of the need for an analytical mind. Becker et al. (1961) found at the Kansas Medical School pre-clinical students learnt what the faculty wanted and that clinical years saw a change. Our data suggest something similar may be occurring here. It is tempting to speculate to what extent the type of examinations set up to third year encourage rote learning - unfortunately the research workers have no material on this point-- but the Board of the Faculty of Medicine would no doubt be able to go into the matter.

In terms of ability, almost four-fifths of the students felt that above average intelligence was required for doing well at the Medical School, while the remaining fifth felt that a well above average intelligence was

required. Neither race nor year of study influenced response.

The students were also asked to specify the type of personality which they felt would be of importance for doing well at Medical School. Two-thirds mentioned being independent and self-reliant, while almost one-fifth mentioned being self assertive. Six per cent - only the Africans (17% of the Africans) - mentioned being submissive. There was a definite tendency for stress on independence and self-reliance to increase with the advancing year of study, so that for example whereas 50% of the preliminary students mentioned it, nine-tenths of those in the sixth year mentioned this. Increasing consensus appears to develop over the years. It is clear that the Indians place greater emphasis on independence and self-reliance as an important trait (three-quarters) than did the Africans (only 45% mentioned this).

The students saw behaviour in class as being a factor in success or otherwise at Medical School. Half of the students felt that those who asked lots of questions in class were more likely to be successful, while one-fifth felt that the amount of questioning that a student engaged in in the classroom situation made no difference at all. The remaining students held the converse view that one should ask few questions. Thus, while there is no overall consensus, it is clear that the largest single number of students felt that asking a lot of questions was important.

The last question which was put to the students in regard to the type of student who would be successful at Medical School concerned the question whether or not the family of the student knew staff on the Medical School. Two-fifths of the Africans, as against one-fifth of the Indians, and only a tenth of the Coloureds, (or 27% of all students interviewed) said that it would help a student to be successful if his or her parents or other relations knew some of the staff members socially. However, the proportion of students sharing this view decreased fairly systematically with year of study, so that the more senior the student was, the less likely he would see this as being an important factor in academic success. However, we should note that overall only 8 per cent of the students interviewed said without hesitation that it made no difference whatsoever to success or failure at the University if one's family knew socially staff of the Medical School. It seems that particularly for the African, the close contact characteristic of the small-scale intimate way of folk life under rural conditions is still important, and possibly reassuring to the student when facing the crises of exams.

8 Patterns of Work and Recreation of Students.

An attempt was made to obtain a picture of the work habits of the students, and they were asked to indicate how their workday was broken up. In order to try to avoid the problem of recall, they were asked about what they had done on the previous week-day closest to the interview. Even so, while the activities then were the day before or, if they were interviewed over the week-end then only a day or two previously, we had the problem of incorrect estimates of how their work was spread over the day. Short of keeping diaries, and keeping them meticulously, there is always the risk that some of the students reported incorrectly. Therefore the following results should be interpreted with some caution.

If we combine practical work and lab work, we have the following figure in terms of mean number of hours for the various years of study: Preliminary year 1.9, first year 1.3, second year 3.3, third year 2.8, fourth year 0.6, fifth year 1.6 and sixth year 1.0 hours. From these we note that the figure for second year is highest, while the figure for fourth year is lowest. Ward work starts in fourth year, but students do not see it as onerous as lab work. This supports the argument by the students that, given the syllabus in 1969, the second year involved harder work than the other years, while the fourth year was seen as being the easiest in terms of work load.

Nearly all the students interviewed had spent part of the previous week-day in recreation. None of the preliminary, third, fourth and fifth year students in the sample had worked the whole day without any recreation. A total of 5 per cent of the first-year students, 6 per cent of the second-years, and 30 percent of the sixth-year students had worked the whole of the preceding week-day without any recreation whatsoever.

The figures were broken down according to the race of the students. Generally the figures suggest that Africans tend to work longer hours, and in this sense harder, than do the Indians, provided that the figures obtained from the subjects were more or less correct. For instance, taking all years together, the mean number of hours spent on study by African students was 3.9 hours as against 2.7 for Indians. The differences are not large, but overall the Africans reported an average of three-quarters of an hour less sleep than the Indian students.

Students were also asked about how they had spent the previous week-end and were asked to give an estimate of the amount of time they had spent on various activities, ranging from lectures, practicals, laboratory and ward work, to private study, relaxation and sleep.

Table 3

Average Number of Hours Worked per Week-day and also spent on Recreation by a Sample of Medical Students at the University of Natal, 1969.

Mean number of Hours calculated from the Sample.

Year of Study	Mean Number of Hours per Week-day							GRAND TOTAL FOR WORKING DAY
	Lectures Seminars Tutorials	Practicals	Laboratory Work	Ward Work	Private Study	TOTALS	Recreation	
Preliminary	2.0	1.9	0	0	3.3	7.2	2.8	10.0
First Year	3.9	1.1	0.2	0	4.8	10.0	2.8	12.8
Second Year	3.5	2.8	0.5	0	3.2	10.0	2.5	12.5
Third Year	2.7	2.4	0.4	0.2	3.1	8.8	4.0	12.8
Fourth Year	1.9	0.6	0	5.1	1.0	8.6	3.9	12.5
Fifth Year	3.8	1.6	0	3.1	2.5	11.0	3.4	14.4
Sixth Year	2.2	1.0	0	5.8	3.4	12.4	1.5	13.9

Once again we got the picture that the second-year students worked hardest in terms of the longest hours, while the fourth-year students had the most time off. This corroborates our earlier findings from the interviews that fourth year was seen as an easy year. The general pattern was that students estimate that they spent about 8 to 9 hours of the previous week-end on private study, and more or less 12 hours on relaxation. Not many students had lectures, practicals or laboratory work, but 3 to 5 hours were spent by senior students in clinical years on ward work.

Looking at the total number of hours which students reported that they worked per week, we arrive at an overall average for all the students of a $58\frac{1}{2}$ -hour working week, excluding meal times. Forty-and-a-half hours were given over to lectures, just over 8 hours to practicals, $1\frac{1}{2}$ hours to private lab work other than practicals, $9\frac{1}{2}$ hours to ward work, and just over 25 hours to private study. Obviously this picture will vary by year of study, as has been shown.

The African students reported a higher overall figure than the Indian students. In the sample, Africans worked a reported 63-hour week as against a 58-hour week for the Indian students, and a 51-hour week by Coloured students.

In the absence of an idea of how White students work, it is impossible to interpret these figures on a comparative basis. However, we can conclude that they suggest that most of the students do work reasonably hard, and some work long hours.

Details were obtained of the recreational activities of students on the day preceding the interview. A very wide range of activities, covering a list of twenty-five activities, was obtained. The main activities, in rank order, are reading (45 per cent of students), physical exercise or sport (37 per cent), talking (36 per cent), bioscope (12 per cent) and going for a walk (11 per cent). Other activities were mentioned by less than 10 per cent of the students. Drinking was mentioned as a pastime by only 2 per cent of the students interviewed.

Information was also obtained on the activities which students had engaged in on the previous week-end (in contrast to the above figures which are for the previous week-day prior to the interview). The patterns of activities are very much the same as before, but with greater emphasis on sport. Sixty per cent of the students played some form of sport or engaged in some form of exercise during the previous week-end. In rank order this was followed by reading (39 per cent), talking (37 per cent), listening to the radio (34 per cent), going to bioscope (22 per cent), attending a party (16 per cent), watching sport (15 per cent), playing chess or draughts (15 per cent), and visiting (13 per cent).

These figures suggest that the students have a satisfactory pattern of recreation, and that they have a sufficient variety of outlets to relieve tension and anxiety, which may be the result of studying and working in the wards.

There is a wide range of activities open to students at the Medical School, and we were interested in finding out what type of activities attracted them most. The greatest single proportion, amounting to 33 per cent of the students, mentioned educational activities as being the ones which appealed to them most. By contrast, only 16 per cent of the students mentioned sport. This is a most interesting pattern, which staff of the Medical School regard as being very much the reverse of the type of pattern which they remember when they were students and different from what they have found in other medical schools where they have taught prior to the University of Natal. It emphasizes the very high value which the Black students, particularly the Indian students, place on education. There is a seriousness of intent and a need to achieve on the part of these students that seems absent amongst most White students.

Political activities on the campus (using the word 'political' in a very broad sense) attracted almost as many enthusiasts as did sport. Whereas 16 per cent of the students felt that sport was the student activity which appealed most to them, almost as many - 15 per cent - mentioned political activities. This is about the same level as that for social activities, mentioned by 17 per cent of the students.

While there was no clear-cut pattern in the choice of the student activity appealing most, according to year of study, there were some racial differences. In rank order, the Indians favoured first educational activities (42 per cent) and then social activities (25 per cent). The Africans had equal proportions opting for sport (26 per cent), political activities (25 per cent) and educational activities (25 per cent). The small group of Coloured students interviewed showed a different pattern, but one which was largely similar to that of the Africans. Sport was again placed first by 26 per cent of the Coloured students, but religious activities were mentioned by 19 per cent of them. Political activities (16 per cent) and educational activities (14 per cent) were mentioned.

The above results cover the main responses of students. The remaining proportion of responses in each case represent only a low number of students replying for each category. The overall picture is one of a serious interest in education, followed by social and political activities, with sport taking a far lower place than is typical amongst White students.

There is an earnestness of purpose of the students, reflected by the many seminars and educational symposia and political discussions which they have. Indeed one senior member of staff commented to us that his major criticism of the students was that they regarded their education in too serious a light, and should relax far more than they did.

9. *Inter-Personal Relations.*

An attempt was made to obtain a picture of inter-personal relationships between the students. Only one-fifth thought they were poor - this is encouraging - with rather more Africans than Indians expressing this view. About a third of the Africans as against one-sixth of the Indians interviewed felt this. The main reasons given for feeling that the relations were poor were that the races did not mix easily; or that friendships are determined by race and also year of study; or that while students in general got on fairly well, they could get on better. Some students told us that they had come to university with high hopes for good relationships between students, and found themselves disillusioned for the reasons given.

Apart from the minority of the students who regarded inter-personal relationships as poor, the rest regarded relationships as average or good, expressing views such as 'students get along well with all at Medical School', or that 'most mix well'. Two-fifths saw race either as a divisive factor or as a factor determining friendship patterns. However, we must note that amongst the Africans, in particular there is a strong tendency for agreement with the views that inter-personal student relationships affect student life adversely to increase with year of study. Thus, only 20% of the Africans preliminary year agreed with this view, whereas by fifth year 80% agreed. This pattern is not shown as strongly by the Indians, but there is still this tendency. This could suggest rising friction and some disillusionment as the students become more senior. The main ways in which the students felt student life was adversely affected were that students' affairs show racial lines of demarcation; or that the poor relationships deprived students of the chance to discuss problems and understand each other; or that there is a certain amount of resentment between the races.

A minority of students were satisfied with the student-teacher relationships within the Medical School and felt that no changes were required. A third of the students took this view. Breaking the answers down according to race, 38 per cent of the sample were Africans, 27 per cent Indians and 43 per cent Coloureds, showing this view. The main response of students was that they felt there should be more contact between students and teachers at the Medical School, and that students should be made to feel

'more at home'. Forty-three per cent of the students shared this view. Again there was some variation according to race, with the greatest percentage expressing this view being Indian students. Fifty-one per cent of Indians in the sample, as against 37 per cent of the Africans and 26 per cent of Coloureds, expressed this view. Other comments were mentioned only by a small proportion of students, and covered topics such as: teachers should not ridicule or shout at students, but be more sympathetic, or that students should not fear to express opinions to teachers, or that teachers should not be fussy over trivial matters such as dress.

From the interviews the impression obtained was that the students needed the support of the staff to an extent which is not characteristic of White students. They wished to have, and in a sense expect to have, greater support and contact than White students normally do. This points to a certain amount of insecurity and anxiety on the part of the students.

From time to time students have contact with administrative members of the staff of the Medical School, and we were interested in obtaining an idea of the students' view of these relationships. It is noteworthy that a far smaller proportion of students were satisfied with student-administrative relations than were satisfied with student-teacher relations. Only 7 per cent of the total sample interviewed, or 12 per cent of the African students, 5 per cent of the Indians and none of the Coloureds felt that there was no need for change at all. The main changes asked for were that the administrative staff should be more courteous and co-operative towards students, or treat students with respect as adults. A total of just under half of the students expressed these views. Other views put forward were really alternative expressions of the same point. Examples are that administrative staff should not regard students as a nuisance; or that they should show greater appreciation of student problems; or should be more co-operative, and so on. The staff administering student bursaries and grants are probably the members of the administrative staff who have the greatest contact with students, and therefore it is understandable that some of the students singled out these particular administrative staff as the ones whom they would wish to see change.

A general trend was observable that the proportion of students wishing for greater politeness and understanding increased with the year of study, so that more of the senior students voiced this desire than the juniors, who appear more submissive and less critical.

During the interview information was also obtained on the attitudes of the senior clinical students (i.e. fourth to sixth years) towards relations with hospital staff. Half felt that no changes were required. It is noteworthy that it was mainly the senior African students

rather than the Indian or Coloured students who mentioned the desire for changes. The type of points made were that nurses should be more co-operative and less restrictive in the wards (18%), or should not treat students as interfering 'children' (4%), or that students should be made to feel part of the hospital (6%), or that petty bureaucracy should not place 'unnecessary' restrictions on activities of students (8%). Whether in fact the Africans were more sensitive and perhaps insecure as a group, and therefore were the main ones who mentioned these points or whether there are differences (perhaps unconscious) in the way that the different racial groups are treated by the hospital staff - perhaps there is a racial 'pecking order' - is something which we were not able to establish. However, in terms of the definition of the situation by the students themselves, it was clear that particularly the African students felt there was some problem in the hospital-staff-student relations.

We were interested in the friendship patterns of the students. Year of study clearly was the most important determining factor. There was a high correlation between the year of study of the student and his 'best friends'. (Phi-coefficients varied from 0,58 for Africans, to 0,75 for Indians and 0,94 for the small number of Coloureds). Ninety-seven per cent of the Africans had an African as their very best friend, while corresponding percentages for Indians and Coloureds were 95% and 43% respectively. The lower percentage for Coloureds is due to the fact that there are few Coloureds in the Medical School, and the chances of making 'best friends' with a Coloured in one's year of study is fairly small. These figures show that racial lines are followed with best friends in most cases. Home-town was not a basis for forming friendships. Sex was a moderately important factor in friendship selection, with a tendency for the best friend to be of the same sex. It was found that the reasons for choice of friendship, while being many and varied, tended to involve common understanding and enjoyment of each other's company.

As far as the second best friend was concerned, there was somewhat greater flexibility in race. Year of study and sex again emerged as the two most important factors, and the same is true of the third best friend. The general pattern is that friends tend to be from one's own race, particularly the best friend, but second or third best friends can sometimes be of another race. On the whole one's friends tend to be of one's own sex and same year of study as well as of one's own race. Because women students are few in number at the Medical School, a higher proportion of female students named a male student as a friend than did men students mention a woman student. This is merely a reflection of the limitations of the situation.

10. *The Residence for Medical Students.*

There is a university residence for medical students, called the Alan Taylor residence at Wentworth in Durban. Situated some 10 or more kilometres from the Medical School by car or bus, the residence is a complex of buildings based on a nucleus of old Defence Force barracks and buildings. Some new buildings have also been added to the existing ones which were taken over by the University shortly after World War II as a temporary measure. Like many temporary measures in University affairs, it seems to have become a permanent fixture. The University authorities have tried, with some success, to improve the buildings and the site, but they can do nothing about the adjacent oil refinery nor the fact the residence is on the flight path of the nearby airport, nor its physical isolation from urban amenities. The residence must be about 20 kilometres from the central business district of Durban, and is even further from many of the African, Indian and Coloured residential areas of Durban where friends and relatives of students may live. In addition to the residence facilities, teaching facilities exist on the same site for teaching preliminary and first year students. However, it is the hope of the Faculty of Medicine that the preliminary year will soon fall away due to better high school preparation of students, and that first years will be taught at Medical School as soon as the teaching facilities there are expanded. There will then be only the residence at Wentworth.

As the large majority of students live in residence, they were asked about their attitude towards the residence. Most of the replies were critical - in fact only 4% felt it was satisfactory and had no complaints. Almost two-fifths mentioned that it was dull and depressing and looked like dreary barracks; while almost a quarter mentioned that it was not fit to be a university residence. (They probably compared it mentally with the new Black universities, which have had large capital grants to put up modern well-designed buildings. As converted military buildings, the Wentworth site cannot compare). A sixth thought the residence had insufficient rooms and was overcrowded, while other less frequently mentioned criticisms were that while the accommodation was bearable, more rooms were required, and there should be a general improvement all round in facilities; or that it was badly sited and suffered from noise and fumes from the refinery and airport. Furnishings came in for criticism too, but by a small minority. There were no differences by race or year of study - on the whole nearly all students were critical of residence. Unfortunately we do not have a White group to compare responses with. It is common folklore that resident students generally tend to be critical of residence, but we cannot help feeling that

the criticisms in this instance are probably rather more widespread than would be the case with White students in the typical White residence.

As far as actual life in residence was concerned, two-fifths of the students saw it negatively. Of those who had such attitudes, most felt that life was dull and monotonous, with meagre recreational facilities.

Two-thirds of the students felt that those living in residence had special problems. The main problems mentioned in order of frequency, were transport difficulties because the residence was very isolated from both the Medical School and either Black residential areas or town (43%); rigid meal times creating a problem in relation to transport (a quarter of the students); poor quality of the meals (also a quarter); the expense involved by living in residence and the necessary transport (mentioned by a sixth of the students); while one-eighth specifically mentioned the isolation of the residence from the rest of the community. Strict regulations about women and drinking were criticised by only 8%, while 6% mentioned poor facilities at residence, and 5% picked on the fumes and noise from the refinery.

Suggestions for improvements in the facilities at residence were first of all a plea for new buildings and a general renovation (mentioned by half of the students); better sports facilities (mentioned by one-third), better food (also mentioned by one-third), and better furniture (mentioned by one-fifth).

As far as regulations were concerned, the major change wanted by almost half of the students was that they be allowed to have alcohol and women in their bedrooms. There was a tendency for the proportion of students for each year of study who felt thus to increase as they became more senior, so that three-quarters of the final year students felt that they should be allowed to have drink in their rooms. However, it is intriguing to notice that 11% of the students felt that there should be greater discipline in regard to drink and women, and that while alcohol should be allowed, the warden at the time of the survey in 1969 was too lax. Eight per cent felt that there should be no alcohol allowed. This shows that the students were not all of one mind in regard to the changes of regulations, but that nonetheless most of them favoured greater freedom as indicated above. This is in line with student trends throughout the world, and by American or British standards the rules in force at the time of the survey were strict, but not more so than in many South African universities.

Over one-third of the students felt unable to comment on student-residence staff relationships, and this is understandable as most of them have had a limited experience of life in residence. Of those who felt able

to comment, three-fifths did not wish to have any changes. This is encouraging. None of the changes suggested were asked for by more than 8 per cent of the students, which indicates a fair scatter of replies, and no major grievances. Eight per cent felt that the warden should take a greater interest in student social affairs and consult them about rules; seven per cent wished to see the house committee have a greater say in student affairs; six per cent wished the warden to treat students as adults; five per cent mentioned that they felt the residence staff should be more polite and co-operative; and a further five per cent felt the kitchen staff/matron should be more sympathetic towards students when they were late for meals. Other comments accounted for less than five per cent of those replying.

In terms of these replies, it appears that the students did not have any serious grievances about relationships with residence staff. This of course relates to 1969, whereas in 1971 the Medical School residence experienced some unrest. We should note in the latter connection that both staff and more particularly students have changed since the fieldwork was undertaken, so that the situation today, at the time of writing (1975) is no longer exactly the same as it was when the survey was undertaken. It is common experience that hostels tend to have periods of student discontent, and the history of the Medical School hostel tends to underline this. All that can be said is that in terms of the few years prior to the present situation there were no grounds for believing that the students were very unhappy about the way the staff handled them.

11. *Problems of Oppidani:*

Fifty-six per cent of the students felt that the Oppidani (i.e. those who live at home or in 'digs' in town) had special problems not shared by those in residence. It was more the Indians (who had more oppidani) than the Africans who felt this. The main problems mentioned were time and money wasted on the journey to the Medical School; problems about trying to find a quiet place at home to study; and feelings of lack of contact with other students.

12. *Problems of the Students at the Medical School and Persons to whom they would turn for Help.*

Almost three-fifths of the students felt that they had special problems which were not shared by White medical students in South Africa. The percentage stating this viewpoint tended to increase steadily with the year of study - 35% of preliminary students, as against for instance 100%

of all final year students said this. The major problem mentioned by three-fifths was that the financial problems of the Black students at the University of Natal Medical School were far more acute than those faced by White students. A sixth felt the facilities were not as good as at White medical schools, while one-eighth felt the recreational facilities were inferior, and a tenth thought that there was no choice of training facilities as this Medical School is the only one officially for Blacks. From this it will be seen that the main problem looming in the minds of the students was finance.

Some reflection of student life can be obtained by asking students to whom they would go when faced with a variety of problems. First of all in the interview the students were asked who their first choice would be for consulting if they had a serious academic problem. As was expected, the most frequent first choice was a fellow student. Just under half of the students said that they would go first of all, if they had a serious academic problem, to a fellow student. Considerably fewer - one sixth - mentioned a lecturer as their first choice; one-tenth a parent; and a similar proportion mentioned their professor. Only 8 per cent mentioned a dean. The remaining proportion of students mentioned a variety of persons.

The second choice of person to consult with a serious academic problem in many instances is probably the person to whom the student would go if the first person were unable to help. Here we find first place taken by a lecturer (44 per cent of students mentioned this). Next is a professor (21 per cent of the students), followed by fellow students (11%) and then parent (10%). The remaining types of choices were mentioned by less than 5 per cent of the students in each case.

The third choice of who to consult, given a serious academic problem, has a different distribution from the second choice. This probably reflects the sequence in which students would pursue an attempt to solve their academic problem by consulting various people. The most frequently mentioned person (mentioned by 21 per cent of the students) was a professor. Fifteen per cent mentioned the Assistant Registrar at the Medical School, and the same proportion mentioned a lecturer. Fellow students were mentioned by 14 per cent, seven per cent said they would go to a relative, and six per cent said the Dean. Other comments were made by less than five per cent of students in each case and need not concern us.

There were no major differences in the responses students gave according to race. What differences there are seemed largely a function of the fact that more of the Indians were oppidani than Africans, and under such circumstances would be more likely to consult someone at home than

would be African students living in residence. Ranking together the choices made, regardless of whether they were first, second or third choice, we find that in first place was a lecturer (mentioned by 75% of the students) and then fellow students (mentioned by 70%). The professor was in total mentioned by 53% of the students, and a parent by 21%. From these figures it will be seen that a professor does not rank highly as someone who would be a choice to go to with serious academic problems, and the students obviously feel that they are more easily able to approach people of less exalted rank than the professor. This suggests that because of their status the professors are probably somewhat insulated from the students.

We were interested whether students would name different persons as the ones to whom they would turn to with a personal problem from those to whom they would go with a serious academic problem. Ranking first among the first choices again were fellow students, with a tendency for the proportion naming a fellow student to increase with the year of study. Overall 44% of the students selected a fellow student. Next, reported by 35% of the students, was a parent. The tendency here was for the proportion choosing a parent to decrease with year of study, so that the more advanced students were less likely, at least in terms of what they said, to turn to a parent. The remaining choices in this case amount to 5% or less of the students, and we can ignore them.

In second choice parents came first mentioned by 28% of the students. Then followed a relative, mentioned by 24%, and a fellow student by 20%. The Assistant Registrar was mentioned by 8%, and 5% mentioned a lecturer. As third choice, a relative topped the list at 23%, followed by 12% (fellow student), and 10% (parents), and 9% (a lecturer). The Assistant Registrar and a priest or other religious official each were mentioned by 6% of the students.

Again we therefore see the emphasis on turning to a fellow student, but parents and relatives are more likely to be choices here than in the case of academic problems. In fact what emerges is that personal problems are not likely to be taken frequently to members of the academic staff at the Medical School.

We also asked students who they would turn to if faced with a serious financial problem. The person most frequently named as first choice was a parent. Just over half of the students mentioned this, while the person most frequently mentioned as a second choice and likewise as third choice was a relative. Second in place as a first choice was the Assistant Registrar, mentioned by one-quarter of the students. Far more of the

Africans felt this way, (46% of the Africans as against only 13% of the Indians mentioned the Assistant Registrar as a first choice. This probably reflects the greater poverty of the families and kin of African students. Other individuals mentioned in order of importance were fellow students, and the Dean of the Faculty.

The picture that emerges is clear. A parent or relative is the first thought of the student if they have financial problems, with the Assistant Registrar (who has funds from various sources at his disposal) as a second choice.

The responses to this section on the various types of problems give some indication of the social network of students and their choices of people in whom they would confide when faced by a problem. The definition by the students of who they would regard as most helpful and therefore who they would turn to depends on the nature of the problem, with decidedly different responses being given for personal problems in contrast to academic problems or financial problems. Whether or not the replies indicate problems depends on what concept the Medical School has of whom the students ought to consult in any particular situation. Certainly on the academic side it would seem that while the students feel they would approach the academic staff, they see the professors as being rather more unapproachable than the lecturers, and this is probably a reflection of the position at most universities.

It is a policy of many universities to have a full-time student counsellor or counselling services, and the Howard College and Pietermaritzburg campus of the University of Natal have such facilities. The medical students were asked as to whether they thought there should be one for the Medical School. Most of the students (seven-tenths) felt there should be a full-time student adviser at the Medical School. This should be seriously considered by the Administration.

13. *Marriage.*

In overseas countries, particularly in America, it is frequently found that students marry while they are still studying. However, in South Africa this is a far rarer phenomenon, and particularly amongst the impecunious medical students marriage often presents a serious financial embarrassment. Three-fifths of the students did not think it ideal to marry while still training. There was some difference according to race - only 36 per cent of the Africans interviewed as against 74 per cent of the Indians and 79 per cent of the Coloureds thought it unwise to marry while still in training. Conversely, 25 per cent of the students, (or 39 per cent of the Africans, 20 per cent of the Indians and only 5 per cent of the

Coloureds), agreed that it was ideal to marry while one was still training to be a medical practitioner. The remaining students could not make up their minds in the matter.

As one would expect, the proportion thinking that marriage was ideal while studying was highest amongst the engaged group, and lowest amongst the unattached students. In between these two fell those who were actually married and therefore knew some of the problems of marriage while being a student. Only 21 per cent of the unmarried students, as against 36 per cent of those who were married and 77 per cent of those engaged thought that marriage was ideal while one was still a student. Understandably, age also tended to be a factor in the responses, with an increasing proportion of the older students voting for marriage during student days.

An attempt was made to understand why students held their attitudes towards marriage. The main reasons against marriage were that a wife was too distracting when one was studying. Fifty-four per cent of the students mentioned this. (There was a difference according to race, with 27 per cent of the Africans as against 69 per cent of the Indians and a similar percentage of Coloured students mentioning this). Only a minority of one-tenth thought that if finance was not a problem, marriage could be a stabiliser. Few saw that marriage would present a problem in that married students could not live together in residence - there are no married quarters.

In relation to marriage, the students were asked what they saw as the ideal occupation for a doctor's spouse (usually a doctor's wife in that the student was male). Only 8 per cent thought that any occupation was acceptable, the personality of the spouse being the important factor. The main occupations selected were in the professional field - either a doctor, or a lawyer, or a nurse, or a social worker, or some other professional person. The necessity of being educated was also mentioned. There were some differences in replies according to race. Thirty-six per cent of the Indian students felt that the spouse should be a housewife, as against 22 per cent of the Africans and 19 per cent of the Coloureds. This is understandable in that many Indians still have the tradition that a wife should be a housewife and her place is in the home. Thirty-five per cent of the Africans mentioned being a nurse as the ideal occupation for a doctor's spouse, but this was mentioned by only 5 per cent of the Indians and 10 per cent of the Coloureds. Again, 24 per cent of the Indian students said that the spouse should be a professional person, as against 7 per cent of the Africans and a similar proportion of the Coloured students. These variations reflect variations in the socio-cultural background and way of

life of the different racial groups. In general we can conclude that it is felt by most students that the doctor's spouse should be someone whose social position in society in terms of his or her occupation was commensurate with the professional standing of the doctor. The reasons for this given by the students related to the need to share and understand common interests and problems.

14. *Type of Socio-Medical Problems Students envisage they will have to face ten years after qualifying.*

We now turn to the future-oriented perspectives of the students. In order to obtain some idea of how they saw their future careers as medical practitioners, we asked them about the type of socio-medical problems which they thought they would typically have to face ten years after qualifying. As experienced medical practitioners, their replies on the whole are realistic in outlook. Only 18 per cent were unable to give any clear picture of what problems they thought they would have to face, so that over four-fifths had some idea. A total of 54 per cent mentioned the diseases of poverty and ignorance, (including witchcraft with ignorance). Diseases such as kwashiorkor, other forms of malnutrition, tuberculosis and the like were mentioned. A further tenth thought their problems would typically centre around patients who came to the doctor as a last resort, after various folk medicine practitioners and remedies had failed. Five per cent mentioned problems related to alcohol, drugs, and abortion.

We can conclude that generally the students see their main problems in the future, once they are practising as medical practitioners, as lying in areas related to the socio-economic cultural conditions of the Blacks in this country. There were no important differences between the replies of African as against Indian students, except that 16 per cent of the Africans as against 5 per cent of the Indians mentioned patients turning to the doctor as a last resort, after folk medicine had failed. This is probably a realistic reflection of the differences in behaviour of the Indian and African patients.

The replies suggest that the students have a fairly accurate idea of the problems they are likely to face.

The students were asked whether they thought the training they were currently receiving at the Medical School was fitting them to face the problems outlined above. Thirty per cent of African students and 38 per cent of Indian students were quite emphatic that their training was not fitting them adequately to deal with these types of problems. Taking only senior students in the clinical years (that is, fourth to sixth year students), we find that the proportion taking this negative view is even higher.

Two-fifths of the Africans interviewed and almost half of the Indians in the sample felt that they were not being adequately prepared in their training for the problems outlined above. The students were asked for their reasons for these attitudes. The main reason mentioned by those taking this negative view was that there was insufficient training in the social sciences - sociology, social anthropology and psychology - during their medical school education. Another important comment which should be noted was that the type of problems they would have to face were such that training could not help - poverty and ignorance cannot be combated by the training of medical students, as they are rooted in the social fabric. About one-eighth of the students mentioned that the social science courses they were being taught would help them to solve future problems in practice. Related to this, it should be noted that a proportion of students wished to have a course in preventative and social medicine reintroduced into the syllabus.

While it will be seen the majority of the students either feel that their training is fitting them to face the problems they envisage once they are medical practitioners, or are not sure whether this is in fact so, a significant group takes the view that their training is not preparing them for the situation they will have to face in practice. These attitudes are worthy of note by the Board of the Faculty of Medicine, for they suggest revisions in the syllabus.

15. *The Type of Medical Practitioner the Students Expect to be Ten Years After Qualifying.*

In order to explore further the mental picture which students have of their future career, they were asked to describe what type of practitioner they thought they would actually be ten years after qualifying. Of the sample interviewed, 31 per cent thought they would be general practitioners; 21 per cent hospital consultants; 14 per cent specialists in private practice; 13 per cent hospital medical officers; 7 per cent researchers, and 5 per cent medical teachers. The remaining one-tenth were not sure. It is significant to note that over one-third of the students saw themselves as being specialists, either within a hospital set-up or in private practice. This is about the same proportion as those seeing themselves in general practice or as a non-specialist medical officer in the hospital service. One cannot help commenting that the proportion who see themselves as specialists is probably far higher than will be achieved in practice.

There are differences between the races in terms of the replies

they gave. The largest single number of Indians (one-third) thought that they would be hospital consultants, followed by 17 per cent commenting that they would be general practitioners. This compares with 54 per cent of the Africans seeing themselves as general practitioners, as against 11 per cent thinking they would be specialists in private practice. The specialisms mentioned varied widely over the whole range of medicine, but the most frequently mentioned specialism by Africans was surgery, in contrast to psychiatry and neuro-surgery mentioned by Indians.

Most of the students think that they would be happy if what they envisage for ten years after their qualifying comes to pass. Seven-tenths of the Africans as against four-fifths of the Indians and three-quarters of the Coloureds said that what they mentioned was what they would like to be. This indicates that roughly one-quarter of the students think that what they will be is not what they would like to be. Those who envisage that what they will be ten years hence is not what they would wish, were asked what they would in fact like to be - and again specialisation comes very much to the fore. In fact, the largest single group of students would like to be specialists, if they could have their wish. Whether this is a desirable or undesirable attitude in the light of current medical practice and the needs of South Africa is something which medical experts must assess for themselves - such an assessment lies beyond the scope of the present report. Nonetheless, it seems to the author, as a layman in the field of medicine, that given the very low doctor:patient ratio amongst Blacks in South Africa, the need for decades to come will be for general practitioners.

16. Qualities of the Ideal Medical Practitioner.

What do students see as the qualities of the ideal medical practitioner? Or, to put it another way, what type of ideal do they feel they should model themselves on? In rank order the following features were mentioned, with the per cent of students mentioning the characteristics in parenthesis:

Being understanding and sympathetic	(48 per cent)
Keeping up with medical developments	(14 per cent)
Unassuming	(14 per cent)
Able to establish good interpersonal relations	(12 per cent)
Conscientious and devoted to his work	(11 per cent)

Other characteristics were mentioned by less than 10 per cent of the students, and ranged from items such as being interested in welfare activities of the community, through to showing qualities of leadership and inspiring respect and confidence.

It is noteworthy that there is no stressing of technical competence except in so far as it is implied by the 14 per cent who mentioned keeping up with medical developments. Does this mean that the students take technical competence for granted in a qualified practitioner? Unfortunately the interview information does not allow us to reach a firm conclusion on this point. All we can say is that the 'responsibility and experience perspective' found by Becker and his colleagues amongst clinical students (1961, Ch.12) was not explicitly evident in our interview with students. Perhaps participant observation may have revealed it - we do not know.

There was some difference in the frequency of characteristics mentioned by Africans in contrast to Indians. Different items were stressed. The Indians tended to stress sympathy more than the Africans, while African students tended to stress the unassuming nature and devotion to work. Whether the ideals mentioned by the students are the ones hoped for by the staff of the Medical School will be examined in a later part of this report.

17. An Analysis of Student Records.

Records for all of the 690 students admitted during the period 1951 - 1970 inclusive were computerized and analysed. Only 18% of the students were women - with roughly equal proportions of females amongst African and Indian students (16 and 19 per cent respectively). Coloureds with 30% female were higher. Forty-two per cent of the admissions were African, 51 per cent Indian and six per cent Coloured.

Overall, only 43% of the students (37% African, 50% Indian, and 40% Coloured) graduated. Thus the Indian students fared best. These differences are despite the tendency noted before for Africans to work harder. The results probably reflect differences in the educational and cultural background of students relevant for a medical education. There is a very high rate of attrition. A third of all students were excluded by the Board of the Medical Faculty on academic grounds, while a quarter withdrew for a variety of reasons, typically related to poor achievement. Women students fared less well than men students - only 31% graduated as against 46% of the men. The reasons for this difference are unknown.

A quarter of all students admitted during 1951 - 1964 graduated on schedule - i.e. repeated no years. This represents only half of those who finally graduated. Further details are given in the Table below.

Seventeen per cent of all African admitted graduated on schedule as against 29 per cent of the Indian and 28 per cent of the Coloured students. Taking only graduates, the respective percentage become 44%, 58% and 68%.

Africans would appear to struggle more with medical studies probably due to a more limited educational and home background. Women do less well than men. Sixty-nine per cent of all women students as against 54% of the men were excluded or withdrew from the Medical School before completing their studies. Out of the graduates, 55% of the men as against 42% of the women completed their degrees on schedule.

Table 4

*Length of Time Students took to Graduate 1951-1964
Admissions, Taken up to 1970 Records*

LENGTH OF TIME	NUMBER OF GRADUATES	%
On Schedule	158	53,0
1 year extra	69	23,2
2 years extra	41	13,8
3 years extra	22	7,4
4 years extra	5	1,7
5 years extra	2	0,7
6 years extra	1	0,3
TOTAL	298	100,0

Excluded or withdrew N = 392

The mean age of graduates was 28,6 years. African graduates tended to be two years older than Indians at the completion of their studies. This is another indication of the greater obstacles educationally which Africans have to overcome.

One quarter of the admissions were students with some university experience - 10% had passed a first or second year university course, while 13 per cent possessed a degree. Those with some previous university experience proved to be more likely to graduate as a doctor than those without. Thirty-five per cent of the graduates had some previous university experience as against 22% of the withdrawals and 18% of those excluded.

An investigation of the various years of study repeated showed that second year had the highest repeat rate - 18% (21% of Africans and 15% of Indians) repeated second year. This supports the contention of students that it is this year which is the most difficult. Preliminary year and first year had a tenth of the students repeating each, while third year dropped to 8%. The final year (sixth year) had 9% repeats. The heaviest 'weeding out'

of students took place at the preliminary year of study. Twenty-five per cent of the men and thirty-four per cent of the women were excluded or withdrew after failing this year. Individual subjects were examined, and the percentages failing them at the first attempt were computed. The results, for those subjects where 10% or more failed at the first attempt, are as follows in rank order:

1. Physiology	40%	failed	at	their	first	attempt
2. Zoology*	35%	"	"	"	"	"
3. Psychology* (second year)	32%	"	"	"	"	"
4. (Anatomy	30%	"	"	"	"	"
(Biological Sciences	30%	"	"	"	"	"
6. (Pathology	29%	"	"	"	"	"
(Physics I	29%	"	"	"	"	"
8. Botany I*	28%	"	"	"	"	"
9. Botany* (preliminary year)	27%	"	"	"	"	"
10. Chemistry (preliminary year)	23%	"	"	"	"	"
11. (English	22%	"	"	"	"	"
(Zoology I*	22%	"	"	"	"	"
13. Physics (preliminary year)	21%	"	"	"	"	"
14. Chemistry I	20%	"	"	"	"	"
15. Maths (preliminary year)	18%	"	"	"	"	"
16. (Pharmacology	17%	"	"	"	"	"
(History*	17%	"	"	"	"	"
18. Sociology I*	14%	"	"	"	"	"
19. Medicine	13%	"	"	"	"	"
20. Surgery	11%	"	"	"	"	"

* Signifies that the course concerned is now discontinued in the original form.

The average (mean) failure for subject's rate was 21%. Physiology with a failure rate for first attempts of 40%, appears as the most difficult subject and this provides factual support for the students' view of it as such.

18. *Summary and Conclusions.*

This report is the first part of several based on an evaluative study of the Medical School of the University of Natal. This part has concerned itself with students from the School, their characteristics, behaviour and ideas. Subsequent parts will deal with graduates of the School, and the staff. In addition the health beliefs and practices of an urban African community and also of an urban Indian community will be investigated, to give some idea of the social context within which graduates have to practice. The study of students was based on a social survey,

following group interviews with a range of students.

The students are mainly Indian and African, with a few Coloureds. They come from a variety of backgrounds, but urban families with above average education predominate. There is a strong altruistic element in the reported motivation of the students, although elements of the financial security and status offered by medicine as a career are included. These findings are similar to those for American students at the University of Kansas Medical Centre (Becker, et al. (1961) *Boys in White*).

Finance is often a matter of considerable concern for students, and a not insubstantial number will start medical practice with considerable debts which they must repay. These debts take the form of educational loans from a variety of sources. The plight of those who fail and are excluded, or have to withdraw, from the Medical School, and yet have large debts, is such as to make fear of this happening a matter for anxiety on the part of many students.

Considerable dissatisfaction was expressed by students about the manner in which bursary and loan money is paid out and the administrative staff involved were seen as a source of humiliation and as giving cause for resentment. This raises problems relating to interpersonal communication and public relations, which the Medical School must look into. From our own student days we can remember instances of petty bureaucrats in a university wielding considerable authority over students in a most unpleasant manner and it would seem there is always a potential danger of this occurring in a large-scale hierarchically-structured organisation. In this particular case inter-racial contacts are involved, so that the matter is more important. Furthermore, while no quantitative evidence is available, the focussed group interviews led the author to think that Black students in a White-run educational institution are likely to be more sensitive, and more suspicious of motives, and in fact more insecure, than White students would be. If this is so, there is all the more reason for making sure that the Black:White interface at an administrative level is staffed by suitable personalities. Furthermore, there are tentative indications that some White staff are more paternalistic towards Black students than their counterparts in a White institution would be towards White students, and this becomes a source of grievance. While the students want to be reassured and handled with sensitivity, the group interviews left the impression that paternalistic relationships are unacceptable. Good intentions on the part of staff are, by themselves, insufficient.

The picture students have of the Medical School generally is favourable - only 3 out of 101 interviews compared the school unfavourably with others in South Africa.

In terms of the 1969 syllabus, the students saw the fourth year of study as the easiest, and the second year as the most difficult. Physiology, with the highest failure rate of any subject was the main problem in second year. Students felt the volume of work involved by Physiology was the essential problem. If this issue has not been covered by the syllabus alterations already introduced by the Board of the Faculty of Medicine, then it should be considered.

Details of student work patterns were presented. A senior member of the staff felt the students were 'too serious and worked harder' than (White) students did in his own student days. Our own impressions are that they work harder than the Science and Arts students at the Howard College campus, and that whatever else might be the case, lack of work on the part of students was not a problem. Apart from anything else, there are fewer professional and well-paid openings for Black than for White students, so that the Black student who has to leave Medical School has more to lose than the typical White student, who consequently has far less compulsion to work hard.

Student views on teacher-student relations were obtained. Sympathetic, reassuring, approachable staff were valued. While again only an impression can be quoted, the author's impression was that in this the Black medical students suffered from a higher level of anxiety than typical White students and therefore looked for closer contacts with staff. They seemed to need and expect more from their teachers than White students at the Howard College campus of the University. Given the politico-socio-economic contexts of the Black and White students, such differences are understandable.

Close student friendships tend to be along racial group lines - i.e. probably along sub-cultural and not racialistic lines. Some students were disenchanted by this, but it should not necessarily be regarded as a problem. When throughout their educational life students have been educated only with members of their own group, University life is not going to change the pattern of friendships in the twinkling of an eye.

The physical features and siting of the medical students' residence came in for criticism and unfavourable comment. The site is isolated and inconvenient; it is close to major sources of noise and smell, and despite the University's efforts, the buildings still betray their military origin. Unfortunately in terms of Group Areas Legislation the University does not have a free choice in the matter, and without very substantial government grants a new residence cannot be built elsewhere. Ideally, the residence should be close to the Medical School. The whole complex issue of the siting and building of a new residence should be pursued if at all possible.

Residence rules, especially in regard to entertaining women students in rooms, and alcohol on the campus, were unfavourably commented on. In keeping with students elsewhere in the world, greater student autonomy in these matters is desired.

The decision of the Board of the Faculty of Medicine to move the teaching of first years to the Medical School is in line with student thinking.

Student preconceptions of the type of problems they will meet as medical practitioners are realistic, but the author wonders whether the country needs as many specialists as there would be if all who wish to specialize, did so. Given the large areas of South Africa which are, at least underdeveloped, the general practitioner seems to be the main need. However, it is doubtful whether more than a fraction of those who wish to specialize will be able to do so after qualifying.

43.

A P P E N D I X A

DETAILS OF THE SAMPLE OF STUDENTS FROM THE MEDICAL SCHOOL OF THE UNIVERSITY OF NATAL DRAWN FOR INTERVIEWING, 1969.

After exploratory group interviews it was decided to select a sample of about 100 students from the Medical School for interviewing by means of a standardised interview schedule. The official class lists for 1969 were used to define the universe to be studied. The students were stratified according to year of study and race.

It was decided that a sample of 100 cases was the minimum acceptable in terms of the level of precision required for the analysis. As the original conceptualisation of the study after exploratory interviews, suggested that the Africans were the main body of students to be studied, the sample was non-proportionately stratified by race accordingly. Details are as follows:

DETAILS OF ALL STUDENTS, AND THE SAMPLE SELECTED,
FROM THE MEDICAL SCHOOL OF THE UNIVERSITY OF NATAL,
DURBAN, 1969.

YEAR OF STUDY	COLOUREDS		INDIANS		AFRICANS		TOTAL	
	NO.	SAMPLE	NO.	SAMPLE	NO.	SAMPLE	NO.	SAMPLE
PRELIMINARY	5	2	22	4	30	10	57	16
FIRST YEAR	11	4	46	7	23	10	80	21
SECOND YEAR	4	1	45	8	42	14	91	23
THIRD YEAR	3	1	31	5	21	7	55	13
FOURTH YEAR	7	1	35	6	12	4	54	11
FIFTH YEAR	2	1	23	4	13	5	38	10
SIXTH YEAR	4	1	24	4	10	4	38	9
TOTAL	36	11	226	38	151	54	413	103

Cases were selected randomly, using random numbers, from each stratum formed by race and year of study. As far as possible one-third of the Africans, and one-sixth of Indians and Coloureds were drawn. The response was 101 cases, as one fifth year Indian student and one in sixth year refused to be interviewed. All the rest responded.

Prior to computer tabulation of the results the responses were raised by factors calculated from the reciprocal of the sampling fraction for each stratum, in order to ensure the tables were estimates of the position for the school as a whole.

In retrospect, being wise after the analysis, it is regretted that the same sampling fractions for Africans and Indians were not used, and that equal numbers of both were not drawn, as the findings suggested Indian students had as much to contribute to the study as African students. The Pilot Study had not suggested this, and hence the sampling scheme adopted.

Fieldwork was undertaken by trained interviewers from the Institute for Social Research during August to October, 1969. After the computer tabulation the results were analysed. The analysis is a description of the sample results. It has not seemed necessary to resort to tests of significance (which in any event would have been complicated and time-consuming - and hence expensive - because of the non-proportional stratification of the sample).

46.

A P P E N D I X B

INTERVIEW SCHEDULE USED FOR INTERVIEWING A SAMPLE
OF MEDICAL STUDENTS FROM THE UNIVERSITY OF NATAL,
DURBAN, 1969.

Following exploratory group-interviews, a draft interview schedule was prepared for the study. This was tested during a pilot survey. The final form of the schedule is given below.

STRICTLY CONFIDENTIAL

ISR.4/69

Item No. 1

Schedule No.

INSTITUTE FOR SOCIAL RESEARCH

University of Natal, Durban

EVALUATIVE STUDY OF THE MEDICAL SCHOOL

OF THE UNIVERSITY OF NATAL

PART I : STUDENT INTERVIEWS

Name:

Address:

.....

.....

RECORD OF FIELDWORK				
Date of Visit	Time	Result of Visit	Reason	Interviewer

Schedule checked by: Date:

Schedule coded by: Date:

Coding checked by: Date:

B. FINANCING OF MEDICAL EDUCATION.

	<u>Item No.</u>	<u>Code No.</u>
B ₁ . How are you financing your medical education?		
Own savings and/or earnings. (1)		
Non-repayable money. (2)		
Money you feel obliged to repay. (3)		
Money you are bound to repay. (4)		
Combinations of the above: (Specify and codes will be assigned later)	(9)	()

B ₂ . If you are using in whole or in part non-repayable money (other than the State Loan-Bursary) to finance your education, indicate the source:		
Own Private Income/savings. (01)		
Husband/Wife. (02)		
Parents. (03)	(10)	()
Relatives. (04)		
Friends. (05)		
Grant or Bursary. (06)		
Combinations of the above: (Please specify - a code will be assigned later):		

Not applicable. (09)		
B ₃ . If you are receiving a non-repayable grant or bursary, please name the source: _____	(11)	()
B ₄ . Are you receiving a state loan-cum-bursary?		
YES / NO		
(1) (2)	(12)	()
B ₅ . If you are using in whole or in part money which you must repay, give the source:		
-----	(13)	()
B ₆ . If you are relying in whole or in part on your savings and earnings, are you adding to these by:		
i) Weekend jobs	YES / NO / Not appli- (1) (2) cable (3)	(14) ()
ii) Vac. jobs	YES / NO / Not appli- (1) (2) cable (3)	(15) ()
B ₇ . Do you have serious financial worries?		
YES / NO		
(1) (2)	(16)	()

	<u>Item</u> <u>No.</u>	<u>Code</u> <u>No.</u>
B ₈ . Some bursaries are <u>paid out</u> to the student by the Medical School, which receives and holds the monies for the student.		
a) What criticisms, if any, do you make about the system whereby the money is paid out?		
1. _____	(17)	()
2. _____	(18)	()
3. _____	(19)	()
4. _____	(20)	()
5. _____	(21)	()
b) What suggestions for improvement can you offer? _____	(22)	()

C. ACADEMIC ASPECTS

C ₁ . Had you been to university before coming here?	YES / NO (1) (2)	(23)	()
C ₂ . If yes, how did the previous university compare with the Medical School? Mention points which have struck you:			
1. _____		(24)	()
2. _____		(25)	()
3. _____		(26)	()
C ₃ . Which year of study do students at the Medical School generally regard as:			
a) The easiest?			
Prelim. / 1st / 2nd / 3rd / 4th / 5th / 6th yr. (1) (2) (3) (4) (5) (6) (7)		(27)	()
Reasons: No exams / Repetition of / Other Matric work		(28)	()
(1) (2) (3)			

	<u>Item</u> <u>No.</u>	<u>Code</u> <u>No.</u>
C ₄ . b) The most difficult?		
Prelim. / 1st / 2nd / 3rd / 4th / 5th / 6th yr. (1) (2) (3) (4) (5) (6) (7)	(29)	()
i) Why? _____ _____	(30)	()
ii) Is the volume of work in this year too great? YES / NO / D.K. (1) (2) (3)	(31)	()
iii) Is the work of above average difficulty? YES / NO / D.K. (1) (2) (3)	(32)	()
C ₅ . How can the year you mentioned as being the most difficult be eased? Better Distribution of work load over a longer period (i)/Other: (Specify): _____ _____	(33)	()
C ₆ . If students regard one year as particularly difficult, how does this year of study affect: a) Their academic performance? _____ _____ _____ _____	(34)	()
b) Their behaviour patterns? _____ _____ _____ _____	(35)	()
C ₇ . a) Which single phase of study do students generally regard as <u>most</u> important in training to be a doctor? Prelim. / Second / Clinical / D.K. and / and / Years / 1st year / 3rd year / (1) (2) (3) (4)	(36)	()
b) Why? _____ _____ _____ _____	(37)	()

C₈. Thinking back over each separate year of your studies so far at Medical School, please make any criticisms or suggestions for changes you deem fit. Include the headings specified below in your considerations, and be as specific as possible:

Item
No. Code
No.

Pre-Clinical Years:

Include the curricula lectures, seminars and tutorials, practicals and post-mortems, where relevant, in your considerations:

- a) Preliminary Year: _____
 _____ (38) ()
 _____ (39) ()
 _____ (40) ()
- b) First Year: _____
 _____ (41) ()
 _____ (42) ()
 _____ (43) ()
- c) Second Year: _____
 _____ (44) ()
 _____ (45) ()
 _____ (46) ()
- d) Third Year: _____
 _____ (47) ()
 _____ (48) ()
 _____ (49) ()

Clinical Years:

In addition to the curricula, lectures, seminars and tutorials, practicals and post-mortems, include ward rounds, clerking and other hospital work in your considerations. If you have any suggestions about elective periods of study, include them here:

- e) Fourth Year: _____ (50) ()
 _____ (51) ()
 _____ (52) ()
- f) Fifth Year: _____ (53) ()
 _____ (54) ()
 _____ (55) ()
- g) Sixth Year: _____ (56) ()
 _____ (57) ()
 _____ (58) ()

		<u>Item</u> <u>No.</u>	<u>Code</u> <u>No.</u>
C ₉ .	What type of student has a chance of doing well at this Medical School? Choose <u>one</u> characteristic from the following in each section:		
a)	In terms of work habits: Hard Worker / Average Worker / D.K. (1) (2) (3)	(59)	()
b)	Type of Mind: Analytical, Questioning / Photographic / D.K. Mind / Memory / (1) (2) (3)	(60)	()
c)	In terms of ability: Very Intelligent / Average Intelligence / D.K. (1) (2) (3)	(61)	()
d)	In terms of personality: Independent, / Self-assertive / Submissive / D.K. Self-reliant / / / (1) (2) (3) (4)	(62)	()
e)	In terms of behaviour in class: Asks lots of / Asks Little / Never opens / D.K. questions / / mouth / (1) (2) (3) (4)	(63)	()
f)	In relations with staff: Has little contact / Deliberately curries / D.K. with staff / favour / (1) (2) (3)	(64)	()
g)	Parents or other / None of the / D.K. relatives know / student's / some staff / family knows / members socially / any staff / / members / (1) (2) (3)	(65)	()

C₁₀. Examinations:

Examinations are a feature of all university training. What changes would you like to see made in the examination system of the Medical School?

- a) Written Examinations:
1. _____ (66) ()
 2. _____ (67) ()
 3. _____ (68) ()
- b) Practical Examinations:
1. _____ (69) ()
 2. _____ (70) ()
 3. _____ (71) ()
- c) Vivas:
1. _____ (72) ()
 2. _____ (73) ()
 3. _____ (74) ()

		<u>Item No.</u>	<u>Code No.</u>
C ₁₁ .	a) Have you ever experienced a set back in an <u>examination</u> at the Medical School? YES / NO (1) (2)	(75)	()
	b) If yes, please describe nature of this set back. ----- ----- ----- -----	(76)	()
	c) What did you do after the set back? ----- ----- -----	(77)	()
	d) After the set back did you seek help and guidance from the teaching staff? YES / NO / N.A. (1) (2) (3)	(78)	()
	i) If so, was the help obtained satisfactory? YES / NO / N.A. (1) (2) (3)	(79)	()
	ii) If it was not satisfactory, why not? ----- ----- -----	(80)	()
	e) If you did not seek help and guidance from the teaching staff, why not? ----- ----- -----	(81)	()
C ₁₂ .	How many hours in total did you spend yesterday on the following: (Note: If 'yesterday' was a Sunday, take the preceding Friday; if 'yesterday' was a Saturday, take the preceding Thursday):		
	a) Lectures, Tutorials, Seminars?	(82)	()
	b) Practicals?	(83)	()
	c) In the lab (other than during set practical times)?	(84)	()
	d) In the wards?	(85)	()
	e) In private study and written assignments?	(86)	()
	f) In recreation and relaxation?	(87)	()

(Code number of hours as they stand, to the nearest whole number).

	<u>Item</u> <u>No.</u>	<u>Code</u> <u>No.</u>
C ₁₃ . How many hours sleep did you get last night? (If last night was a Sunday, take Friday night, if it was a Saturday night, take Thursday night): Code number of hours 01 09, 10, etc.	(88)	()
C ₁₄ . <u>Last weekend</u> , (from Saturday morning to Monday morning) how many hours did you spend in total on:		
Lectures, Tutorials, Seminars	(89)	()
Practicals?	(90)	()
In the lab (other than during prac. time)	(91)	()
In the wards?	(92)	()
In private study?	(93)	()
On Relaxation and Recreation?	(94)	()
Sleeping?	(95)	()
C ₁₅ . List all the things you did by way of relaxation.		
a) Yesterday -		
1. -----	(96)	()
2. -----	(97)	()
3. -----	(98)	()
4. -----	(99)	()
5. -----	(100)	()
6. -----	(101)	()
b) Last weekend -		
1. -----	(102)	()
2. -----	(103)	()
3. -----	(104)	()
4. -----	(105)	()
5. -----	(106)	()
6. -----	(107)	()
7. -----	(108)	()
8. -----	(109)	()

D. INTER-PERSONAL RELATIONS.

D ₁ . a) Do you find inter-personal relations among students <u>in general:</u>		
Good / Average / Poor / D.K. (1) (2) (3) (4)	(110)	()
b) Your reasons: -----		

-----	(111)	()

- | | Item
No. | Code
No. |
|--|-------------|-------------|
| b) Your reasons: _____ | | |
| _____ | (112) | () |
| _____ | | |
| _____ | (113) | () |
| D ₂ . Do the inter-personal relations between students you
have described affect student life adversely? | | |
| YES / NO / D.K. | | |
| (1) (2) (3) | (114) | () |
| If so, in what ways? | | |
| _____ | | |
| _____ | | |
| _____ | (115) | () |
| D ₃ . What changes, if any, would you like to see in
student-teacher relations? | | |
| _____ | | |
| _____ | | |
| _____ | (116) | () |
| D ₄ . What changes, if any, would you like to see in
student-administrative staff relations? | | |
| _____ | | |
| _____ | | |
| _____ | (117) | () |
| D ₅ . What changes, if any, would you like to see in student-
hospital staff relations? | | |
| _____ | | |
| _____ | | |
| _____ | (118) | () |
| D ₆ . What changes, if any, would you like to see in student-
resident staff relations? | | |
| _____ | | |
| _____ | | |
| _____ | (119) | () |

E. SOCIAL VALUES AND IDEAS.

- E₁. Imagine yourself ten years after qualifying as a doctor:
- a) What type of socio-medical problems do you think you
will typically be dealing with?
- _____
- _____
- _____
- (120) ()

Item Code
No. No.

b) Do you think your present training is fitting you to deal with these problems?

YES / NO / D.K.
(1) (2) (3)

(121) ()

Reasons: _____

(122) ()

E2. a) What type of medical practitioner do you think you'll actually be 10 years after qualifying?

Research Worker / G.P. / Specialist in / Hospital
/ / private prac- / M.O.
/ / tice. /
/ /Specify type: /
/ / /
/ /----- /

(1) (2) (3) (4) (123) ()

Hospital Consultant / Teacher / D.K.
(5) (6) (7)

b) Is this what you would like to be?

YES / NO / D.K.
(1) (2) (3)

(124) ()

c) If not, indicate what you would like to be (use same codes as for a). If specialist, specify type _____

(125) ()

E3. Describe your ideas of the qualities of the medical man you think is the ideal medical practitioner:

(126) ()

E4. The medical course is a long one, and some students marry before they complete it.

a) Do you think this is an ideal step?

YES / NO / D.K.
(1) (2) (3)

(127) ()

Reasons: _____

(128) ()

- | | | <u>Item
No.</u> | <u>Code
No.</u> |
|---|--|---------------------|---------------------|
| b) | What do you think is the ideal occupation for a doctor's wife/husband? | | |
| | ----- | (129) | () |
| | Reasons: ----- | | |
| | ----- | | |
| | ----- | (130) | () |
| E ₅ . | How do you think the University of Natal Medical School compares with the other medical schools in South Africa? | | |
| | About the same / Better / Worse / D.K. | | |
| | (1) (2) (3) (4) | (131) | () |
| | Reasons: ----- | | |
| | ----- | | |
| | ----- | (132) | () |
| E ₆ . | Do you at the Medical School, feel an integral part of the University of Natal? | | |
| | YES / NO | | |
| | (1) (2) | (133) | () |
| | Reasons: ----- | | |
| | ----- | | |
| | ----- | (134) | () |
| <u>F. RECREATIONAL AND SOCIAL ACTIVITIES.</u> | | | |
| F ₁ . | Are you satisfied with the recreational facilities available to you as a student at the Medical School? (EXCLUDE residence facilities which apply only to students in residence) | | |
| | YES / NO / D.K. | | |
| | (1) (2) (3) | (135) | () |
| | Why? ----- | | |
| | ----- | | |
| | ----- | (136) | () |
| F ₂ . | Which of the following categories of student activities appeals to you <u>MOST</u> ? | | |
| | Political / Educational / Religious / Social / | | |
| | (1) (2) (3) (4) | | |
| | Cultural / Sport / Administrative and Organisational | | |
| | (5) (6) (7) | (137) | () |
| | Why? ----- | | |
| | ----- | | |
| | ----- | (138) | () |

Item No.	Code No.
-------------	-------------

G. RESIDENCE.

- G₁. What do you think of the Alan Taylor Residence?
Give your reasons: (139) ()
- -----

- G₂. What do you think of life in the Residence? (140) ()
- -----

- G₃. Do you think a student in residence has special problems?
YES / NO / D.K.
(1) (2) (3) (141) ()
- What are these reasons:
1. ----- (142) ()
2. ----- (143) ()
3. ----- (144) ()
4. ----- (145) ()
- G₄. What changes do you wish to see made in the facilities
at the Residence?
1. ----- (146) ()
2. ----- (147) ()
3. ----- (148) ()
4. ----- (149) ()
- G₅. What changes would like to see made in the regulations
at the Alan Taylor Residence?
- | | | | | | | |
|-----------------|---|----------------|---|-------|---|-----------|
| Alcohol allowed | / | Women visitors | / | 1 + 2 | / | |
| in rooms | / | in bedrooms | / | | / | |
| (1) | | (2) | | (3) | | (150) () |
- Other, specify:
- -----

		Item No.	Code No.
G ₆ .	How does life in residence affect the students' behaviour? ----- ----- -----	(151)	()
<u>H. GENERAL.</u>			
H ₁ .	Do the oppidani students have any special problems not shared by those in residence? YES / NO / D.K. (1) (2) (3)	(152)	()
	If so, specify: ----- ----- -----	(153)	()
H ₂ .	Do the students at this Medical School have any problems not shared by White medical students in South Africa? YES / NO / D.K. (1) (2) (3)	(154)	()
	If yes, specify: 1. ----- -----	(155)	()
	2. ----- -----	(156)	()
	3. ----- -----	(157)	()
H ₃ .	If you have:		
a)	<u>A serious academic problem</u> , whom would you go to for discussion and advice? Indicate 1st, 2nd and third preference.	First	
	Fellow / Parent / Relative / Priest or Religious Student / / / Official (1) (2) / (3) / (4)	(158)	()
	Warden / Professor / Lecturer / Assistant Registrar (5) (6) (7) (8)	(159)	()
	Dean / Other / No more (9) (10) (11)	(160)	()
b)	<u>A serious personal problem?</u>		
	Fellow / Parent / Relative / Priest or Student / / / Religious Official (1) (2) (3) (4)	(161)	()
	Warden / Professor / Lecturer / Assistant Registrar (5) (6) (7) (8)	(162)	()
		(163)	()

Item No.	Code No.
-------------	-------------

b) Dean / Other / No more
(9) (10) (11)

c) A serious financial problem?

Fellow / Parent / Relative / Priest or religious Student / / / Official (1) (2) (3) (4)	First (164) ()
Warden / Professor / Lecturer / Assistant Registrar (5) (6) (7) (8)	Second (165) ()
Dean / Other / No more (9) (10) (11)	Third (166) ()

H₄. Do you think there should be a full-time student
Councillor appointed to the staff of the Medical School?

YES / NO / D.K. (1) (2) (3)	(167) ()
--------------------------------	-----------

H₅. Describe your three best friends in Medical School:

1. Year of study (Code 1-7 with 1 for Prelim.,
2 for 1st year, etc.)
----- (168) ()

Sex (male (1)/female (2)) _____ (169) ()

Race (African (1)/Indian (2)/Coloured (3))
----- (170) ()

Home town (same or not?) YES / NO
(1) (2) (171) ()

Why did you choose him/her as your good friend?

----- (172) ()

2. Year of study (Same codes as above)
----- (173) ()

Sex _____ (174) ()

Race _____ (175) ()

Home town (same or not?) YES / NO
(1) (2) (176) ()

Why did you choose him/her as your good friend?

----- (177) ()

		Item No.	Code No.
H ₅ .	3. Year of study (Same codes as above)		
	-----	(178)	()
	Sex -----	(179)	()
	Race -----	(180)	()
	Home town (same or not?) YES / NO (1) (2)	(181)	()
	Why did you choose him/her as your good friend? -----		
	-----	(182)	()

I. PERSONAL PARTICULARS.

I ₁ .	Age: 20/20-24/25-29/30-34/35-39/40-44/45-49/50+ (1) (2) (3) (4) (5) (6) (7) (8)	(183)	()
I ₂ .	Sex: Male/Female (1) (2)	(184)	()
I ₃ .	Race: African/Indian/Coloured (1) (2) (3)	(185)	()
I ₄ .	Year of Study: Prelim./1st /2nd /3rd /4th /5th /6th (1) (2) (3) (4) (5) (6) (7)	(186)	()
I ₅ .	Place of abode: Residence/Oppidani (1) (2)	(187)	()
I ₆ .	Home Language: -----	(188)	()
I ₇ .	Home: Town: -----	(189)	()
	District (if rural) -----	(190)	()
	Province -----	(191)	()
I ₈ .	Parents' Religion -----	(192)	()
I ₉ .	Your Religion -----	(193)	()
I ₁₀ .	Father's Occupation at present (rank grade): -----	(194)	()
I ₁₁ .	Mother's Occupation at present: -----	(195)	()
I ₁₂ .	Father's Education: -----	(196)	()

I₂₁. Notes: Use the following abbreviations:

Sex - Male = M
 Female = F

Marital Status - Never Married (Single) = N.M.
 Married M
 Living together L
 Engaged E
 Separated S
 Legally Divorced D
 Widow/er - ed

For education, please put an (X) next to all cases which have completed their education.

THIS QUESTION WILL BE CODED LATER.

J. OFFICIAL RECORD DATA.

	<u>Item</u> <u>No.</u>	<u>Code</u> <u>No.</u>
J ₁ . Date entered Medical School: 1960/'61/'62/'63/'64/'65/'66/'67/'68/'69 (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)	(205)	()
J ₂ . Number of years at Medical School? (Code)	(206)	()
J ₃ . Years which repeated:		
1. _____	(207)	()
2. _____	(208)	()
3. _____	(209)	()
J ₄ . Number of years spent repeating so far? (Code)	(210)	()
J ₅ . Subjects failed:		
1. _____	(211)	()
2. _____	(212)	()
3. _____	(213)	()
4. _____	(214)	()
5. _____	(215)	()
6. _____	(216)	()

If all a year's subjects were failed, code as such.

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