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“A Classroom of Life”

*A qualitative analysis
of the reflections of medical students
on their entry into an obstetric community of practice*

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SUPERVISORS

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*Winter Morning Reluctance**

Here in the fifth dimension

The interlude between wake and sleep

This bed is a womb

Warm, Dark, Soft and

Safe

Momentarily I am rebellious

But Time constricts inexorably around me

Responsibility ruptures these sheets from this mattress

And deposits me in the giant hands of the new day

I grimace at electric light –

Naked, Newborn

Still smothered with the substance of sleep –

And groan

Timo Freethe

**A poem written by a student during his 3-week attachment to an obstetric unit*

DECLARATION

I, George Henry Draper, hereby declare that the work on this dissertation is based on my original research and has not, in whole or in part, been submitted towards another degree, at this university or elsewhere. The university is empowered to reproduce either the whole or any portion of the contents for the purposes of research.

Signed by candidate

Signature

..... 24/5/06
Date

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To God

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Abstract

This study looks at how students describe their entry into an Obstetric community of practice. In common with other Health Science Faculties in South Africa the MBChB curriculum offered by the University of Cape Town is in a state of transition with the last final year class of the outgoing curriculum graduating at the end of 2006. The Obstetric programme in the outgoing curriculum provided courses in the fourth and sixth years of study. The fourth year rotation provided students with their first contact with childbirth and the related service / learning environment. The final year programme prepared students for internship and subsequent independent practice.

The overall theoretical framework for this study is the situated learning theory of Lave and Wenger (1992), particularly its notions of community of practice and legitimate peripheral participation. Additional insights are provided by ritual theory, with its notions of separation, transition and integration. Other important concepts include the role of reflection in learning and critical discourse analysis as a means of analyzing textual data.

Students' descriptions of their entry into an obstetric community of practice in reflective commentaries and a focus group interview provide the data set on which the analysis is based. Specific aspects considered are identities, roles, relationships and issues of power. Shifts in these aspects over time and the implications of these issues for curriculum change are explored.

Within a qualitative research framework a case study strategy is employed. The 'case' consists of a 'focal group' of five students purposively selected from the group of students who had voluntarily submitted reflective commentaries. Their commentaries written in their fourth year and the transcription of a focus group interview conducted at the end of their final year provide the data for the analysis. The research process involves a layered, sequential approach. A limited quantitative analysis of demographic data compares the students who submitted commentaries with those who did not. Using a content analysis of all the student commentaries common themes are identified. These inform the more detailed discourse analysis of a sample of textual material derived from the reflective writing and the transcriptions of the focus group interview. The results overall indicate that the spheres of practice for the two years are related but differ in key areas.

The obstetric domain in fourth year is largely confined to the labour ward. The student's role is one of support, caring and only rarely, advocacy. The midwife is the key role model and

this is experienced in both positive and negative senses. The patient is seen to play a crucial role in the student's identity formation.

In the sixth year the domain involves all service areas, senior doctors are the role models and the key role is that of a doctor with the focus on curative rather than supportive functions. Relationships at this stage with midwives and patients are more detached. Being 'part of the team' is experienced as needing to share the work load but excludes being treated as a member of staff. This is allied to a negative perception of the Obstetrics and Gynaecology department as a whole. Overall, for the students not being able to speak out, based on a fear of repercussions, evokes strong feelings of disempowerment.

A number of concerns are raised. These include the current application of the apprenticeship model of training, the quality of care received by patients and the need for a support system for students and teachers. A number of recommendations to address these issues are made and possible areas for future research suggested

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(academically speaking) I lacked the confidence, firstly, to trust any feelings of disquiet and secondly, to make dramatic changes. Given time that situation was destined to change.

Three separate but related influences set in motion a process of renewal or transformation. The first was my enrolment in the Higher Education Studies (HES) programme run by the Centre for Higher Education Development (CHED) at the University of Cape Town (UCT). This provided me with theories and tools to study the academic and working or service environment in which I was engaged. One such tool was reflective writing. Having learnt about being a reflective practitioner through the HES programme, I decided to explore the use of reflective writing in the fourth year environment. The task presented to students (Appendix A) focussed on their experiences around their first deliveries. It was to be regarded as a learning exercise with submission of a written commentary being a voluntary option. From that source came the second major influence for change, namely the raw insights into the process of transition as experienced by the students. The third and decisive influence came from the Faculty of Health Sciences which had embarked on a process of curriculum transformation with the first intake on new students in 2002 coinciding with the fourth year of the students involved in this study. The transformation process provided the initial motivation to review training in O & G and later the momentum to sustain a process of renewal.

With my later involvement in the curriculum transformation process as the convenor of the third or clinical phase of the curriculum, these three influences converged and in that, became a more potent drive for change. The challenge was to make pedagogically sound decisions, to do justice to what I was learning from my students and above all to build constructively on experience gained from the outgoing curriculum.

Obstetric training in the outgoing curriculum

The students who participated in this study were part of the outgoing curriculum. What follows is a description of the overall obstetric programme presented in the fourth and sixth years of the outgoing six-year MBChB degree course. It should be noted that in the outgoing curriculum training in Gynaecology as opposed to Obstetrics, was provided in the fifth and sixth years of study thereby providing students with further contact with the Department of O & G in each of the three clinical years of the course.

The fourth year obstetrics programme

The obstetrics block presented to the fourth-year class of 2002 consisted of the standard eight-week programme. It introduced students to the discipline and provided their first real clinical contact with pregnant mothers and their experiences of giving birth. In reality most

students had never seen a birth before the start of the block. During this period the programme provided opportunities to acquire the necessary knowledge and skills. Practical experience included initially witnessing deliveries and later conducting at least fifteen under supervision. It was assumed that in the process students would develop professional attitudes relevant to obstetric practice.

The sixth year obstetrics programme

The final year programme, which the class under focus did in 2004, involved a four-week block in an obstetric unit in one of three referral hospitals. Students became part of the service by joining a clinical team, were given certain responsibilities and practiced under supervision. The aim was to prepare them for internship in the following year. As before, professional development was an implicit rather than explicit component of the block.

Outlined above is the local context against which to view the student comments. There are a number of other broader contextual issues which are highlighted below in order to provide a more textured background against which to assess the comments of students, the analyses of those comments and the recommendations which flow from that process.

Shifting social practices

Social practice is a term frequently encountered in the literature and increasingly so across a wide range of disciplines. It is not always clearly defined but generally is intended to signify a growing sense that context matters. According to Lave (1993, p.7) social practice should be viewed as “*a single encompassing theoretical entity*” which draws together “*relations among person, activity, and situation*”. She maintains that without a “*theoretical conception of the social world one cannot analyse activity in situ*”. This study examines these relations such as it applies to the emerging obstetrician and certain important and relevant social practices. Each of these practices is in a dynamic state of change and therefore it is more appropriate to describe shifts than make categorical statements. The three key social practices are childbirth as seen in its broader sociocultural context, the practice of obstetrics as a clinical discipline with a specific focus on childbirth and the teaching of obstetrics (and medicine) as viewed from a biopsychosocial perspective.

Childbirth as an evolving sociocultural phenomenon

As noted earlier context matters, and looking at the bigger picture the nuclear family, patriarchal societies and sexuality are all changing under the influence of the process of globalisation (Castells, 2001). Wide contraceptive choices, the availability of termination of

pregnancy services and the possibility of conception taking place outside the human body (including in the absence of a known male partner) highlight some of the many choices which confront women. Circumstances that relate directly to childbirth have also changed. These include changes in the place of delivery, the role of religion and culture, the identity and gender of the most influential person or attending professional and the actual role of the professional. The general trend in any case is a move from supporting a woman in labour to active management of such labour. What is seen as a medicalization of pregnancy and birth has resulted in a physiological event being seen increasingly as a medical condition with a concomitant trend towards a surgical rather than a medical happening (Draper, 2002a). This 'technocratic' shift (Davis-Floyd, 2001), whilst contributing to the technical safety and outcome of a pregnancy, has, at times, been associated with a decline in the quality of caring as experienced by mothers at an interpersonal level and the loss of key rituals that previously provided links with the mother's community (Davis-Floyd, 1994). In the local context, perhaps the most critical factor currently affecting what happens around childbirth is the HIV/AIDS epidemic. Apart from taking its toll on mothers and babies it fundamentally influences delivery practice as efforts are made to limit transmission of the virus to babies and workers.

Shifts in obstetric practice

In many respects the disciplines of obstetrics and gynaecology are on the frontier of critical human developments. These include the recombination of DNA and the implications thereof for genetic engineering, new techniques for in vitro fertilization (IVF), cloning, surrogacy and improved techniques for terminating unwanted pregnancies. All these place the profession in a crucial and rather vulnerable ethical position.

Another important shift involves the systematic review of clinical practice based on the best available research data with the challenge to practice 'Evidenced Based Medicine' (EBM). This is finding practical expression at a basic level through the 'Better Births Initiative', a global project to improve care and which is implemented in under resourced settings (Gülmezoglu, 2003) including South Africa (Smith et al, 2004). Because of the hierarchical nature of the service, generally it is the medical profession that dictates the nature though not always the pace of such change. In terms of human dynamics, the latter is often determined by members of the nursing profession.

Shifts in medical education

Curriculum change as regards medical training is a global phenomenon and efforts are being made to standardise training globally (Core Committee, 2002 and Van Niekerk, 2003). In

North America the change has been described as “*a quiet revolution*” (Parsell, 2000, p.972). As is the case with clinical practice, medical education is also coming under review. Following the example of EBM there is now Best Evidence Medical Education or BEME a concept suggested by Harden et al (1999). These changes are influencing the development of the incoming curriculum at UCT and the aim of producing a knowing, empathic and reflective practitioner is very much in line with trends elsewhere.

Attention has been drawn to changes that are relevant to childbirth in general and obstetrics in particular mainly because they provide the backdrop against which the transition which students describe should be viewed. A final factor that needs to be taken into account is my role as researcher.

A personal reflection

In some respects I have the sense that I am involved in ‘*participant observation*’ and am mindful of the risk of influencing the action being studied and/or having a biased viewpoint (Abramson, 1979, p.101). At the same time I am conscious of the unique insights and perspectives that being a member of the community of practice brings. With that in mind it makes sense, I believe, to briefly map out my own entry into and trajectory through the discipline of Obstetrics.

My decision to do Medicine was associated with a strong sense of call to work in a Christian medical mission environment. My medical training during the apartheid era traversed the full political spectrum from a conservative ‘whites-only’ setting to a political radical ‘blacks-only’ university situation where the only white students allowed were at postgraduate level. In between came the politically more neutral and multicultural environment of the Institute of Child Health in London.

The situations where I have worked similarly cover a wide spectrum from a remote mission hospital with only basic health services to what is probably one of the best urban perinatal services in the country. Overall my journey took me through three former provinces and three former ‘homeland’ areas. A period of eight years in private practice in a small town seeing middle class patients complemented the otherwise mostly disadvantaged, racially diverse public service hospital exposure.

Exposure to these various environments left me with clear impressions of the legacy of the apartheid system, the impact of environment on the development of professional identity and the nature of ‘community’ at cultural, social and professional level. These insights shaped my

response to the writings of the students. An early and largely thematic analysis showed that reflective writing provided a unique perspective on the personal and professional development that obstetrics students were undergoing in a situated learning environment (Draper, 2002b). It also hinted at issues relating to identity, medical hierarchy, quality of care and the quality of the teaching environment. The challenge was to find a method of analysis that would bring to light the deeper issues related to power and practice.

A framework for understanding

Given the nature of the data produced, it was clear that a qualitative rather than a quantitative analysis would be more appropriate. From a personal point of view, the various courses of the HES programme provided insights and a range of skills that could be used for harmonising various bodies of literature and doing an analysis. It became clear that 'situated learning' as originally described by Lave and Wenger (1991) was the one theoretical framework that would not only speak to the learning environment but would also provide a credible link to other relevant theories and disciplines. A combination of content analysis followed by elements of discourse analysis was chosen as the way to analyse the text. An overall critical approach was needed in order to identify and deal with issues of roles, responsibilities, power, and gender, amongst others, as well as indicate changes in discourse in times of shift. 'Critical' is not being used here in the sense of voicing disapproval but looks at how situations have evolved historically (Car and Kemmis, 1986) and seeks to dispel ideology and bring emancipation (Hammersley, 1993). These theoretical frameworks are described in the next chapter. Drawing on these frameworks, the main research question and its more specific inquiries were formulated.

The research question

How do students describe their entry into an obstetric community of practice?

More specifically:

- a) How are roles, identities, relationships and issues of power represented?
- b) What changes in roles, identities, relationships and power are evident over time?
- c) What are the implications of the above for training and/or induction into the profession?

Research in medical education matters

Where does this research fit, in the context of medical education research in general? In a review of several editorials and commentaries focussing on research into medical education the following picture emerges. Medical education is seen to be in a state of transition and consequently medical education research is “*small scale, local and descriptive*” (Bligh, 2000). The development of a theoretical context that will generate appropriate questions and answers is stressed (Prideaux and Bligh, 2002). That is a process which must happen within the profession whilst at the same time being open to conversation with others (Pirrie, 2000). Bligh (2000), commenting on the development of research capacity related to medical education, notes the absence of an “*embracing*” theory. To correct that, Bligh and Parsell (1999) had suggested looking to the social sciences who offer frameworks for interpreting students’ experiences and qualitative research methods to study complex educational phenomena. MacNaughton (2002) notes that creating a research tradition that involves the social sciences is likely to present a dilemma as to whether to retain the medical research tradition with its emphasis on fact and evidence or to embrace the social sciences where evidence is open to interpretation and where the evidence itself is presented by reasoned argument. Regarding this choice Prideaux (2002) speaks of a biomedical ‘elitism’ of quantitative designs. Other concerns are that clinicians involved in providing evidence for EBM do not bring the same intellectual rigour to teaching or curriculum change (Murray, 2002) and that what is published is dominated by assessment of trainee performance and satisfaction (Prystowsky and Bordage, 2001). Where does this leave the patient? Shea (2001, p.319) feels that “*medical education is primarily for students*” and that any impact on patient care is “*often diluted and distant*”. Bligh and Parsell (1999) however feel that research will ultimately have an impact at the bedside and therefore that “*Research in medical education matters*”. It is one of the premises of the research done here. Showing that is the purpose of the chapters that are to follow.

Chapter 1

Introduction

***“To me, obstetrics has been a kind of initiation rite into medicine”
(Hazel)***

Introduction

This thesis is about the induction of newcomers into the obstetric profession. I write as a member of that profession, as a member of the staff of an obstetrics department in a health sciences faculty and as convenor of that department's fourth year obstetrics programme. I write, too, as one in whom a deep and abiding interest has been awakened through interactions with medical students and the real life experiences they go through in coming to terms with the demands made on them during their introduction into obstetric practice. A watershed moment in that awakening came during my first readings of the student reflective commentaries which subsequently became a focus of this study. The tentative reflective exercise that I had introduced simply to see what students had to say, revealed much more than I had anticipated. I realised that individual students, apart from learning about obstetrics, were undergoing a personal transition or transformation that had hitherto not been fully appreciated. The student quoted above described it as an '*initiation rite into medicine*' (Hazel)¹. Similarly, what lay beyond that in terms of personal and professional development, needed further exploration. This thesis is the culmination of that appraisal and exploration. As I reflected on the process, it became clear to me that in seeking to define and understand their learning trajectories, I was at the same time plotting one of my own. More simply put this dissertation is the story of a teacher of obstetrics and what happened to his fourth year class of 2002.

Background to the study

My involvement in the formal teaching of obstetrics began when I joined the Department of Obstetrics and Gynaecology (O & G) in 1998 and was assigned the task of convening the fourth year programme. The programme which evolved over the next few years was largely a continuation of what had gone before. Maintaining the status quo was based on an early assumption that basically all was well and a rather naïve philosophy that 'you don't fix what ain't broke'. Conversely, having just left private practice and being the 'new kid on the block'

¹ To protect student identities pseudonyms are used

Chapter 2

Theoretical Framework

"These experiences have given me the opportunity to look at the world from a different view and in so doing I believe that I have been changed for the better"

(Sarah)

Introduction

'Experience' has been defined as "*Authentic (real as opposed to simulated) human contact in a social or clinical context that enhances learning of health, illness and disease, and the role of the health professional*" (Dornan and Bundy, 2004). Sarah, the student quoted above draws attention to the fact that 'experience' is often associated with significant personal change. This study is about listening to such student voices, whether in written or spoken form and hearing what students say about their induction into an obstetric community of practice. Such revelations need to be reflected on and responded to in a manner that will do justice to the risk students take in making known what they think and feel. That requires the kind of "*theoretical conception of the social world*" that Lave (1993, p.7) sees as a crucial prerequisite to any analysis of social practice.

This chapter is about providing such a framework, more specifically one that encompasses the production and analysis of text, the analysis of the learning / service environment and finally one that can consider related medical issues. Theorising the learning environment is the central and most important aspect and 'situated learning' as described originally by Lave and Wenger (1991) has been selected as the most appropriate framework. Reflection, narrative, and discourse come into question regarding the production of the textual material as does discourse analysis when considering the exploration of textual data. The field of ritual theory provides a more nuanced understanding of childbirth as a social event and also the transition that students undergo in the process of learning about obstetric practice. Quality of patient care and professionalism are important medical or clinical issues which should be regarded as contextual givens rather than as indicators of a need for additional theories.

Situated Learning

Upon reading the first few student commentaries I was confronted with the realization that they had learnt much more than they had been taught. Much of the learning seemed to be related to what students had experienced affectively, going way beyond the simple acquisition of knowledge or skills. Students had discovered much about themselves, about those with whom they worked and how the 'system' worked. Learning 'happened' but was not adequately explained by concepts of learning based on behaviourist, humanist or cognitivist orientations. It became clear that the explanation would only come from a perspective shaped by a "*social and situational orientation*" (Smith, 1999) and ultimately lay in a fuller understanding of learning related to real world experience.

A social theory of learning

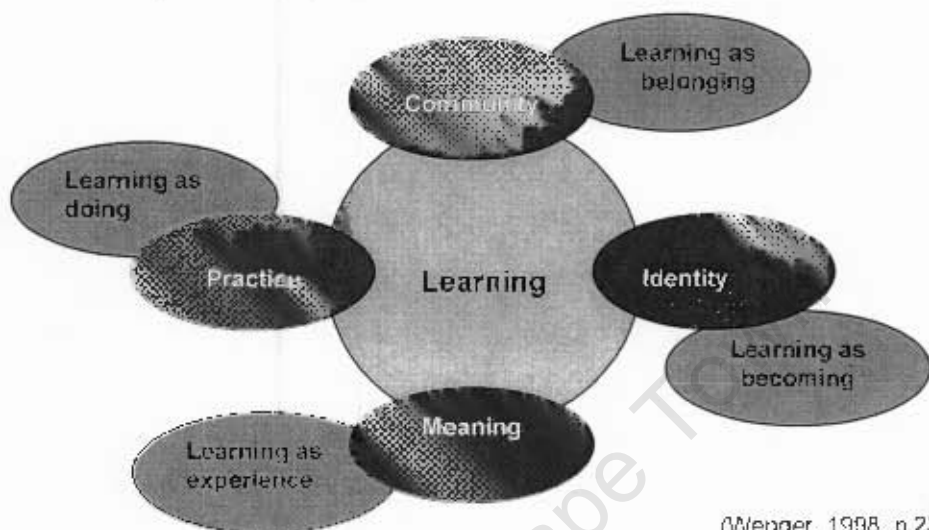
'Learning by doing' takes on many theoretical forms, each having its own characteristics, strengths and weaknesses. Situated cognition as first described by Brown, Collins and Duguid (1989) but more specifically situated learning, as defined later by Lave and Wenger (1991), best describes the obstetric learning environment. That assessment is based on two key aspects of that environment. The first is its 'situatedness' i.e. it is an integral part of the social practice of childbirth with the associated provision of and learning about obstetric care taking place in real time in the real world. The second is its application of the concept of apprenticeship albeit in a modified form.

Wenger, a computer scientist, collaborating with Lave, an anthropologist, looked at ethnographic studies of apprenticeship with a view to establishing what such studies might contribute to a general theory of learning. The concept of situated learning came out of that collaboration and reaffirmed the inherent social character of learning as opposed to the traditional understanding as the transfer of factual knowledge or information. Simply put, learning should be viewed as a social practice, with the term 'situated' intended to indicate that learning as it normally occurs is a function of the activity, context and culture in which it occurs.

In later work Wenger (1998) explores the link between learning and the social world in a social theory of learning which is depicted visually in figure 1. It shows a social theory of learning that incorporates learning as doing, belonging, becoming and experience. It is precisely these aspects of learning that students described in their commentaries that aroused my interest at the very first reading of their submissions and ultimately influenced the framing of the research question being addressed in this thesis. The diagram illustrates how *learning as experience* contributes to finding **meaning** in our lives and the world, how

learning as doing involves **practice** which is a sharing of resources, frameworks and perspectives in mutual engagement, how *learning as belonging* creates **community** wherein both our activities and our participation are considered worthwhile and finally how *learning as becoming* describes the formation of **identity** which attends the change brought about by learning.

Figure 1 Components of a social theory of learning



(Wenger, 1998, p 23)

To explore the meaning and implication of these aspects of learning more fully it is important to explore the basic concepts which underpin the theory of situated learning. Lave and Wenger (1991) propose two concepts which are crucial to the understanding of situated learning. The first, called "community of practice" (COP) describes the functioning environment in which the learner labeled a "newcomer" becomes involved in the activities of the existing practitioners or "old-timers". The second, labeled "legitimate peripheral participation" (LPP), has to do with the nature of the participation of the newcomer in such a COP.

Understanding community of practice

A community of practice is seen as "a set of relations among persons, activity, and world, over time and in relation with other tangential and overlapping communities of practice" (Lave and Wenger 1991, p.98). Once newcomers (apprentices) enter a COP they gradually build up an idea of what a COP is like in terms of who is involved, what they do and how it is done. In particular they observe how masters operate, how non-participants interact with the community and what a learner needs to learn to become a full practitioner. Regarding role models there is "an increasing understanding of how, when, and about what old-timers collaborate, collude, and collide, and what they enjoy, dislike, respect, and admire" (p.95).

Sustained engagement in a COP has several outcomes such as discernable changes in forms of participation, identity and membership. As a result in place of the traditional teacher/learner dyad with which we are familiar, Lave and Wenger identify a range of actors, roles and forms of participation. It is also important to recognise that learning involves “*the construction of identities*”, that “*learning is not merely a condition for membership, but is itself an evolving form of membership*” (p.53) and that “*identity or membership is strongly tied to a conception of motivation*” (p.122).

With regard to talking in a COP, Lave and Wenger distinguish between *talking about* and *talking within* a practice. They note that learning to become a legitimate participant in a community involves “*learning how to talk (and be silent) in the manner of full participants*”. The purpose for newcomers therefore “*is not to learn from talk as a substitute for legitimate peripheral participation; it is to learn to talk as a key to legitimate peripheral participation*” (p.109). Another form of talking, relevant within a COP, is the telling of stories. It was found that stories play an important role in decision making as it became evident that “*apprenticeship learning is supported by conversations and stories about problematic and especially difficult cases*” (p.108).

Established communities of practice have histories and development cycles and reproduce themselves. Given this reality the authors remind us that “*communities of practice are engaged in the generative process of producing their own future.*” (p.57). In a COP the transformation of newcomers into old-timers is a known and generally accepted part of practice. In various contexts (including obstetric practice) this process is complicated by hierarchies and interdisciplinary rivalries. The process of reproduction is complicated further when the clinical practice of ‘masters’ or ‘young masters’ is substandard and their role modelling of professional behaviour poor.

Where there is an exchange of labour for opportunities to become part of mature practice problems can also arise. “*The commoditization of labour can transform apprentices into a cheap source of unskilled labour, put to work in ways that deny them access to activities in the arenas of mature practice.*” (p.76). In the context of this study the use of students to monitor patients or assist in operations, although legitimate, can at times assume proportions where such activities preclude involvement in other more appropriate learning activities.

Understanding legitimate peripheral participation

Legitimate peripheral participation (LPP) is seen as “*a way to speak about the relations between newcomers and old-timers, and about activities, identities, artefacts, and communities of knowledge and practice*” (1991, p.29). It should be seen as an analytical

viewpoint on learning or a way of understanding learning rather than an educational form or teaching strategy. Learning through LPP is not dependent on any particular educational form or an intention to teach.

The notion of peripherality addresses the issue of the placement or location of an individual within the social world which is entered as a newcomer and hints at various forms / levels of involvement in the areas of participation as defined by a community. Entry into a COP via legitimate peripherality allows the newcomer to be more than an observer. Through participation the newcomer has the opportunity of both absorbing and being absorbed in the “*culture of practice*” (p.95). An extended period of exposure under these conditions “*provides learners with the opportunity of making the culture of practice theirs*” (p.95). Lave and Wenger chose to call that to which peripheral participation leads *full* rather than *central* or *complete participation* (p.36). “Full” better conveys the diversity of relations involved in the varying forms of community membership.

The fact that there is a need to ‘legitimize’ participation suggests that participation may be regarded otherwise by some. Such a view may be rooted in social structures, hierarchies and relations of power. Peripherality therefore has the potential for being both empowering and disempowering. It is empowering in the sense that it secures a safe entry into practice for the newcomer with legitimacy conferring recognition on the learner as a future member of the community. There are instances when it may be appropriate to withhold full participation and disempowerment’ may be seen to be in the interests of society at large (for example if competence has not yet been achieved). At other times it may have more negative connotations and newcomers are kept in a state of peripherality so that progress into fuller membership is hindered.

The inevitable changing of locations and shifting perspectives inherent in such a process is reflected in “*learning trajectories, developing identities, and altering forms of membership*” (p.36). The notion of a trajectory is a useful term in the sense that it links where the student comes from to where he/she is going and captures the essence of the newcomer-becoming-old timer process. It is also a way of locating present experience in the context of one’s origin (the past) and intentions and expectations (the future). Wenger (1998) describes a number of trajectories: an *inbound trajectory* describes the learner destined to become a full member; *peripheral trajectories* describe participation that will not necessarily lead to full membership; *boundary trajectories* describe participation where membership is maintained across boundaries of different communities of practice. This dynamic or progressive framework for describing learning is helpful when tracking shifts in students’ perspectives or experiences. It also provides a useful link to other views on the learning process with a dynamic or change

perspective. Reay (1995) reminds us of Kolb's learning cycle (sometimes portrayed as a spiral) which includes experience, reflecting, theorizing and experimentation. Flyvbjerg (2001) draws attention to the Dreyfus model of learning which describes a novice moving through stages of being an advanced beginner to a competent and then proficient performer and finally becoming an expert. Whilst these alternative views address issues relating to learning and competence they do not address issues of identity and membership in the same way as situated learning.

Implications for teaching and learning

There are a number of challenges and possibilities implicit in the changes that flow from such a new understanding of learning. The changes involve looking at who students learn from and where and how they learn. Looking beyond the customary teacher/learner dyad has a number of consequences. Firstly, the potential for peer learning becomes evident. Lave and Wenger note that such an exchange of knowledge is rapid and effective. Secondly, the locus of mastery shifts from the master to the COP of which the master is part. Thirdly, the focus of analysis moves away from teaching to the creation of a learning environment. In the process the learner takes much greater responsibility for learning.

The continuity-displacement contradiction

There is a tension created by the fact that newcomers become old timers and then masters and as such have to redefine their role in the community. Lave and Wenger (1991, p.114) refer to this as the "*continuity-displacement contradiction*" and explain that there is a major contradiction between "*legitimate peripheral participation as a means of achieving continuity over generations for the community of practice*", and "*the displacement inherent in that same process as full participants are replaced (directly or indirectly) by newcomers-become-old-timers*".

The ways in which newcomers and old-timers establish and maintain their identities are discordant. Out of that comes competing viewpoints on the practice and its development. Newcomers are often caught in a dilemma and faced with difficult choices particularly when peripheral participation places them in a disempowered situation. This is compounded when there are added tensions due to the presence of hierarchies which exist such as those within and between professions such as the nursing and medical professions as well as between teachers and learners.

Other perspectives on situated learning

When viewed in the context of learning as part of social theory, situated learning is only one aspect of the larger academic focus on learning. However it should be noted that in practice the principles of situated learning are being applied in a variety of fields such as computer based education (Herrington & Oliver, 1995) and management and organizational learning (Contu & Wilmot, 2003). Although these applications have specific characteristics there are generic issues, some of which are discussed below.

Brown and Duguid (1991) note that conventional learning theory at one time favoured abstract knowledge over actual practice. This resulted in a separation of learning from working and learners from the workers. Based on the work of Lave and Wenger they argued that a concept of "*learning-in-working*" best describes what they called "*the fluid evolution of learning through practice*" (p.41). Lee and Roth (2003) in the context of graduate education describe how increasing participation, as part of the LPP process, leads to transformation, not only of the learner, but also of the community of practice of which he/she is becoming a member. Fox (2000) reminds us that organizations or institutions do not always represent a large single homogenous community of practice but rather several communities of practice. Within a COP he highlights the change from the dyadic teacher / learner relationships to more complex triadic group relations between 'masters' or 'old-timers', 'young masters' and 'apprentices' as identified by Lave and Wenger (1991).

Critiques of Situated Learning

The theory of situated learning has been critiqued on a number of issues. Gourlay (2003) argues that 'practice' is used in ambiguous and contradictory ways and furthermore, that in the context of organizational studies, it is difficult to distinguish communities of practice from informal workplace groups. Fox (2000) argues that COP theory has weaknesses in the way it addresses power in the analysis of the learning process. Contu and Wilmot (2003) take this point further noting that the use of words by Lave and Wenger such as 'hegemony', 'alienation' and 'historical realization' gives the initial description of their theory a Marxist tone. They draw attention to a commitment to examine power issues; "...*unequal relations of power must be included more systematically in our analysis*" (Lave & Wenger, 1991, p.42). They note that Lave and Wenger conceptualize "*legitimate peripherality*" as "*a complex notion implicated in social structures involving relations of power*" and that legitimate peripherality "*can be a source of power or powerlessness, in affording or preventing articulation and interchange among communities of practice*" (Lave & Wenger, 1991, p.36). They argue that this is never really followed through and that the viewpoint is lost as Lave and Wenger move from expounding their theory to providing an analysis of practical

examples of apprenticeship. They argue further that Lave and Wenger's conceptualization of power relations in learning is limited by "*an underdeveloped appreciation of how social practices are embedded in history and language*" (Contu & Wilmot, 2003). They contend that in the application of the theory of situated learning, managerial preoccupations with harnessing 'communities of practice' to achieve group objectives have displaced a fuller appreciation of power relations as first hinted at by Lave and Wenger.

In the context of this study, which specifically requires a critical focus, reference is made to 'critical reflection' and 'critical discourse analysis' as a means of regaining and maintaining a critical perspective and thereby a means to examine issues of power. It should be noted that the term critical is being used here as in critical theory or "*a philosophical approach to culture, and especially to literature, that seeks to confront the social, historical and ideological forces and structures which produce and constrain it*" (Pearsal, 2001). This will be spelt out more specifically below under the respective headings.

Reflection, reflective writing and reflective practitioners

Making sense of what the students expressed in their reflective commentaries and later in the focus group situation requires some understanding of reflection as **a process** and reflective writing and being a reflective practitioner as **products** of such reflection.

Reflection – the process

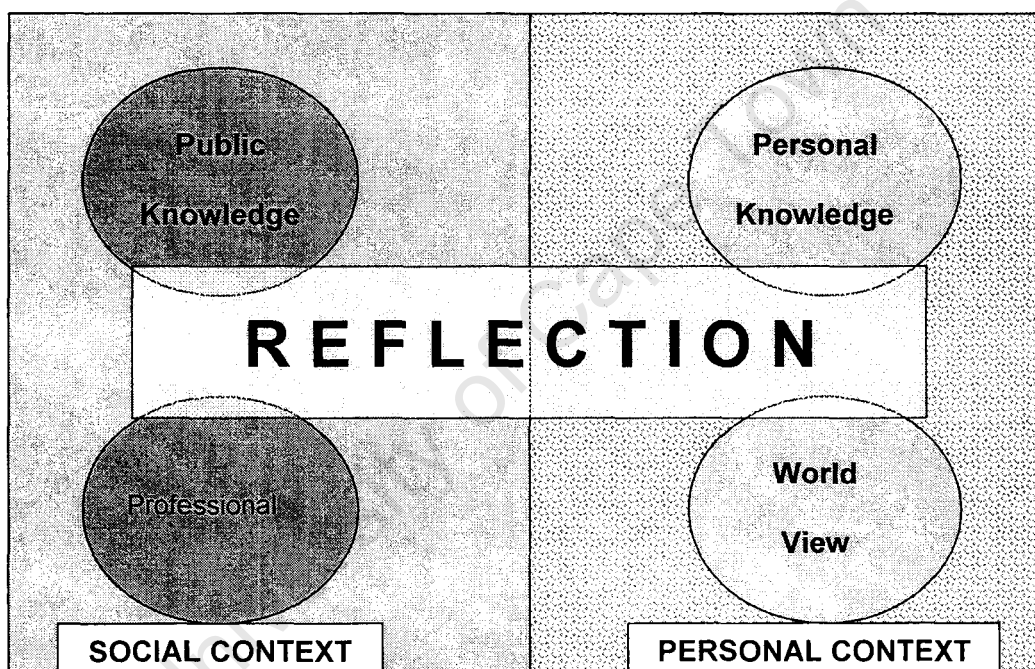
Boud, Keogh and Walker (1985, p.19) define reflection, in the context of learning, as "*a generic term for those intellectual and affective activities in which individuals engage to explore their experiences in order to lead to new understandings and appreciations*". Boud, Cohen and Walker (1993) explore further the notion of reflection as a way of turning experience into learning while Criticos (1993) maintains that experience not examined and reflected on has no educative value. The positive role that reflection can play in enhancing learning and professional practice is increasingly recognised (Butler, 1996 and Maudsley & Strivens, 2000). Mamede & Schmidt (2004) outline how the link between reflection and learning is rooted in the work of Dewey, with his concept of 'reflective thought' and Schön, who proposed the idea of 'reflective practice'. Reay (1994), quoting the work of Kolb (1984), describes how reflection is one of four key stages in the learning cycle.

As to the need for a reflective approach, Pee et al (2000, p.755) note that while traditional medical education focused on "*the assimilation of vast amounts of knowledge and on clinical apprenticeships*" the student today needs to be a lifelong learner. Modern education must

foster deep learning and produce students who are self directed learners and for that a reflective approach is required.

Butler (1996, p.269) notes that reflection links everyday thinking and doing, more specifically “*reflection is guided by action and action is guided by reflection*”. The linking of theory and practice takes place within two contexts i.e. the self and the social. He captures the linking of the social and the personal in his model of human action (see Figure 2). It depicts the outer social world and the inner world of self as separate contexts and shows how reflection overlaps, links and brings the two together and in so doing, harmonizing personal and social or professional development. He goes on to describe different modalities of reflection namely

Figure 2. Components of the model of human action



(Butler, 1996)

reflection to, reflection in and reflection on action. Put differently it is possible to think about what we are going to do before we do it, what we are doing as we do it and what we have done after we have done it. When reflection, as outlined above, becomes an integral part of what we do i.e. it is part of our practice, it begins to define who we are (i.e. reflective practitioners). The three modes of reflection provide useful links to the other theoretical frameworks. Firstly the three points fit in with the notion of a learning trajectory and secondly, they resonate with the before, during and after nature of narrative which, as we shall see, is the dominant form of writing adopted by the students in their commentaries

Reflective practice / practitioners

Barnett (1992) maintains that all professionals, irrespective of how theoretical a course or 'pure' a knowledge field may be, need to be reflective practitioners. The ability to reflect critically on knowledge, action and values is seen as key to professional development. Mamede and Schmidt (2004) note that bodies such as the General Medical Council (UK) and the American Board of Internal Medicine see the ability to reflect on practice as a key requirement for doctors. This raises the question as to whether educational interventions can promote reflective practice among doctors. Coming from varying perspectives such capability has been described as Mindful Practice (Epstein, 1999) and Narrative Competence (Charon, 2001a). The former involves mindfulness which is "*a quality of the physician as a person, without boundaries between technical, cognitive, emotional and spiritual aspects of practice*" (p.835). The latter is a competence that develops from being a reflective practitioner and has been described by Charon (2001a) as "*the ability to acknowledge, absorb, interpret, and act on the stories and plights of others*" (p.1897). Charon suggests further that reflective writing explores four central narrative situations: physician and patient, physician and self, physician and colleagues, and physician and society. Elsewhere Charon (2001b) expresses the view that narrative writing "*confers on medical practice a kind of understanding that is otherwise unobtainable*" (p.83). Others highlight the importance of teachers being role models as reflective practitioners in their teaching (Laughran, 1996) and clinical practice (Branch and Paranjape, 2002).

Much of what has been said relates more to a desired end point or finished product such as the professional in practice. What of the health professional in the making? It is a question that relates directly to the students of this study.

The product of student reflection

Charon (2001b) notes that, "*when becoming physicians, young medical students undergo dramatic personal transformations, often in a relatively short time...*" (p.84) and that there is a need to express that. She sees writing as an important way of doing that. Reflective commentaries are often written in a narrative format or story form which according to Gergen (1994) "*we use to identify ourselves to others and to ourselves*" (p.247). Reflective writing therefore presents us with a new way of 'knowing' and appreciating what is happening in the lives of students at a very personal level.

A number of studies report on reflection in the context of the early introduction of students to clinical practice. Niemi (1997), investigating the reflections of medical students on early

patient contact in the preclinical years, found that many students had yet to form a sense of professional identity and that professional considerations were still very tentative. Woodman et al (2002) reporting on their experience with dental students found that although they focused on negative experiences and problem situations it was clear that students were aware of their developing professional identity. Ker (2003) reports on the use of reflection in the context of teaching intimate examination by combining a reflective approach with simulation to bridge the gap between theory and practice. Sobral (2000) investigated medical students' reflection in learning at the start of clinical apprenticeship and found that higher levels of reflection indicated deep approaches to learning which was associated with a more positive learning experience.

A number of studies report on students reflecting on critical incidents. Lichstein and Young (1996) in their analysis found a high frequency of nonbiomedical themes. One of their conclusions was that reflective exercises provide "*a window into the experience of students*" (p.406). In another, Hendersohn et al (2002) report on difficulties experienced by students while they were analysing key events. There were a number of unforeseen emotional reactions called "*conflicts*" by the reviewers. These conflicts were "*always seated within the student*" (p.121) and the source of the conflicts was divided into factors that were "*internal*" i.e. personal issues related to emotions, personality or being a medical student and "*external*" i.e. issues pertaining to the student / teacher relationship or faculty issues. In their study, Baernstein and Fryer-Edwards (2003) found that prior reflective writing did not contribute significantly to the quality or quantity of reflection in subsequent one-on-one interviews.

Newton (2004) describes the introduction of reflective practice into a nursing undergraduate programme as a journey "*with potholes in the road, hills to climb and needed breaks*" (p.155)! However what it did was to enable some students to access prior learning and experience. Thorpe (2004) reports on the use of reflective learning journals. Based on this experience students are categorised as *non-reflectors* (there is no evidence of having thought about their practice), *reflectors* (i.e. students demonstrate a process of analysis and evaluation), and *critical reflectors* (students indicate a change in perspective).

Assessing the value of reflective writing has many facets. Toohey (1999), writing about academic assessment in general, lists the need for evidence of a student's progress in self-reflective and critical knowledge i.e. that a student has engaged in a process of self-examination. Reflective essays and journals are mentioned in this regard. Such items have begun to form part of portfolio assessments (Challis, 2001).

Regarding the reflective writing being considered in this study then the comment above about a reflective exercise being a 'window' into the experience of students is most apt, with a study focusing on what can be learnt more appropriate than what can be proved. Before proceeding to consider methodology in this regard it is necessary to find some framework within which to consider the reflective writing. For that we turn to the work of Hatton and Smith which is detailed below.

Evidence of reflection

Hatton and Smith (1995) asked what seems to be an obvious and very basic question related to assessment of reflection, namely what constitutes evidence of reflection. In their search for an answer they identified four types of student writing. They called these *descriptive writing*, *descriptive reflection*, *dialogic reflection* and *critical reflection* and a detailed description of each category is provided in the methodology chapter. Only the last three are characterised as different kinds of reflection. Critical reflection is the most relevant as it takes account of the socio-political context in which events take place and decisions are made (roles, relationships, responsibilities, gender, ethnicity, etc). It is these very issues which are key to a situated learning environment and emerge as themes in the writings of the students in the current study. This classification of student writing has been used in other studies looking at student writing (Pee et al, 2002) and is one aspect that is considered in the analysis of the commentaries in this study.

How does reflection relate to other theories?

Reflection is not a key element of Lave and Wenger's description of situated learning. However it is crucial to other perspectives on situated cognition. A practical expression of the 'learning-in-working' concept proposed by Brown and Duguid (1991) is service learning (Hatcher & Bringle 1997). The importance of bridging the gap between service and learning is noted and reflection is seen as a key element of that process. Hatcher and Bringle note that if students do not think seriously about their service, their experience may "*support presuppositions, reinforce stereotypes, and fail to critically guide future action*" (p.153).

Usher (1993) stresses the importance of writing in the context of experiential learning, "*one either writes or is written of(f)*", (p.174). Out of that process a text is produced. Of that text he says: "*A written text is ...constructed and, through its particular mode of construction, a 'world' is created. Experiential learning, through its implication in writing, creates a world to be discovered*". How the 'world', written about by the students in this study, is discovered and explored, is explained in the next section on discourse analysis.

Critical Discourse Analysis

If we are to understand the 'world' described above we need to look not only at the text but also the context in which the text is produced. To appreciate language in its social context Gee (1990) argues that we should not focus on language but on what he calls 'Discourses'. He defines Discourse as being "a saying (writing) – doing – being – valuing – believing combination" (p.142). Elsewhere he says, "There is no such thing as 'reading or writing', only reading or writing something ... in a certain way with certain values, while at least appearing to think in certain ways" (1990, p.xviii). It is a notion that provides a useful framework for understanding the link between doing and writing or vice versa. In this instance the text is the reflective writing of students. In the discussion which follows key elements of the context and therefore factors to be considered both in the process of production and interpretation are highlighted. For the student as 'reader', there is a process of discovery of what people do, how they do it, why they do it and what they believe in their doing. For the student as 'writer' there is a revelation of who they are and where they come from and what is happening to them. This process is dynamic and continuous as

we continually and actively build and rebuild our worlds not just through language, but through language used in tandem with actions, interactions, non-linguistics, symbol systems, objects, tools, technologies, and distinctive ways of thinking, valuing, feeling and believing (Gee, 2001, p. 11).

Gee's concept of primary discourse (what we grow up with) and secondary discourse (what we pick up later at school, university etc) and the notion of acquisition (what is acquired subconsciously) vs. learning (conscious knowledge gained through teaching) add dimensions that are helpful in understanding the process of change that the student undergoes (Gee, 1990). Gee's notion of being apprenticed (Gee, 1990) aptly describes the situation of a student entering the discipline, acquiring the rudiments of knowledge, skills and behaviour and becoming a part of a living, working situation in order to master the discipline and in the process acquiring the Discourse. This understanding of apprenticeship resonates with that of Lave and Wenger's theory of situated learning.

It is important to locate the above within the writings of others. The link between what is written and what is experienced is recognised. Kress (1989) notes, "The discursive history of each individual [therefore] bears the traces of the discourse associated with the social places which that individual has occupied and experienced" (p.8). With regard to issues being dealt with, what is written can reveal what is changing in the life of the writer. He adds,

Texts are therefore the sites of struggle, always, and in being the sites of struggle, texts are the sites of linguistic and cultural change. Individuals, as agents and constructed in discourse, are the bearers and the agents of that struggle (Kress, 1989, p.27).

Reflective writing belongs to a personal narrative genre. The personal and intimate nature of such writing and the experiences that inform it need to be recognised, understood and respected. *“Thus as we urge our students to speak or write, and as we listen or read, we need also to consider what discourses are constructing those moments of speaking and understanding”* (Pennycook, 1993, p.132). The complex interaction between individual and society and the role of language in articulating and shaping those links is described by Jaworski and Coupland: *“Discourse is language use relative to social, political and cultural formations – it is language reflecting social order but also language shaping social order, and shaping individual’s interaction with society”,* (1999, p.3). They emphasize that discourse is a key concept for understanding society, responses to it and even language itself.

On the constructive effects of discourse Fairclough (1992) notes that discourse contributes to the construction of social identities, social relationships between people and systems of knowledge and belief. In his view discourse analysis provides a method for investigating social changes. His three-dimensional view of discourse as being a piece of text, an instance of discursive practice and an instance of social practice provides a useful framework. Critical discourse analysis involves a combination of micro (textual) and macro (social) analysis. It is in the area of macro analysis that differences become more apparent and divergence is evident. As a result interpretations are more hotly contested. For the macro analysis contemporary social, political and cultural theories come into play (Luke, 2002, p. 4).

Are there important criticisms of the Fairclough approach? Pennycook (1993) takes issue with the explanation that Fairclough and others working in critical discourse analysis give for the inequalities that mark social relations. Their neo-Marxist perspective in his view creates too rigid a framework that leaves little room for individuals to make a difference. He argues for a truer adherence to a Foucauldian approach where power is seen in personal rather than institutional terms. On the other hand, Fairclough, although he acknowledges the value and influence of Foucault, expresses the view that Foucault does not go far enough in addressing inequalities and other social issues. Widdowson (1998) argues that if the producers of text are not consulted their intentions have to be inferred from the text, something which will be influenced by the position of the analyst and in his view a source of prejudice. Jaworski and Coupland (1999) note that at times there will be difficulty justifying the choice of material used as research data. However despite some of the difficulties mentioned they see that there is a *“fundamental positive in discourse”* which they see as the *“possibility of a greater clarity of vision, specifically of how language permeates human affairs, offering us opportunities but also constraints* (Jaworski and Coupland 1999, p.37).

Quite apart from the factors which are important in the analysis of language there are also factors which influence the production of language or text. One such factor is the place of ritual firstly as it relates to childbirth as a social practice and secondly to the initiation of students into obstetric practice.

Ritual and rites of passage

In a foreword to the book written by Lave and Wenger (1991), Hanks describes learning as follows: "*Learning is a way of being in the social world, not a way of coming to know about it. Learners... are engaged both in the contexts of their learning and in the broader social world within which these contexts are produced*" (Lave and Wenger, 1991, p.24).

Each of these contexts (learning and the broader social world) involves a social practice (becoming a doctor and having a baby). Whilst what is happening to the student in training is the focal point of this study, it is important to remain cognisant of childbirth, as a key event in the student's experience and a specific social practice. It is important, if we are to adequately understand what is happening in the life of the student and be true to the '*societally significant practice*' described by Chaiklin (1996, p.386) which views practice from a social, societal and/or historical perspective. Such a broad perspective might in fact be best gained by looking at the transitions mentioned through the lens of ritual theory.

Before exploring this topic further it is advisable to clarify the terminology used. Key terms often used, and at times misused, are routine, ritual(s) and rites of passage. A **routine** is a sequence of actions regularly followed. A **ritual** is that and more i.e. it is "*a patterned, repetitive, and symbolic enactment of a cultural belief or value; its primary purpose is alignment of the belief system of the individual with that of society*" (Davis-Floyd, 1994, p.324). The term 'ritual' is at times used in a pejorative sense to describe "*unthinking, routinized action...which lacks any empirical foundation*" (Philpin, 2002, p.144). Martin uses "*ritual action*" (1998, p.189) as an alternative to describe such behaviour and represents one way to prevent losing the wider symbolic meaning of the word ritual. A **rite of passage** is "*a series of rituals that move individuals from one social state or status to another, for example from girlhood to womanhood*". The purpose of a rite of passage is to "*transform both society's perception of individuals and individuals' perceptions of themselves*" (Davis-Floyd, 1994, p.324).

Machin and Scamell (1997) draw on the pioneering work of van Gennep to describe the behaviour that surrounds childbirth as a 'rite of passage' with women making "*a journey during labour and childbirth from pregnancy to motherhood and the fetus a journey to becoming an independent being*" (p.81). They remind us of the three crucial stages of a rite

of passage viz. separation, transition and re-integration. In Western society changes in rites of passage related to childbirth are evident. According to Seel (1986) these rites of passage are incomplete, a change which he maintains is implicated in the development of postnatal depression. Draper (2003) traces the historical development of transition or ritual theory and suggests that rather than a loss of ritual there has been an exchange of one set for another. The notion of a new set of rituals is taken to a completely different level in the context of what has transpired and is ongoing in some highly medicalised contexts such as North America. Davis-Floyd (2001) argues that the rituals that went with a more holistic view of birth have been replaced by a hospital based series of rituals that come from a technocratic view of childbirth.

What of the medical student who enters this arena and is undergoing a transition of his or her own? In a recent study investigating the development of professional identity Apker and Egly (2004) raised the issue of rituals forming part of this process. They conclude that the clinical activity which they studied was a ritual that was *"emblematic of the larger medical culture"* and that *"its ritualized discursive practices produce, maintain, and reproduce traditional medical ideology and perpetuate a professional identity embedded in the underlying power relations of medical care"* (p.417). They note that in the process technical medicine is privileged and biopsychosocial approaches to care marginalized.

In a review of curriculum reform Hafferty (1998) refers to the notion of a multidimensional learning environment that includes at least three inter-related spheres of influences i.e. the formal curriculum, the informal curriculum and the 'hidden curriculum'. The last, by its very nature, is not addressed in reform processes but as noted by Hafferty *"a great deal of what is taught – and most of what is learned – in medical school takes place not within formal course offerings but within medicine's 'hidden curriculum'"* (p.403). Just what is the hidden curriculum? In a study set up to investigate its influence in an undergraduate curriculum, Lempp and Seale (2004) build on Hafferty's description and define it as: *"The set of influences that function at the level of organisational structure and culture including, for example, implicit rules to survive the institution such as customs, rituals, and taken for granted aspects"* (p.770). In the process of identifying what students say about their entry into the obstetric COP it is important to identify influences such as a 'hidden curriculum' particularly as one of the specific research questions looks at the implications of what the students have to say on training and induction into a COP. As research tools both reflective writing and the focus group interview can be expected to yield insights into such influences.

If a rite of passage is a series of rituals that moves individuals from one social state or status to another then it would seem fairly clear that in places in the real world students experience at least a series of rituals if not a rite of passage. Certainly in the context of this current study at least one student (Hazel) described it as such: A recurring comment from students, *"It was the first time I felt like a doctor"* speaks clearly of an individual entering as one person and leaving as another. If the reality for the students is a rite of passage then this thesis is looking at students in the transition or liminal phase. It is a perspective that clearly complements the chosen theoretical framework of situated learning and in fact is simply a different way of talking about 'peripheral' participation becoming 'full'. This additional perspective could provide nuances in the interpretation that would be crucial to a fuller understanding.

Conclusion

Situated learning is the broad theoretical framework used here to describe and analyse the learning environment of the obstetrics component of the fourth-year MBChB programme. This chapter has described how this needs to be informed by a number of sometimes related but always relevant other theories. How this was applied practically in the methodology of the study is described in the next chapter.

Chapter 3

Methodology

"This is the real world"

(Roger)

Introduction

Research in the 'real world' or "*Real World Research*" as labelled by Robson (1993), involves "*seeking to say something sensible about a complex, relatively poorly controlled and generally 'messy' situation*" (p.3). Roger, the student quoted above, in summing up his experience describes a perspective on the "*real world*" that includes service, relationships, expectations, emotions and experiences. How does one research that? As indicated in the introductory chapter a qualitative approach has been adopted in this study and this chapter discusses the relevant methodology in more detail. Before proceeding to do so, it is necessary to locate the discussion within the situated learning / community of practice theoretical framework and to indicate why a qualitative approach and more specifically a case study strategy was adopted.

There are links between the terms and phrases such as 'situated' and 'community of practice' as defined earlier and 'real world' or 'natural context', as used in this chapter in that they describe the same phenomenon. Each frame of reference focuses on the same people, the same practice, and the same context but views them through a different pair of "*analyst's reading glasses*" (Malterud, 2001a) and then uses its own conceptual terminology to describe what it sees. There is no conflict, but rather a need to be open-minded, flexible and to view things holistically through a pair of 'multifocal' glasses, to expand Malterud's analogy.

Just what is a qualitative approach? Malterud (2001b) explains that a qualitative approach allows for "*the exploration of meanings of social phenomena as experienced by individuals themselves, in their natural context*" and that such an approach involves "*the systematic collection, organisation, and interpretation of textual material derived from talk, writing or observation*", (p.397). Some authors define qualitative inquiry by comparing it to quantitative inquiry. Cresswell (1998) notes that the key difference between the two traditions is simply that quantitative research involves few variables and many cases whereas qualitative research relies on a few cases and many variables. Flyvbjerg (2006) sees as spurious the sharp separation sometimes referred to between qualitative and quantitative methods. In his

view, "Good social science is problem-driven and not methodologically driven in the sense that it employs those methods that for a given problematic best help answer the research questions at hand" (p. 432). Flick et al (2004) point out that a research report amounts to a reconstruction of someone else's social construction of reality. The provision of a 'thick' description by the researcher allows others to assess the validity of the researcher's reconstructions and contributes to transferability or generalizability i.e. it allows readers to make judgments about whether the findings will fit other settings (Robson, 1993 and Johnson, 1997). The concept of 'thick' descriptions was brought to the fore by Geertz (1973), and according to Nunan (1992) the "*principle of 'thick' explanation*" (p.58) relates to the taking into account of and reporting on all the factors which may influence the phenomenon under investigation. Flick et al (2004) argue that such investigations provide knowledge "*about views on such themes as health, education, politics, social relationships; responsibility, destiny, guilt; or about life-plans, inner experiences and feelings*" (p.7). Clearly such an approach is needed to explore the context embraced by this study.

Case Study Strategy

Robson (1993) takes the qualitative approach a step further and argues that the 'real world' nature of the context being studied calls for a specific strategy concentrating on 'cases'. He defines such a case study strategy as one "*which involves an empirical investigation of a contemporary phenomenon within its real life context using multiple sources of evidence*" (p.5). Yin (1984) says that when 'how' or 'why' questions are being asked then case studies are the preferred strategy. In his review of a case study approach, Nunan (1992, p.75) speaks of a case study as the study of an "*instance in action*" and the notion of a "*bounded system*" which Cresswell (1998) describes as bounded by time and place. On the issue of boundaries Cresswell notes that these are not always "*clean*" and that at times a researcher may need to work with "*contrived boundaries*" (1998, p.64).

Referring to the work of Adelman et al (1976), Nunan (1992) suggests that there are several advantages to adopting the case study as a research strategy. The fact that it is based on real life situations should make it easier for people in practice to identify with the issues and concerns raised. Several viewpoints can be presented thereby providing support for alternative interpretations. Well conducted case study research can provide a database for use by subsequent researchers. Insights provided by such research can be used quite readily for feedback, staff development, evaluation and policy-making. Lastly, case study data are presented in a format that is usually more accessible than conventional scientific research reports. Being available to multiple audiences contributes to a democratisation of knowledge and decision making. Flyvbjerg (2001) suggests that the closeness of the case

study to real-life situations and its wealth of details are important for researchers in two respects. Firstly, it is important for a nuanced view of reality. Secondly, cases are important for the researchers own learning process in developing the skills needed to do good research.

It is important not to confuse the use of 'case' or 'case study' in a research context with their use as medical or legal terms. In the context of qualitative research "*the case is the situation, individual, group, organization or whatever it is we are interested in*" (Robson, 1993, p.51). Here our interest is the 159 students in the fourth year obstetric class of 2002 which later became the final year group of 2004. Our particular focus is on the group who described their entry into an obstetric COP. In this situation what is the 'case' - the whole class, the responders or a few selected individuals?

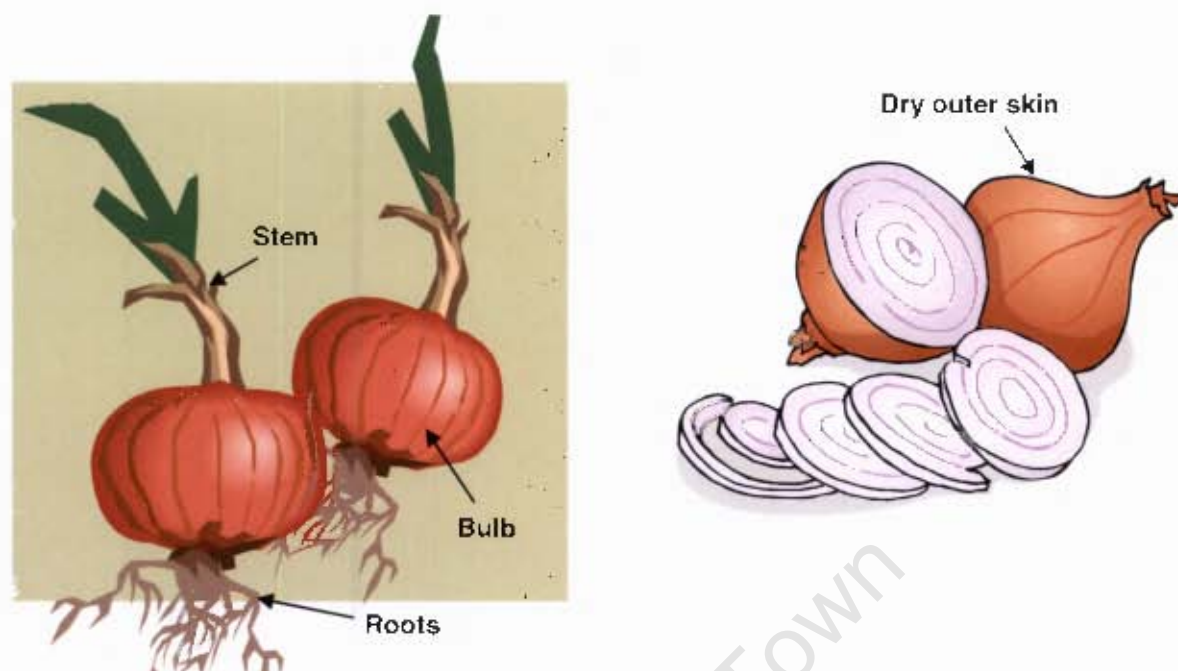
In his discussion on a case study strategy Stake (1998) refers to an "*instrumental case study*" (p.88) which he describes as a particular case being studied with a view to providing insight into a specific issue. He goes on to describe how a number of cases may be studied jointly not as a study of a collective but as an instrumental study extended to several cases. Such an approach is followed based on the notion that understanding the individual cases leads to a better understanding about an even larger group. He calls this "*collective case study*" (p.89). Robson (1993) also describes how a case study can be the study of a single instance or evolve into a study of multiple instances. The former is labelled individual case study and focuses on one person. The latter is called a set of individual case studies. The study being reported here looks at the phenomenon of how students enter a community of practice using a case study strategy involving a set of five individual cases.

Based on the strategy outlined above this chapter must provide a description of how a handful of students were chosen from a class of one-fifty-nine to be subjects in the study, and how their written and spoken reflections were gathered and analysed. I would like to use an everyday metaphor of peeling an onion to describe the process followed.

An onion metaphor

If one were to do research focussing on the onion and the human sense of taste, then a natural science approach would reveal which elements and compounds are present and that a sulphur containing volatile oil is responsible for the characteristic pungency of the onion. This bit of information, though true, will reveal nothing about what an onion actually tastes like. To experience the taste, a 'real world' or qualitative approach would be required, such as going into a kitchen to prepare a dish that includes onion in some form or other.

Figure 3 Peeling an onion



In figure 3 I have chosen a picture of a complete onion to show that 'an onion' includes parts which are not used for eating, and another of a sliced onion to make the point that you only have to eat one slice or even a single ring to know what a whole onion tastes like. The process involves a series of steps: choosing an onion, trimming off the unusable bits, peeling off the dry skin, slicing the onion, selecting a slice and tasting the onion.

Starting with the whole class, a process analogous of the choosing, trimming, peeling, slicing and selecting was undertaken to arrive at the group of five students whose reflections became the final data set for the study. The process is outlined below.

Responders vs. non-responders (or 'choosing' and 'trimming')

The fourth year obstetric class of 2002 was chosen as the initial focus of the research. The whole class had been presented with an optional task of writing a reflective commentary based on their early delivery experiences (see Appendix A). The group who responded and submitted a commentary are hereafter referred to as the 'responders'. The remainder i.e. the 'non-responders' were trimmed and were no longer considered part of the potential study group except for comparative purposes. A brief overview of the differences between these two groups using a quantitative approach is provided below with a more detailed analysis provided in Appendix E. The intention is to provide background information that will contribute to fuller understanding of the qualitative analysis and an assessment of the

applicability of the findings of this study to other settings. A more complete description of the statistical analysis performed is also provided in Appendix E.

Of the class of 159 students the majority (62%) were female. The age distribution of the class in the fourth year of study (2002) was 21 to 32 years. The racial make-up² of the class is diverse, with a spread of white (37%), black (25%), coloured (19%) and Indian (19%)..Most students (74%) gave English as their first language. The majority of the ESL (English Second Language) group spoke one or other of the official languages with isiXhosa being the most frequent, followed by isiZulu. The matriculation scores³ of the 143 students who had South African qualifications ranged from 27 – 50 points (a student with 6 distinctions would get at least 48 points). Of the whole class only 66 (42%) responded to the request to submit a reflective commentary.

When the responders are compared to the non-responders using the abovementioned demographic details as predictor variables (characteristics about data that predict outcome or response) then it appears as if there may be differences between students who submitted commentaries and those who did not. However, statistical analysis shows a slightly different picture. The actual statistical analysis of the raw data was done in two phases. An exploratory analysis which looked at each variable independently using basic standard statistical tests showed that the two groups differed according to age and sex. A definitive analysis using logistic regression which makes it possible to explore interaction and confounding effects between variables showed that age was the only significant factor. In this study an older student was less likely to submit a commentary.

Critical reflectors vs. non-critical reflectors (peeling)

As noted earlier Hatton and Smith (1995) described four types of student reflective writing. Pee et al. (2002) used the criteria suggested by Hatton and Smith in their research and produced a useful summary of their criteria. Table 1 provides their summary in a tabular form and indicates how the types were determined in this study.

² **Racial make-up:** For the purposes of this study, 'white' refers to Caucasian or European descent, 'black' refers to indigenous African descent; 'coloured' refers to those of mixed race (in this context referred to as 'coloured'); and 'Indian' refers to those who are of Indian descent but are South African in nationality. The racial classification is used with some reluctance because of its historical apartheid connection.

³ **Matriculation score:** Rating of mathematics and physical science and 4 best other subjects based on symbols obtained and whether passed on higher or lower grade. Additional marks based on supplementary criteria.

Table 1 Types of Reflective Writing

TYPE OF WRITING	DESCRIPTION
Descriptive	This is not reflective, merely reporting events with no attempt to provide reasons. (<i>I did x; he said y</i>)
Descriptive reflection	Provides reasons (often based on personal judgment), although only in a reportive way (<i>I did x because y</i>)
Dialogic reflection	This is a form of discourse with one's self, mulling over reasons and exploring alternatives (<i>I wonder...? Perhaps...? Maybe...?</i>)
Critical reflection	Takes account of the socio-political context in which events take place and decisions are made (roles, relationships, responsibilities, gender ethnicity, etc)

Based on Pee et al. (2002, p.578)

In this study 'critical reflectors' were identified using a form of content analysis of the reflective commentaries of all the students, looking in particular for references to roles relationships, responsibilities, gender, ethnicity as noted above. At this stage the non-reflectors were 'peeled' off leaving behind those characterised as 'critical reflectors'.

Purposive selection ('slicing')

From the group of critical reflectors a group of five students were purposively selected to participate in a focus group discussion. Purposive selection is an example of non-probability sampling (Robson, 1993 and Mays and Pope, 1995) where the aim is not representivity but a participant's ability "*to generate talk that would extend our range of thinking about an issue*" (Macnaghten and Myers, 2004, p.68). Care was taken to satisfy the requirements identified by Rubin and Rubin (1995) namely that the participants should be knowledgeable about the situation or experience being studied; they should be willing to talk; and when there are different perspectives, the interviewees should represent the range of points of view. The basic principle of such selection is the researcher's judgment as to who would be typical or suitable (Robson, 1993 and Barbour, 2001). In this study a potential group of participants was initially identified and students invited to participate. The list included first and second choice candidates. Two candidates chose not to be involved for personal reasons and alternatives were selected. In order to identify this group clearly they are hereafter referred to as the focal group and collectively they form the case in the case study.

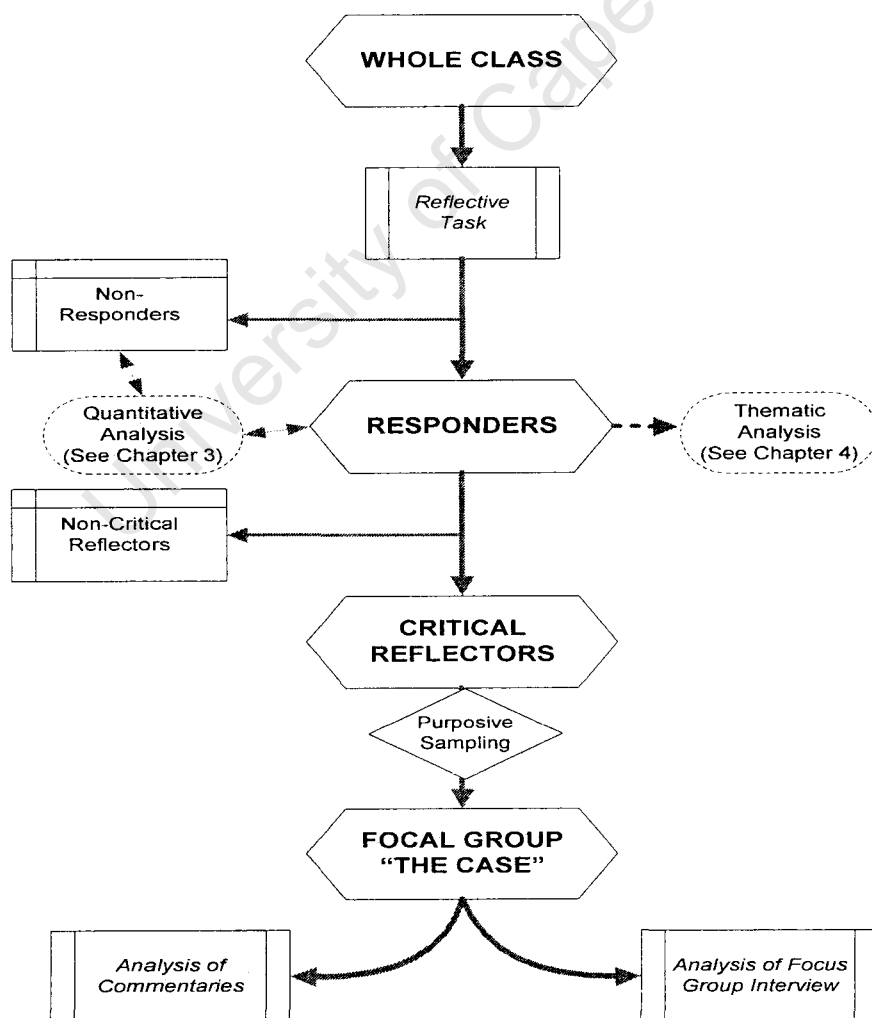
The purposive selection represents the 'slicing' in the onion metaphor. What of the taste? Both the reflective writing and the focus group⁴ interview provide a sense of 'flavour'.

⁴ Please note the use of the term 'focus group' instead of 'focal group' when it is used in the context of a focus group as a research methodology

However the focal group is important for two other reasons. It is an alternative research instrument providing evidence which is important for triangulation (see discussion on p. 33) and secondly it is a method often used to explore people's experiences of health services and the attitudes and needs of staff (Kitzinger, 1995). To explore what was said further we need to turn to discourse analysis to really appreciate the full 'flavour'.

The flowchart depicted in figure 4 provides a more formal summary of the research process. The dotted lines around the quantitative and thematic analyses are intended to indicate that these analyses were not the main focus of this study. However each provides important background information that contributes to the overall understanding of what students said and therefore brief summaries are provided in the text (quantitative analysis in this chapter and thematic analysis in the next). A more detailed account is provided in Appendix E and F respectively.

Figure 4 Flowchart of the research process explained



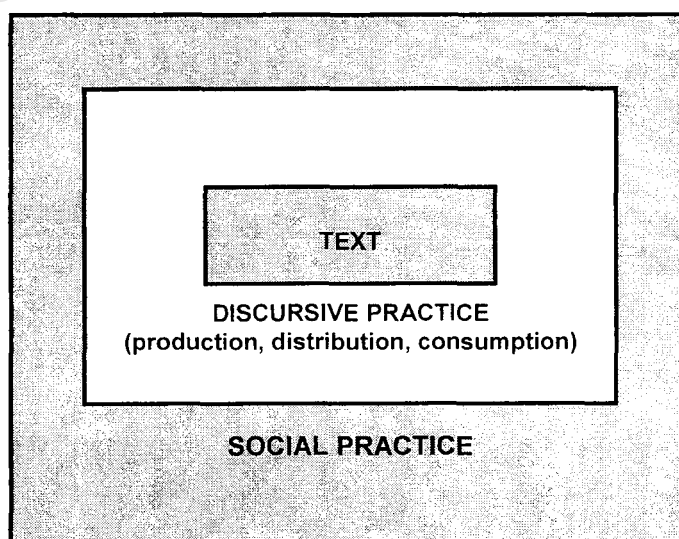
Discourse Analysis

Critical Discourse Analysis

Because Critical Discourse Analysis (CDA) is the principal method employed in this study it is appropriate to give a more detailed description of how this was done. As has been noted in the literature review there are several approaches that could be used. I have chosen the approach of Fairclough (1992, 2003) as his approach to some extent is more intuitive and his description of what to do and how to do it leaves the newcomer feeling bold enough to make a start. The approach addresses issues of power which are neglected by Lave and Wenger. His three-dimensional concept of discourse (see figure 5) and discourse analysis provides a useful framework for analysis. According to this concept any discursive 'event', such as the reflective commentaries is simultaneously "*a piece of text, an instance of discursive practice and an instance of social practice*" (Fairclough, 1992, p.72).

The 'text' element deals with the analysis of the language of the text. Fairclough (1992, p.75) organises text analysis under four headings i.e. "*vocabulary, grammar, cohesion and text structure*". The 'discursive practice' element refers to the process of how the text was produced and should be interpreted. The analysis is done under the headings of "*'force' of utterances (what sorts of speech acts), the 'coherence' of text and 'intertextuality' of texts*". The 'social practice' dimension focuses on a social analysis which looks at institutional, organizational and other broader aspects. More simply stated the 'text' dimension provides a description of what was said whereas the other two dimensions address aspects of interpretation.

Figure 5 Three-dimensional conception of discourse



'Borrowing lightly'

A full description and application of Fairclough's methodology is beyond the scope of this thesis. I have opted for an adaptation using elements of the methods for each of the three dimensions which Fairclough describes. In the analysis presented in the next chapter I have focused on the use by students of certain *words*, *metaphors*, *various forms of emphasis* (bold letters, italics etc), the use of *pronouns*, and the *placement and sequencing* of ideas and descriptions. Other aspects which Fairclough refers to include *coherence* (how the paragraphs link or are held together) and *modality* or the force with which something is expressed.

Triangulation

In the context of a qualitative study how can one be sure that the explanation or interpretation that one has come up with is valid? Mays and Pope (1995) write about "*safeguarding validity*" through triangulation i.e. by deliberately seeking evidence from a wide range of different, independent sources and often by different means. Janesick (1998) and Stacy and Spencer (2000) describe various types of triangulation, and of these, the following were used in this thesis:

1. Data triangulation: the use of a variety of data sources in a study
2. Theory triangulation: the use of several perspectives to interpret the same set of data. In this study the theories of situated learning, ritual and others have been used.
3. Methodological triangulation: the use of several methods to study one problem
4. Interdisciplinary triangulation: the use of other disciplines such as sociology and anthropology to inform the research process so as "*to broaden our understanding of method and substance*" (p.47).

Ethical considerations

My initial response to the commentaries which I received from students is reminiscent of the 'burning bush experience' which the prophet Moses had in the desert. I felt the need to stop, to remove my academic shoes and realise that I was party to something very special. Stake (1998, p.103) captures that sense in his comment: "*Qualitative researchers are guests in the private spaces of the world. Their manners should be good and their code of ethics strict*".

Before this study was even being considered I had asked students in 2002 for permission to use anonymous excerpts from the commentaries in a number of contexts (See Appendix C).

Regarding this study ethical approval was obtained from the Faculty of Health Sciences Research Ethics Committee (Reference No. 227/2004). The main ethical concerns were the maintenance of the students' anonymity, and the giving of an assurance that neither participation nor non-participation would play a role in their academic performance. These issues were addressed in the consent forms (See Appendix C) that were given to all participants in the focal group, and were reiterated verbally at the start of the focus group interview.

University of Cape Town

Chapter 4

Analysis of the Reflective Commentaries

*“One leaves the block knowing that one has learned academically,
but more importantly, that one has developed socially and emotionally”
(David)*

Introduction

The adoption of a case study strategy or more specifically the set of individual cases as described by Robson (1993) was discussed in the previous chapter. The five focal group students were purposively selected for the collective case study and their commentaries provide the data for the detailed analysis that is reported in this chapter. As a background to that analysis and in the interests of a fuller understanding of the broader context, a brief report on an original thematic analysis based on all the commentaries is presented first.

Thematic analysis

The 66 commentaries that were submitted were subjected to an analysis based on the broad principles for qualitative data analysis and more specifically content analysis as described by Robson (1993) and Malterud (1993). An iterative process was followed initially involving several readings of the commentaries for understanding and then subsequent coding and categorization. The analysis was both informal, as commentaries were being submitted during the course of the year, and formal, after all the data had been collected and consolidated with various patterns, categories and themes being identified and finalised. As this is not the prime focus of this study the report that follows is descriptive and brief. For a more detailed account including several extracts from students' commentaries the reader is referred to Appendix F.

It should be noted that the vast majority of students entering the block had not witnessed a delivery previously and only a handful reported having become mothers themselves. Against that background students' responses to childbirth could be described as those of well-informed lay persons. Much of what students wrote relates to what they saw in terms of birth as an event, the people involved (the mothers, the midwives and rarely the partner) and the impact that it had on them as students and as individuals. Some results were not altogether unexpected. What was surprising was the depth of feeling and the profound nature of the

change students experienced, very often having entered the situation naively and emotionally ill-prepared. Their willingness and ability to express what was happening to them in writing and the openness with which this was done was also unexpected. A list of the themes identified as well as the relative frequency with which they were mentioned is shown in table 2.

Table 2 Themes mentioned and relative frequency

THEMES	Number of Students (n=66) (%)
BIRTH	
○ The actual birth as an event *	53 (80)
PATIENT	
○ Pain and suffering *	52 (79)
THE ROLE OF THE MIDWIFE	
○ Midwife's role in caring for the patient *	51 (77)
PERSONAL ISSUES	
○ Own role in the management of patients *	58 (88)
○ Personal Identity	23 (35)
○ Life and death and coping with loss	18 (27)
○ Own birth or whether to have children	13 (20)
CONTEXTUAL ISSUES	
○ Awareness of HIV	4 (6)

* Indicates that it was mentioned by more than half the group

Responses to the birth as an event were varied. Some were positive, expressing wonderment whilst a similar number commented in more neutral fashion. A smaller group were negative with the remainder having a mixed response.

When focusing on the labouring patient, the reality of the pain and suffering of childbirth came as a shock to most (79%). Some were distressed by the fact that many mothers went through the experience alone. Some however were able to process the experience by bringing the labour, the birth and post-delivery situation together into an integrated whole.

Portrayals of the midwife in her role as teacher and role model varied. Almost half of those who commented saw midwives' behaviour as examples of what not to do and many indicated they would not accept difficult circumstances as a justification for poor practice. Just over half of the group found the teaching at both practical and theoretical level very valuable and commented favourably on the midwives' professionalism and tolerance towards both patients and students.

At a more personal level contemplation of their own role in the management of patients featured very strongly (88%). Most mentioned this aspect of care without making a strong value judgment. For others being actively involved made a deep impression on them. Feelings ranged from amazement at being the first human being to touch the baby, to fear and uncertainty regarding their ability to cope. Some were encouraged, even affirmed by the experience and amazed at the level of patient trust. A few chose the option of detachment.

In terms of their developing sense of professional identity many students were challenged to think about their choice of doing medicine. Some were faced with situations involving obstetric loss which was a new experience for most, requiring the acquisition of coping skills. For some life and death issues were integrated at a much more personal level. For some, the obstetric experience involved reflecting on their own birth and the experiences their own mothers went through. Based on what they had witnessed various thoughts were expressed about whether to have children or not. Female students varied, some vowing not to have children, with others looking forward to the experience whereas a few, during the rotation, moved from the former to the latter. At least one of the male students resolved to be at his wife's side during the birth.

Issues such as gender and HIV did not feature prominently. References to the treatment of women in labour were based on considerations of basic compassionate care rather than as a feminist issue. It is interesting to note that male students gained new insights into how women were and should be treated. Considering the pervasive nature of the problem, the issue of HIV/AIDS was conspicuous by its absence. At the stage that these students were doing obstetrics, mothers were not receiving antiretroviral treatment for their own disease and were only given limited drug therapy to prevent transmission of HIV to the baby. As a result the prospect of ultimately producing an HIV orphan was real. The few responses to that situation varied from sadness at that prospect to reflection on the political nature of the decision not to provide full treatment.

The themes outlined above are an important indicator of the domains in which students' interests and concerns lie and thereby an indicator of Discourses drawn on. Using a critical discourse analysis approach the reflective commentaries of purposively selected students will be explored with a view to answering the research questions that form the basis of this thesis. This is done mindful of the reality that the reflective commentaries are reconstructions and not formal observations of life experiences and that the written output should be viewed as text and not fact. The motivation for wanting to explore what students are saying is not what can be proved but what can be learnt. In terms of the case study strategy as noted above a collective case study approach is being followed. The fact that the commentaries of

students are examined as individual exemplars or typical examples does not alter the fact that the final output should be looked at collectively and holistically. To make a valid assessment of the value of what is being said there is a need to have some indication of who is saying it. The next section provides some information regarding the group's profile.

Focal Group profile

The demographic details of the group members are shown in table 3. Whilst the group generally reflects the profile of the class from a demographic point of view it is not claimed to be fully representative. It is important to note that it does represent the range of experiences which in the context of this qualitative study is more appropriate.

Table 3. Demographic details of focal group members

STUDENT*	AGE	RACE	GENDER	HOME LANGUAGE	HOME TOWN
Thulani	25	Black	Male	isiXhosa	Port Elizabeth
Anisha	23	Indian	Female	English	Cape Town
Lynn	21	White	Female	English	Johannesburg
Hazel	22	White	Female	English	Durban
Rajesh	21	Indian	Male	English	Pietermaritzburg

* Pseudonyms have been used to protect individual identities

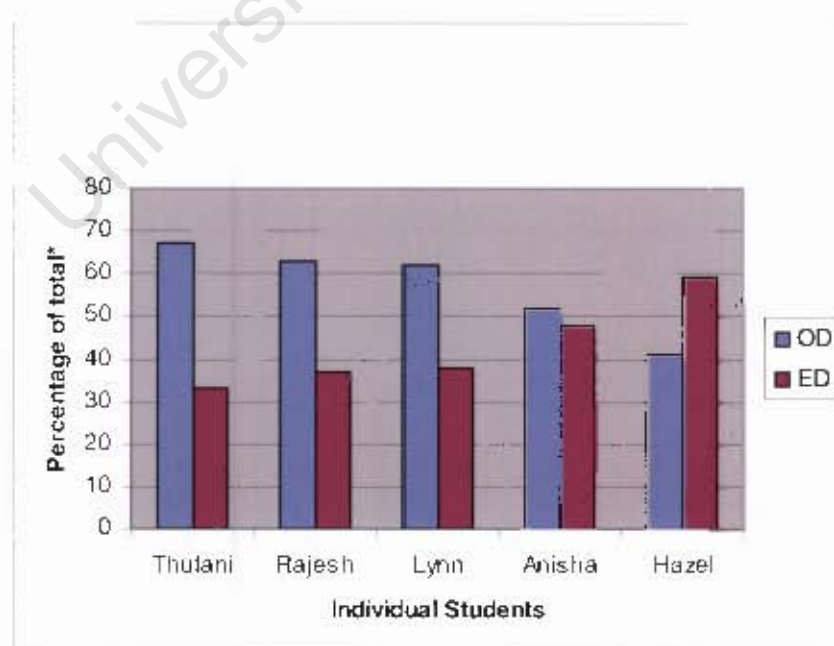
These five students later participated in a focus group discussion that was conducted in their final year i.e. two years after the original commentaries had been written. The analysis of the focus group interview is detailed in the next chapter.

Doing Discourse Analysis

A key focus of this enquiry is the change that students undergo during their introduction to the discipline of Obstetrics. Describing this change using a situated learning framework draws on the notions of a trajectory of learning and movement from peripheral to full participation in a COP. Ritual theory uses the notion of a rite of passage, in particular the transition stage. In the field of discourse analysis Gee's notion of primary and secondary discourses and the processes of learning and acquisition (Gee, 1990) are helpful as is Fairclough's focus on discursive change in relation to social and cultural change (Fairclough, 1992). The reflective commentaries of the students reflect the changes. This chapter is about

exploring that record using discourse analysis as a way of tracking the change that has taken place. Identifying and describing the various secondary discourses which students have acquired or are acquiring is part of that exploration. Two broad Discourses were identified; namely an Experiential Discourse (ED) and an Obstetric Discourse (OD). The former includes the individual's primary Discourse as well as aspects of experience not related to medicine or obstetrics. In the latter case an Obstetric rather than a broader Medical Discourse was chosen because it resonates with the Obstetric COP which is the focus of this study. As will become evident the OD describes what is happening to the student as a learner of cognitive, clinical and professional skills associated with obstetric practice whereas the ED describes what is happening to the student at a deeper, more personal and affective level. A number of methods were used to identify and track the various Discourses (See Appendix G for examples). One method was to use specific indicators for each Discourse. For the OD the indicator was obvious *clinical* words or phrases and for the ED it was the use of *first person pronouns* (I, me, my etc). To some extent this is an arbitrary process. However if applied consistently, it gives an indication of distribution and allows comparisons between students which is the aim here. The relative contribution of each of these discourses based on these indicators is depicted in Figure 6. What is evident is that most students in the focal group draw mostly on the Obstetric Discourse with only one student drawing more heavily on the Experiential Discourse.

**Figure 6 Obstetric vs. Experiential Discourses
(Ranked according to percentages)**



* Total = Number of indicators for OD + number for ED

In the interests of providing a richer description of the students' entry into an obstetric community of practice the commentaries of these 5 students were first explored as individual exemplars of student experience (i.e. instrumental case studies) and secondly collectively by highlighting similarities and differences. These findings are supplemented and validated by the results of the focus group interviews.

The Results - Individual Participants

The analyses of the individual participants are presented here to demonstrate the spectrum of more to less successful introductions into the obstetric COP. The choice is based on the commentaries but to some extent also reflects the influence of what came out in the focus group interview. Both Thulani and Anisha had initial challenges to face but with timely help from the sisters were able to successfully negotiate the hurdles. Their commentaries include several cases and reflect the growth which took place. Hazel and Rajesh also had initial challenges to face. In their situations the midwives involved did not provide the necessary support. Collectively these narratives depict how and how not to introduce students into a community of practice. In terms of the two major Discourses Thulani and Hazel represent the extremes of the ED and OD respectively. Lynn's story is written from a more detached perspective and provides a fairly positive portrayal of an introduction into the community of practice.

Student Thulani - A successful introduction into the obstetric COP

*"I can truly say that I have enjoyed this block.
I have learnt a lot about obstetrics and myself.
Giving birth is a natural process and having been a birth assistant I feel I'm in the right place"*

Thulani is a 25 year old black male student who comes from Port Elizabeth. His home language is isiXhosa and in his contribution to the yearbook that is produced by each final year class he declared that his passion was to be a doctor and that he ultimately intended to work in the remote areas of the Eastern Cape.

He writes an autobiographical narrative which outlines a trajectory of learning which starts with his expectations, details steps of growth along the way and culminates with a clear affirmative statement of having met his expectations. It is a reflective commentary that is critical in nature commenting as it does on the roles, activities and behaviour of the professionals involved in the obstetric community of practice. This particular commentary

provides a clear example of Lave and Wenger's concepts of a community of practice and legitimate peripheral participation being expressed in a practical setting. It also highlights the role of the expert in introducing the novice or apprentice to the practice.

The dominant discourse is Obstetric. A life and death theme with a particular focus on the aspect of fetal loss and management of such a situation features at the end. In between he draws on an Experiential Discourse to describe the less clinical interactions with other individuals and his own personal development. His comment on "*A positive mind-set and an eagerness to make a difference*" epitomizes his approach in this commentary and possibly explains the lack of any reference to other themes such as pain and suffering and HIV/AIDS and the absence of any negative comments about the midwives.

The language is that of a very competent English second language speaker and includes some use of metaphors. "*Thoughts were racing in my mind*" which is mentioned twice, is a key example and indicates a change of pace and a state of heightened anxiety. It characterizes his state of mind at the beginning of the attachment. It is followed in each instance by a statement of the question or questions which constitute those thoughts. The questions and the answers which the reflective piece provides document the unfolding identity of a doctor in the making. It is also the thread that gives coherence to the student's narrative.

Apart from being self aware and in that, documenting the various events and steps which reflect his personal growth, the student shows a keen sense of the other individual or person in his dealings with them. This draws on his ED and is done in a number of ways. Firstly he uses names where it is pertinent. This includes the sister who supervised his first delivery, a fellow student whose care of a patient impressed him, and a baby who had a lethal abnormality and died soon after birth. Secondly whenever he refers to a baby, the mother of the child is referred to as "*the mother*" rather than "*the patient*". Elsewhere in the more clinical descriptions the word "patient" predominates. Thirdly he speaks of bonding with the mothers and babies, refers to "*the look in their eyes*", which requires eye contact and "*the sincerity of their thanks*".

When looking at this reflective piece as a whole the three modalities of reflection suggested by Butler (1996) namely reflection to action, reflection in action and reflection on action are clearly evident and provide a useful framework for describing his introduction to the obstetric community of practice.

Reflection to action – The Novice not knowing what to expect

Not knowing what to expect the student draws on the experience of his peers. “*Feeling part of the medical profession and learning lots of clinical skills*” indicates the expectation of entering the community of practice. At the outset the student asks himself four questions. Each highlights an area in which the student feels he may be deficient. “*What happens during birth?*” – A lack of knowledge. “*Will I be able to handle the baby properly?*” – A lack of skill. “*Will I faint?*” – A lack of staying power. “*Whether I will really enjoy the course?*” – Raising the possibility of expectations not being met. The question of whether or not he will enjoy the course is a thread which runs through the commentary linking the beginning with the end. It is an issue that he has to face at his very first delivery.

Reflection in action – The Newcomer becomes Old-timer

The commentary which deals with his experience within the community of practice makes up 63% of the total text (based on a word count). The language is largely that of the Obstetric Discourse with clinical terms and concepts predominating. He describes in some detail his first delivery experience and his involvement in a number of emergencies.

His first delivery is described as a clinical event with the umbilical cord around the baby's neck. This is a not uncommon finding which if noted early and dealt with correctly usually has no consequences for either mother or child. To the novice it is an unexpected and seemingly life-threatening event. The threat is to the baby but also to the student's confidence and enjoyment of the block. He articulates most students' worst case scenario for the start of obstetrics, namely a tragic first delivery. The management by the midwife of the situation and the people involved, including the student, clearly impressed him. He notes the nurse's quick response as well as her “*calmness and professionalism*” in dealing with the emergency. Her action and the scaffolding of his performance turn his initiation into the practice into a very positive experience which leaves him feeling confident that he will enjoy the block.

His description of several emergencies is entirely clinical and shows a good understanding of the clinical situations involved. The language is not that of a novice but rather that of someone who has picked up the terminology and has insight into management issues. He notes the management as being excellent and links this to outcomes achieved “*successfully*”. His identification of what is a successful outcome is also insightful as evidenced by clinical details which he gives. The choice of cases is interesting. The first depicts a successful

outcome because of team work i.e. *“having people around who are cool headed and working together”*. The second highlights the role of the registrar in making a diagnosis and management in theatre. The third focuses on the sister. The student’s involvement in the cases shifts from a more peripheral, observer type of involvement i.e. *“I was part of”* to a more central, hands-on or *“I assisted”* level. What these descriptions depict is his trajectory of clinical learning and movement from LPP to full participation.

From a gender perspective the only gendered term he uses is *“mother”*. The word ‘woman’ is never used and the more neutral *“patient”* is preferred. In the more clinical discussions i.e. the emergencies, the student uses the term *“patient”*. As soon as there is mention of the baby then she is referred to as *“mother”*. The absence of less clinical terms to describe the birth is also noted. This probably represents an area where the OD and ED overlap.

Reflection on action – He who knows that he knows not

The student in his looking back on the course shows an awareness of other experiences and important skills that have to be acquired. Dealing with fetal loss is one such skill. It is obviously something which he values very highly (it occupies 22% of the total text and 80% of his final reflection) It seems to be his one regret of the course. It is interesting that he uses a peer as his role model. (Her perspective on the case involved is given elsewhere in this document – see comments on student Anisha). He highlights not only his own need of being skilled but sees it as an unmet need from the point of view of mothers as well. His comment *“I see them being isolated and left alone”* suggests that the response of other professionals seems to be to avoid such patients. He indicates a desire to embrace the opportunity of caring for them.

At the end of the day

At the start of the block an unsure student faced the prospect of entering the obstetric community of practice. He had heard what others had to say about the block and despite their positive take on the situation, questioned his own ability to cope. His final comments portray someone who not only found the predictions to be true but also found the answers to his own questions; *“I can truly say that I have enjoyed this block. I have learnt a lot about obstetrics and myself. Giving birth is a natural process and having been a birth assistant I feel I’m in the right place”*.

It is significant that the term *“birth assistant”* reflects firstly, identification with the role of a midwife rather than a doctor and secondly, an emphasis on **caring** rather than **curing**, terms

which are sometimes used to distinguish between the roles of doctors and nurses. This is a theme carried through into the focus group interviews and is a key observation.

Student Anisha - An exemplification of Situated Learning

This entire 8-week block has been one of the best experiences of my life. For the first time since I started medicine I really felt like I was really involved with people.

Anisha comes from Cape Town. She is 23 years old, Indian and speaks English at home. In many respects her experience represents the archetypal example of how a student should enter professional practice i.e. of situated learning in practice. Her reflection represents a fine balance between describing what happened to her in her professional development (OD) and what transpired at personal level (ED). As is the case for most student commentaries she employs a narrative genre in her reflection. Her record includes three encounters that involve her, specific patients and the relevant attending sister.

She draws on the Obstetrics as well as the Experiential Discourses with a sense of balance between Discourses rather than a dominance of one over the other. The Obstetric Discourse is shown to provide the opportunity for other lesser discourses to be expressed rather than suppressed.

The elements of reflection as suggested by Butler (1996) i.e. reflection to, in and on action are less clearly discernable in this case. This is not because they are not there but that the approach is more holistic and the comments embedded in the discussion of the individual case descriptions. This suggests that the student is an intuitive reflective practitioner. This becomes evident in her description of her first case. On entering the practice and preparing to do her first delivery she has *"such a romantic idea of what it would be like"*. The reality is altogether different and she reflects: *"I thought the beauty of watching life come into this world would be an overwhelming experience (reflection to), but in reality I wasn't thinking about the miracle of life (reflection in), I was making my decision to adopt in the future" (reflection on action).*

The student recalls three patient case histories as *"moments to treasure forever"*. What makes them memorable? The first was *"one of the most emotionally draining moments"* of her life, the second *"a truly special experience"* and the third a moment of *"pride"* and *"accomplishment"*. Viewed more objectively these events plot her progress along the trajectory of learning from novice to expert.

The first delivery

In assessing the impact of this experience it is as important to look at what it was not as much as what it was. That first exposure to assisting a mother in childbirth didn't fit the romantic idea; there wasn't the anticipated emotional, "*thinking about the miracle of life*" or the academic, "*chance to watch for all those movements we had learned*". The reality for the student was far harsher than that.

For the mother things also did not turn out as expected. "*Here was a mother, who had just given birth, who should be enjoying the moment and instead she was crying her eyes out*". In the process of birth the mother sustained vaginal tears, to the degree that it required one of the more experienced members of staff to do the repair. The student records it as a painful and traumatic experience for the mother. It clearly does not leave her untouched in the process. What was to be a simple test of her nascent ability was transformed into a harsh personal lesson on capability, accountability, culpability ("*was it my fault she tore like that?*") and sustainability ("*I wasn't sure I could deliver again*"). The question of whether she would deliver again reached beyond the professional to a very personal level ("*I was making my decision to adopt in the future*"). The average student's nightmare of having a disastrous and traumatic first delivery experience had become a reality.

In the face of this nightmare how is it that the student recalls it as a moment to treasure? The answer lies in how the situation was managed by the student and sisters who mentored her. Their "*support and understanding*" is what helped her to process the experience and become not only a reflective but also an empathic practitioner who hopes to "*return the favour one day*". It is interesting that she sees patients rather than colleagues as being in need of such support.

The importance of this experience for the student may be gauged by the fact that she devotes almost a third of her commentary to its description and discussion. Her description of the anencephalic delivery, a situation in which she can "*return the favour*" receives similar attention.

The anencephalic⁵ delivery

This is obviously seen by the student as a defining moment for her. In her commentary she captures the essence of what it means to her in a paragraph of its own. The paragraph has

⁵ Anencephalic: a fetus having part or all of the cerebral hemispheres and the rear of the skull congenitally absent. The condition is lethal although a baby can survive initially for varying lengths of time because the centres controlling cardiac and respiratory function are present.

one sentence. In it she says: *“For me it was a truly special experience”*. Its honesty, brevity and simplicity speak volumes.

Viewed more dispassionately and through a pedagogic lens the rest of story that frames that statement documents so much more than simply what she and the patient experienced. It is both a personal and a descriptive narrative that records how people learn and in the theoretical framework discussed elsewhere it is a prime expression of situated learning. In the story the key characters are the couple with their baby and the caregivers in the form of the sister and the student. From the commentary of a fellow student (see Thulani) it is clear that there is at least one other character albeit a silent but not disinterested observer.

The record of the sister’s involvement shows her mentoring, monitoring and scaffolding the student’s progress (*“sister pulled me aside and asked me if I was sure”*). She provides practical support and a role model (*“sister would feel... and tell”*, *“thanks to the sister’s patience and comforting care”*).

Clearly the care given to the mother allowed the grieving process to happen in an appropriate and meaningful way for both the mother and the father of the baby. In the process it is clear that the student’s ability to deal with loss and provide support to the mother is shaped. Her ability to relate to the mother as well as the baby shows a level of maturity and competence that is not always seen even in colleagues much older and ostensibly more competent. This is evident in her ability to see and relate to the baby as a person (always referring to it as Christopher) and to simply listen to the mother and allow her to tell her story.

In the midst of learning about obstetrics and about people there is also an element of learning about self. In this regard she reveals an ability to relate her faith to her experience. She is also able to turn her own questions about life and death into understanding for and empathy with the parents.

The novice who nearly floundered at the time of her first delivery has learnt, grown and matured. She has moved from peripheral participation of the newcomer to the more central participation of a valued team member or new ‘old-timer’ to use the situated learning terminology.

One of the clearest indications that one has reached a significant milestone is when one becomes a role model for others as Anisha does for Thulani who was obviously affected by what he witnessed. He devotes at least one fifth of the total text of his commentary and most

of his final reflection to expressing a desire to be able to deal with fetal loss in the manner witnessed here. He says

"The closest I've been to this type of situation was when Anisha assisted in the delivery of an anencephalic fetus. The mother was counselled well before and she was accepting while the father did not know what to expect and he broke down. Anisha was there for them" (Thulani)

The first solo delivery

It is never the intention in the 4th year obstetric programme to allow students to function independently at that point. That is deferred until the final year. In this situation it was planned that the sister should do the delivery because the situation was complicated by the fact that the mother was preterm. This baby came before its due time in more ways than one and the student was faced with coping with the situation on her own. The case turns out to be a test of her ability to respond to the unexpected which, in obstetric practice, is a key ability and another marker of maturity and competence. She does what has by now for her become a routine (*"I started doing what we normally do"*) and fortunately the outcome is what it would have been had the sister been there. Later having carried the responsibility and made sure that the outcome remained favourable she feels entitled to savour the moment and ends the night *"smiling from ear to ear... Swelling with pride, overjoyed at my sense of accomplishment"*.

The trilogy of cases describes very eloquently the successful introduction of a fourth year medical student into the obstetric community of practice. What or who made it possible? The success no doubt is due in no small measure to the attributes of the individual herself. However as shown by a number of the other commentaries, events around the first case are not always handled as sensitively or appropriately as they were in this case. Were it not for the sensitivity and support of the sisters at a time when it mattered most, the outcome would in all probability have been entirely different.

In describing her experience this student reveals to what degree she is prepared to be *"really involved with people"*. Her very choice of words (including the recurring 'my') namely *"my first delivery"*, *"my anencephalic delivery"* and *"my final moment, my first solo delivery ... and ...my baby"* speak of a degree of involvement and even ownership (though not in an acquisitive, possessive sort of way). It is one of her strengths as a future physician and possibly one of her areas of vulnerability as a person. Finding the balance will be the next phase in her growth as a professional.

In the next two accounts the introduction is not the same and the lack of support from the midwives diverts professional development along another track altogether. In the case of

Hazel the patient becomes a key influence. In the case of Rajesh he draws on his primary and experiential discourse to deal with his situation.

Student Hazel - Personal change and the influence of power, roles and relationships

"To me obstetrics has been a kind of initiation rite into medicine".

Hazel comes from Durban; she is white, 22 years old and English is her home language. The profound effect which the course had on her is reflected in the title of her commentary: *"An experience that has shaped my life"*. Her commentary documents how, and to what degree that has happened. She uses a narrative style to reflect on her experience of becoming part of the obstetric profession. She places obstetrics in the broader context of medicine and characterizes her entry as an *"initiation rite into medicine"*. Her story is actually about relationships and the interfaces between them. Central is the **intrapersonal** relationship as the student describes *"the growth that has taken place"* in her life against the backdrop of the **interpersonal** relationships or the sister/patient, student/sister and student/patient interactions. The student uses "I" 39 times making her the central character in the narrative. Rather than being a reflection of self-centredness it shows the dominance of the Experiential Discourse.

It is only by exploring the tension between the roles of patient, caregiver and learner as developing caregiver that one can understand the conflict and turmoil that she experiences as well as appreciate the manner in which she resolves the conflict. As her story unfolds, and the personal change required becomes more evident, the description moves from a collective *"Brenda and I"*, the *"patients"* and *"the night staff"* to a more focused *"I"* met *"Ester as a person"* and *"the sister"*. Differences, the unexpected, contradictions and needs become evident, as does the necessity for making choices, changes and adaptations. Some are logical, reasonable and seen as valuable. Others are more difficult to understand and more costly emotionally. At the end of the process her identity is defined in terms of the other major role players both in terms of who and what to be, or not to be.

The Obstetric and Experiential Discourses are evident in this text although in this case the OD is very much in the background. As is shown in Figure 6 this student is the one who draws most heavily on the ED. Consequently the language is more personal and emotive. Within the OD pain and suffering is a dominant theme.

There are a number of unifying threads running through the narrative. The writer creates these by the use of a number of rhetorical or literary devices all of which contribute to the coherence of her writing. These include the use of superlatives, metaphors, repetition and various forms of emphasis (italics, bold lettering and capital letters). A number of examples will be used to illustrate key points.

The use of metaphors

The student uses metaphors and other figures of speech to describe her perception of obstetrics, how a particular midwife regards and treats a patient, her own lack of ability and ultimately the time spent in the obstetric rotation.

The social practice being explored in this study is that of entry into an obstetric community of practice. This student describes this experience as an "*initiation rite into medicine*". A rite of passage traditionally has 3 stages for which various terms have been used. In this context the terms separation, transition and re-integration are the most appropriate.

The obstetric block quite literally involves a process of separation i.e. during 4 of the 8 weeks of the block students live in accommodation on site, having left home, private or university residence. The labour ward becomes the place they frequent most, both day and night. This student describes her state on entry as naïve, "*clueless*" and as "*being real 'greenies' and new to the game*" and lists activities done to try and win approval from an unhelpful and unfriendly staff.

Describing the transition which took place in her life occupies 8 of the 11 paragraphs of her commentary. Most of that describes the interactions between her, the patient and the nurse. One of the ways in which she highlights the transition is through the use of emphasis in the form of italics, capital letters and bold lettering. The words and phrases chronicle the change that is taking place in her life. The use of emphasis is an example of what Fairclough (2003) calls modality which expresses the degree of force with which a statement is made and the degree of commitment on the part of the writer to what is expressed. At the same time it reveals aspects of identity. An analysis of modality helps to reveal what he calls texturing of identity. Quotations have not been italicized in this section as this would obscure the use of italics by the student.

"[Q]uite clueless as to what the challenges *really* would be"

This aptly describes the novice about to start an initiation and indicates that the reality of the situation as it unfolded was a shock to her. "*I was incredulous*" describes her reaction to seeing how patients were being treated.

"Yes! There is one other patient here, it's your job and you're supposed to be providing CARE for this woman who is vulnerable and in pain, you stupid bag! You've got *precisely* all night to be there with her!"

This records her unspoken reply to the sister's rhetorical question directed at the patient, "*Do you think I've got all night to wait for you?*" The student demonstrates that for her the needs, responses, responsibilities, roles and priorities are clear. The words are unspoken because of the disempowered position she finds herself in.

"She REALLY didn't want me to go".

This shows an appreciation of the patient's need and dependence on her and her growing responsibility towards the patient. "*I was torn between leaving E... and going and finding help*" indicates her dilemma of wanting to help but in her inexperienced state needing help to do so.

"I swore to myself that no matter how many patients I see, no matter how 'common' pain becomes, no matter how bad my day has been I will NEVER take that out on someone who is suffering and vulnerable".

Her response to what she has seen is to make a solemn undertaking never to repeat the behaviour she has witnessed, no matter how trying the circumstances.

"And what it's taught me most is that to be with someone in their pain, really **with** them, touches both mourner and comforter with a divine presence that reminds us what it is to be human".

Note the double emphasis i.e. italics and bold lettering. This sentence documents what the student has learnt from the experience. Apart from indicating what has been learnt, this last sentence describes the outcome of the initiation process and gives a glimpse of the individual who emerges from this period of transition i.e. a caring and empathic caregiver acutely aware of her own humanity as well as that of her patient. The transaction has taken place at a level far deeper than the mere provision of clinical care. In the context of a rite of passage some speak of the sacred and the profane. This student's choice of the term initiation rite and her final comment which includes reference to the divine indicates that for her there is an appreciation of the sacred.

Paradoxical togetherness

The juxtaposition of words, ideas and events as done here is another rhetorical device that the student uses to provide emphasis. She indicates at the start of her commentary that she is unaware of the conflict she would undergo. The following examples illustrate this. "*It hasn't been easy. It's been wonderful. It's been incredibly fulfilling. It's been the most amazing privilege. But it definitely hasn't been easy!*" At the end of her commentary she articulates similar sentiments: "*It hasn't been pretty. It's been beautiful and ugly and bewildering and*

very, very real". Sandwiched between these two statements is the record of what transpired between the nurse and the patient with the student as an observer. She records the actual words of the sister and in so doing documents her lack of respect and care. Her juxtaposition of her own unspoken retort which follows the rhetorical question uttered impatiently by the midwife to the patient exemplifies the lack of respect. Hierarchy, decorum, perhaps even fear of a backlash ensures that it remains unuttered.

Issues of power

A detailed discussion of power or even theories of power is beyond the scope of this paper. However a brief reference to how this student experiences powerlessness needs to be made. It relates to both patient and student. Disempowerment takes two basic forms. Firstly, it involves not being able to express disapproval or contrary feelings and sentiments. The student's unspoken retort is an example of this. The second is shown by the withholding of something that an individual, here mostly the midwife, has control over. The student experiences this as a withholding of a friendly welcome at the time of initial contact but more seriously the withholding of professional supervision during the delivery. The patient on the other hand experiences the disempowerment as a lack of practical help when moving from ward to ward, a lack of respect during the consultation, information about what is required of the patient, professional care during the delivery and pain relief when suturing the episiotomy. The end result is that she loses the respect of the student, she ceases to be a role model and the student writes her out of her story entirely thereafter. The exercising of these choices and even the unspoken retort is a form of empowerment for the student.

Rajesh's entry into the community of practice is very similar to that of Hazel in terms of location i.e. a peripheral clinic. In his case the sister is present at the delivery. In this situation he also finds himself in a disempowered situation however he handles it in a manner that separates him from both the midwife and the patient. The ultimate outcome is somewhat different.

Student Rajesh - Personal change – rooted in Primary Discourse

So much for first experiences. ...my mother always said that the only time you ever truly learn to drive is after you actually get your licence...

Rajesh is a 21-year old Indian male student who originally comes from Pietermaritzburg and is an English first language speaker. His commentary is a biographical account of which more than half is devoted to describing the first birth that he observed followed soon after by the first delivery that he participated in. His first contacts with obstetric practice took place in

a peripheral clinic and consequently he had no hospital or medical staff experience against which to compare what he saw at his obstetric debut.

Reflection to action – great expectations

His reflection to action (Butler, 1996) includes brief comments on his expectations. The start of the block is preceded by a *“whole year of expectations and curiosity”*. Despite being taken aback by the manner in which patients are treated by the nurses, the sight of the first delivery overwhelms him and their behaviour is momentarily forgotten. He describes waiting in *“great anticipation”* for the first delivery that he will conduct.

Reflection in action – Shock and Disbelief

His reflection in action consists largely of his description of the first delivery that he sees and the first that he does. His initial reaction is one of horror and shock (*“I could not believe what I saw”*). The language he uses is emotive and the imagery suggestive of torture or abuse. He is *“horrified”* by what he sees and uses words like *“evil”*, *“terrifying”* *“screamed”* *“beat”* *“cruel”* *“slapping”* and *“vicious”* to convey his horror. Looking at the patient he sees a mother who *“couldn’t bear the torture any longer”*, with *“fear levels reaching a high”* and whose *“screams were deafening”*.

In terms of his involvement in the delivery he admits to being afraid and having several questions in his mind relating to his readiness to do the delivery. During the course of the delivery he notes that the patient’s lack of pushing and then her refusal to push is matched by increasing verbal and physical abuse on the part of the nurses. Each of the actors in the scene becomes *“weary”*. The patient is weary of the suffering and pain. The sister is weary of waiting and his mind becomes weary as he questions what he sees and has to deal with his emotions. When the patient eventually pushes in response to the slapping of her thighs and she begins to tear, the sister takes over the delivery, doing an episiotomy without local anaesthetic. For him it is a defining moment. He responds by trying to dissociate himself from the staff by referring to them as *“they”* and describes how *“I felt my soul step aside from that bed”* and how in that state he *“began to question the quality of care that is given in the public sector”*. In that state he considered what his mother would have gone through and *“began to feel guilty”*. He *“tried to picture her in that situation”* and decided, *“I did not like it at all”*.

Reflection on action – Looking back then looking forward

His reflection on action takes on two forms, namely going back to what his mother taught him and then using the insight gained from applying that learning to his current situation he is

able to move into the future with renewed insight and confidence. While reflecting on this first experience he recalls his mother's comment that "*the only time you ever truly learn to drive is after you actually get your licence*". The analogy helps him to move beyond the trauma and horror of his first impression. He discovers later that there are other sisters who are caring and whose "*major concern*" is "*to ensure that the mother's experience of child birth was a sacred time.*" The choice of the phrase "*a sacred time*" and reference to his 'soul' suggest a view of childbirth that draws on his primary Discourse (including his faith) and sees birth in its cultural context i.e. as a rite of passage as has been alluded to elsewhere. It is the start of a deeper understanding and appreciation of what mothers experience during childbirth.

This newfound understanding is also associated with a fresh understanding of his calling as a doctor. His previous reticence to discuss why he became a doctor is replaced by an open acknowledgement of an underlying fear of being a hypocrite and not remaining true to what is said at this point in his life. However witnessing the mother's joy of holding her baby brings a realization of "*how precious life is*", that the discipline focuses more "*on 'making' life*", rather than trying to "*prevent death and disease*". There is a desire to "*build on this calling*" having been made to "*realize how ... much responsibility I am taking on in my life*". Having a clearer understanding of where he came from and who he is now, he has a clearer understanding of whom and what he wants to be in the future. A new sense of ownership and purpose is expressed in the way he talks about "*my degree*" and "*my study*".

This student is an example of someone who enters the obstetric community of practice and is confronted with new experiences for which he is ill-prepared. He has no other option but to draw on his primary Discourse in terms of his existing knowledge about childbirth, the life skills acquired at home and whatever other perspectives his experiential discourse had given him such as a religious faith. Having weathered the initial storms he is able to move forward by drawing increasingly on the Obstetric Discourse.

It is important to note that he concludes by referring to a past tutor by name. The reference is not in the context of the basic sciences knowledge imparted to him by that person but hints at the mentorship role that the particular person is well known and respected for. It is a reminder that significant people and events have a lasting impact on students. The significance of that is reflected in comments made by this student in the focus group session when referring to his debut experience.

The last commentary is fairly short in length but is rich in content because of the student's writing and meta-cognitive skills.

Student Lynn - Personal change – Sometimes a matter of life and death

"In my personal life I have faced death and disease over the past year and to be surrounded by new life and old life mixing together"

Lynn comes from Johannesburg; she is 21 years old, white and English is her home language. This student's commentary follows a narrative genre. She writes with an economy of words and level of abstraction which shows above average maturity and exceptional creative writing ability. Her narrative records a journey into the realm of obstetrics as it is represented by a labour ward with all its activities which are geared towards bringing new life into the world. She explores its space as well as the relationships of the people who occupy that space. In the process she ends up exploring her own personal space and discovers a new life of her own.

The body of the text is divided into three distinct paragraphs. Though separate, the three paragraphs are carefully bound together by threads of time and space. Each paragraph starts with a time label, "As the time for my first night duty.. As the night drew on... Then at 6 o'clock..." The order of events is largely chronological. The terms "second stage" and "first stage" refer to stages of labour. They are also the terms used here to describe physical areas or 'spaces' in the labour ward. At a more abstract level each paragraph defines a place in the personal realm of the writer. The first is a place of **expectation**, the second a place of **transformation** and the third a place of **action**. The trilogy is reminiscent of the 3 stages of a rite of passage – separation, transition and re-integration. The three paragraphs also follow Butler's three stages or modes of reflection very closely.

Reflection to action – The time before the morning after

The first paragraph describes the time before the first night on call and records the writer's reflection **to** action. Being in the last of the five block rotations allows her to construct a picture of what to expect. She draws on her academic texts to some extent, but actually her early understanding of the real world is anecdotal as she is influenced by the experiences of her peers. It reflects a growing sense of expectation that ends with disappointment and the need to return to basic principles and practices.

The Obstetric Discourse is dominant – 13% of the words in the paragraph relate to it. Her entry into OD is basic; the terminology is medical, the focus is on the individual (whether student, patient or nurse), context is not deemed relevant and the immediate goal is to start doing "*your 15 deliveries*". The focus on deliveries is revealed in her use of words relating to

delivery (x4) and the fact that on entry into the labour ward she heads for “*second stage*” i.e. the physical place where deliveries happen, as if to fast-track her ‘development’. In that she is disappointed. Circumstances cause her to go back to “*first stage*” and make a fresh start. She embraces the opportunity by becoming involved in the activities of the ward and helping the sisters. It is this engagement with the tasks and the people that leads her to a deeper understanding not only of the OD but also of herself. In the language of situated learning this student enters the COP but neglects initially to go the route of legitimate peripheral participation. Circumstances cause her to change that.

Reflection in action - The first night

The second paragraph documents the first night on call and the profound change that the student undergoes. It makes up almost 60% of the total text. A new understanding of the nature of the OD is signalled at the start by the comment: “*I began to understand that obstetrics is not about catching your 15 babies*”. The use of “*your*” indicates an awareness of the more self-centred focus of the first paragraph. The personal nature, the process and the degree of change she undergoes is reflected in the progression from “*I began to understand*”, “*I have seen*” (x2), “*I have heard*”, and “*I have faced*” to a final “*I felt*”. The active voice with which it is expressed reflects a deep, clear and sustained process of transformation.

The number of overt obstetric terms in the OD decreases to 6% of the paragraph. Newer and perhaps softer and more human terms enter the discourse. “*Delivery*” becomes “*birth*”, “*sister*”, a term indicating rank and seniority, becomes “*nurse*” which focuses more on the caring role. The patient becomes a focal point. The neutral “*patient*” becomes a more human and gendered “*woman*” and “*mother*”. She reveals a growing understanding of the ‘pain and suffering’ and ‘life and death’ as representations of the ED. It is the last that overlaps with and impacts on her personal world. It is in fact the aspect of her primary discourse that she brings into the situation. There is also a broader understanding of the OD, showing it to be part of what might be seen as a wider childbirth practice that extends far beyond the strict confines of the medical model. Greater awareness of the social context and the need for change within that context is evident.

Insight into the role of the nurse is also shown. The ambiguity of “*which sister to look out for*” in paragraph one is replaced by an appreciation of the opportunity (“*it was wonderful*”) to get to know the nurse, to watch her interacting with patients and therefore to be in a position to portray her in a very positive manner. Her roles as birth companion, teacher, communicator, advocate and carer are recognised, as is her ability to teach at a level required by the students.

The transformation and renewal that the student has undergone is captured in two key phrases. The first relates to the acquisition of the Obstetric Discourse and a new understanding of birth. The woman (not mother) is the focus, with the baby not being mentioned at all.

"The most important part of the birth process is not the delivery but the quiet moments before and after when questions can be asked, doubts can be examined, fears can be faced and ultimately a woman can come to terms with the moment that is going to change her life forever."

The second relates to something far deeper and more personal.

"In my personal life I have faced death and disease over the past year and to be surrounded by new life and old life mixing together I felt a sense of refreshment and the beginning of a paradigm shift"

Reflection on action - the morning after

The third paragraph announces the arrival of a new day as well as a new life. The first two paragraphs open with "As" indicating the passage of time and the happening of a process. Here the first word is "Then" indicating a degree of finality or closure. It is a short paragraph (19% of the text). The OD in its more medical form is represented by just three words. The delivery that initially was so central to the OD, is described in a short rapid-fire sequence of "clamps and cords and hands were one blur..." as if to dispense with the event and move on to the meaning behind and the symbolism of the event.

There is a notable repetition of words and thoughts: "then", "new life" and "choices".

"Then" indicates that an important moment has been reached and something of importance is about to follow. The first is a comment about self. She looks back and is "exhausted". She looks ahead and is "ready to face the new day". The juxtaposition of exhaustion and readiness is something of a paradox. Nevertheless it captures the happenings of the night – changes that are a mixture of the physical and the emotional or the concrete and the abstract. It also marks the achievement of the original goal – to deliver a baby. The second "then" reflects on the meaning of that event.

"New life" or "new, bloody life" is the chosen description for the newborn baby. Notable is the absence of words of wonder or endearment or descriptions of emotion. Is it because the awareness goes far deeper than romanticised and glamorised versions seen on TV or in glossy magazines? And why "bloody" which is a rather evocative term to choose? Blood is symbolic of life, of death, of loss of life or vitality or sacrifice or it may simply be something messy. In the current context of HIV/AIDS contact with blood is something to be feared and

avoided. Is the blood symbolic of the life that the mother has given to her child and the cost to her of bringing that life into the world?

“*Choices*” – The simultaneous reference to “*choices she’d made*” (the mother i.e. the past) and “*choices she’d have to make*” (the baby i.e. the future) reveals an understanding of the continuity or cycle of life and the kind of decision-making that most women have to face at some stage.

As the student has reflected on action she has discovered something of the meaning and continuity of life and in the process has rediscovered meaning and new life within the boundaries of her own personal space.

What this student experience shows is that apart from being present ‘legitimately’ i.e. as a bone fide student allocated to a teaching site, the process of ‘peripheral participation’ needs to be appreciated and followed. She does that and her entry into the community of practice takes on a whole new dimension that is expressed at both personal and professional level.

“A new, bloody life”

The discursive history of an individual shows traces of discourses indicating where that person has been (Kress, 1989). This young woman enters the obstetric domain, bearing the marks of an experiential discourse deeply affected by life and death issues with death overshadowing the life. Here she discovers the life. With that come “*refreshment*” and a “*paradigm shift*” and a new appreciation of life. What she has written in many ways is a dialogue between the subjective and the objective, the personal and the general. Out of that emerge wholeness and a unity of experience. She uses a phrase which says it all, both for her personally, in her state of ‘newness’, as well as for the newly born lying before her:

“Then there on the bed was a new, bloody life...”

“*New life*” – Yes, for they both had futures that awaited them with all its associated choices.

“*Bloody*” – Yes, because the process, for both, had not been without cost or pain.

The Results – The collective experience

What emerges from these various stories is a collective experience. There are differences of degree, timing and how that experience is articulated. Making sense of the whole requires a degree of stepping back in order to see the bigger picture. In doing that it is important to note that Thulani and Anisha use more than one patient to describe their experiences whereas the

other students generally focus on one patient. For Rajesh and Hazel the patient is crucial to their discussion whereas Lynn only mentions the baby.

In the chapter outlining the methodology one author described theoretical frameworks as the analyst's "reading glasses" (Malterud, 2001a). One of the wonders of modern optics is the ability to create multifocal lenses which make it possible to having one pair of glasses that provides good near and far sight. To get a clear picture of the shared experience referred to above we need glasses with such a set of 'multifocal' lenses that include situated learning, reflective writing, ritual theory and discourse analysis perspectives.

Situated learning as the main theoretical framework is exemplified in the experience of Thulani and Anisha. The notion of community of practice and the trajectory from peripheral to full participation is demonstrated very clearly. The key is the interaction between newcomer (student) and old-timer (sister). The other cases highlight problems, not with the theory but the manner in which it is expressed in practice. In one instance the sister abdicates her responsibility as mentor, while in another the nurse provides a model of what not to be and do. In the last instance the student (Lynn) makes a false start but realises her mistake and the process moves to successful conclusion.

The three modes of reflection as described by Butler (1996) are important because each focuses on a particular aspect of the development of the students. Reflection to action draws attention to the expectations that students have before and when they start the block. The degree to which students are prepared for what is to come and their expectations acknowledged and met, in many ways sets the scene for what happens later in their careers in obstetrics if not in medicine as a whole. Reflection in action in many instances triggers change in a whole range of areas e.g. Lynn's way of dealing with life and death. Reflection on action has a similar effect e.g. Thulani's affirmation of his calling or Rajesh revisiting his calling as a doctor. The three modes are also useful for the narrative form (before, during and after).

It is important to view the process of change described above through the lens of ritual theory and specifically as a rite of passage. The process of *separation* signals the need to prepare a student for what is to come. The notion of *transformation* draws attention to the importance and degree of the change that students are faced with. If these stages are not recognised for what they are and the processes ignored then problems can occur because a student's personal and professional development has been arrested. Ideally the individual who emerges should have a new sense of identity and purpose. From an academic perspective the student has acquired knowledge and a range of skills. From a personal

perspective the individual has been challenged socially, spiritually, ethically and also at a deep personal level where identity, a sense of worth and motivation resides.

The collective or shared nature of this experience will be discussed further in the next chapter where the results of the focus group interview will be examined.

University of Cape Town

Chapter 5

Focus Group Interview

*I think that the difference fundamentally between 4th year and 6th year is that the roles change...
...the entry point was as a support....
Now when you're a doctor... a very distant observer of the process... dealing with disease.*

Thulani

Introduction

The focus group session was conducted at the end of 2004. This was the final year of study for the group whose fourth year reflective commentaries of 2002 were used in the analysis described previously. The session took place toward the end of the academic year to ensure that all of the students who had previously been purposively selected for the focus group had done the 4-week obstetric component of the final year. Students were initially asked to comment on their introduction into obstetric practice in the fourth year, who had played a key role in shaping that experience, whether reflective commentaries were helpful, and what was the current view of obstetrics in the class. They were finally asked to give recommendations regarding changes or improvements to the initial experience.

The inclusion of this analysis is important for a number of reasons.

- The focus group provides a **collective viewpoint** as opposed to the individualised viewpoints expressed in the commentaries.
- It is part of the **case study strategy** adopted in this research. As such it would facilitate triangulation and contribute to the validity of the findings. More specifically the group situation is one method of checking the conclusions reached in the discourse analysis.
- The focus group information contributes to the **'thick' description** that would assist those wishing to relate the findings to their own situations.
- Having information from both the beginning and the end of a programme enables the **plotting of trajectories** of learning in terms of changes in both knowledge and attitude.

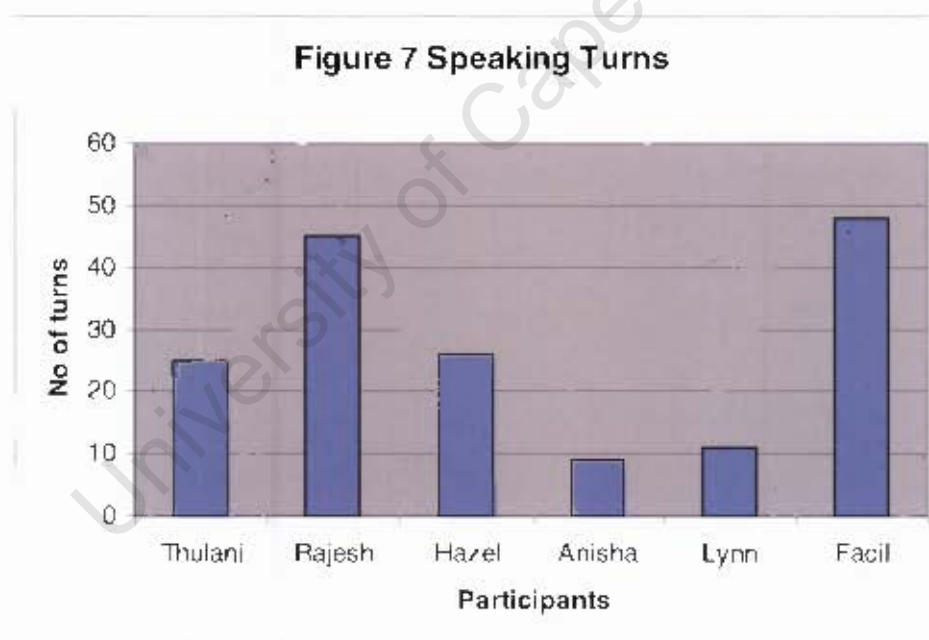
Sample Profile

The focus group is made up of the students whose commentaries were analysed and discussed in the previous chapter and therefore the group profile remains the same. I elected

not to conduct the focus group interviews myself as I felt that my involvement with the students as their course convenor and my status as a fulltime staff member might inhibit free discussion of matters pertaining to the course and the department. The interviewer was a trained research psychologist with several years experience in group facilitation. At the time of conducting the interview with the focal group students from the old curriculum, this researcher was conducting focus group interviews with students from the new MBChB curriculum as part of a PhD project. A copy of the guidelines given to the interviewer and list of trigger questions is attached as Appendix D.

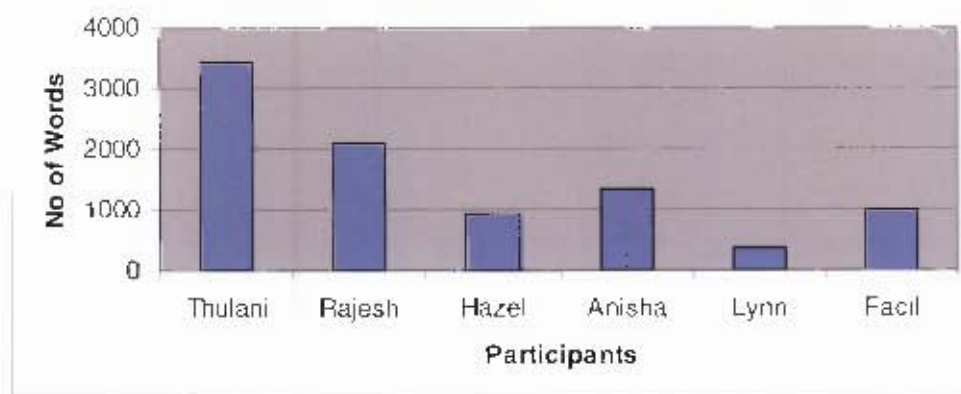
Results

It is interesting to look at the relative contribution of each participant to the discussion. The number of turns and number of words used are depicted in Figures 8 and 9 respectively. This shows that the facilitator spoke most frequently which on review was found to be consistent with her role as facilitator i.e. initiating and maintaining discussion.



Student Thulani participated frequently and easily which may reflect that he comes from a culture with a strong oral tradition. The question and answer style in his commentary shows a similar influence. Rajesh spoke most often although many of his turns were in the nature of interjections or answering questions. Generally the language he used was fairly emotive in character. Hazel's involvement was participatory and interactive with helpful contributions on

Figure 8 Relative Contributions to Discussion



a range of issues. Anisha did not speak often but her contributions were comprehensive and dealt with issues related to power. Lynn spoke least often but made insightful and relevant contributions.

First things first

Reflections on the 4th year programme largely echo and extend what was said in the commentaries. The block was described as being the time when students first experienced “being a first line person”, the first time they felt “useful”, were “hands on” or “responsible”. “[Our] first port of call” was used to describe the introduction to the “profession of Obs & Gynae” as well as the “profession of medicine” and suggests a view that becoming a doctor is seen as a journey.

Negative first impressions have a lasting impact on perceptions:

I remember my first week and watching a sister beat the lady up in the community centre, and that was the first patient...the first birth I'd watched, and because it was the first I imagined it always happened until I spoke to other people and realised that the sister shouldn't be doing that (Rajesh).

[W]hat was shocking was the first few times seeing a nurse shouting at a patient. I've never seen other people treat other people like that before" (Lynn).

A ‘first’ for 6th year is a student’s introduction to bureaucracy and departmental politics. “I think that’s the big difference between 4th year and 6th year, is that in 6th year you are involved in the bureaucracy” (Rajesh). This is experienced in a number of ways. In the context of service cut-backs and the effect of that on the learning environment one student commented:

Obstetrics⁶ just jumps at you...It smacks you the first day you walk in. And the other departments, at least they try as much as possible to protect us from that. from the

⁶ From the context it is clear that at times the students are describing experiences in the gynaecology rotation. ‘Obstetrics’ is used as a handle to refer to the department rather than the specific obstetric rotation.

bureaucracy. But in Obstetrics, you go right in with them and we're at the mercy of the staff, we're at the mercy of the registrars, we're at the mercy of people, and unfortunately we suffer" (Thulani).

Another student explains that a request to share the time assisting at lengthy operations was turned down with the response: "No, the HOD (Head of Department) has cut our theatre time, so you should go complain to her" (Lynn). Sometimes students felt drawn into departmental or institutional politics at a much more personal level: "I think if you feel if you're working with someone, and they're complaining about the people that are senior to you; it's very difficult for you to do anything, because you're almost drawn into the fight between two people..." (Anisha).

In another sense the exposure to Obstetrics was seen as an introduction to a doctor's lifestyle: One student commented: "I think also like Obstetrics was an exposure to the whole life style of actually being a healthcare worker". This involves working "odd hours" and dealing with "not only your stresses but other healthcare workers' stresses", as well as "with patients who were anxious". His conclusion? "And ja, so it brought all of this into place, and you had to experience not only what you learnt academically but also what you should experience individually" (Rajesh).

The fourth year to sixth year transition

A number of comments were made about the transition from 4th to final year. Hazel had recently re-read her 4th year reflection and was surprised at the "intensity of the emotion" she felt when writing it. She concluded that it "was me experiencing things as a lay person" but noted that it was "valuable for me to be able to reflect on that amount of conditioning I've had in the last 2 years, to really make it with that shockedness, which is how I should feel". Working in close contact with midwives brought an appreciation of the nurse's role i.e. that it involved repetitive, time consuming and labour intensive tasks which were taken for granted and were not going to be appreciated. Comments one student: "I realised why I didn't want to be a nurse!" (Hazel). Another appreciated midwives as 'a team' rather than seeing them as part of 'the team' i.e. the one including medical staff. His comment "midwives being quite a valuable team in the system, and us I think being more of a peripheral role in terms of just managing the really complicated cases" (Thulani) hints at a hierarchy or separation which is different to the sentiments expressed in his 4th year commentary.

Comments from Thulani at various stages of the interview are illuminating in that they reflect a trajectory of learning that addresses both knowledge and identity. In the 4th year he foregrounds contact with the patient: "...connection with the patient was the most valuable thing.... That for me was better than wearing a white coat and saying, or staking a claim that I'm a doctor".

Speaking of the difference between 4th and 6th year he notes that,

"the roles change in terms of the entry point was as a support more than as a doctor, and learning what it's about. Now when you're a doctor, you're actually now a very distant observer of the process and more dealing with disease now, rather than actually doing...help the person walking in and walking out".

Later he comments on how the final year student becomes part of the team which has implications for how the student behaves and reflects a fairly fundamental change. He says:

"You no longer have support and you actually come into a system, you're now part of the system, and you're actually part of the problem in a way, in terms of you also become judgmental, pressured, and you also become feisty because you haven't slept or a person doesn't want to understand you or something like that. So, you become part of the problems so to say".

Anisha highlights the fact that involvement in 4th year is shaped by the fact that the obstetric domain in that year is confined to the labour ward and that the roles in that context are limited to caring and delivering. In final year "...suddenly, you're not limited, your view, it's not limited to that delivery". She hints at a repertoire of roles brought on by the fact that the obstetric domain is expanded to include all wards and clinics.

Being "part of the team" was seen as part of the 6th year experience, a requirement in fact i.e. "your role in 6th year was much different in that it required you to be part of a team" (Rajesh). The reality that it was not experienced as being inclusive is reflected in comments such as "they will use us then as part of the team, but they won't respect us as part of the staff" (Thulani) or "...we were not part of a team. We were there to do the dirty work, and we were disregarded thereafter" (Rajesh).

Being "part of the team" brought other insights into departmental practice. One student comments: "Part of being part of a team is that you develop big ears and you hear what, you know, people are saying about junior and senior staff, I think there's a lot of politics in the Obstetrics department" (Lynn). Another says: "I've never come across so much gossip! (laughter). It's just rife with gossip. I don't know...like there's no other department I've come across where it is..." (Hazel). For one student who is involved in student governance this situation is a source of concern and in his view this impacts negatively on role modelling:

It's actually sad; it really is...The thing is that if senior colleagues cannot portray the respect for each other...and they are senior colleagues, how are we as junior colleagues meant to actually use them as role models and examples. It really is painful actually (Rajesh).

Power and powerlessness

In the context of what students have seen and experienced power is framed in terms of interpersonal relationships more typically in terms of receiver / provider relationships. These relationships include patient / midwife, student / midwife and student / doctor dyads.

Powerlessness is experienced as the withholding or influencing of something which is within the control of the person who is higher up in the hierarchical structure. The experience in 4th year differs in some sense from that of 6th year.

One common feature is the fact that in situations where students described interpersonal relationships the individual student is generally caught in a tripartite alliance and usually in a junior role. In 4th year it includes the student, the patient and the midwife whereas in the final year it includes the student, a more senior colleague and a vague entity variously called the 'department' or 'Obstetrics' i.e. 'the system'. In 6th year the midwife is rarely spoken of and, if at all, it is rarely in the teaching role reminiscent of 4th year. The use in final year of a term such as 'the department' to describe the third partner in the alliance shows that the community of practice has been expanded from something small and parochial to a much broader institutional framework.

At times a student is placed in a position that calls for advocacy or intervention but feels unable to act or speak up for fear of reprisal. This applies to both years. The issue of not being able to challenge practice or speak up is allied to a feeling of compromise regarding either principles and/or quality of care. One student expresses these issues as follows:

[A]s 4th years, you don't have any power... so even though your view is now it's not right to speak to a patient like that, or it's not right to force a patient to push because the shift's going to change... you can't stand up and you can't tell it to a nurse, because at the end of that night you need her to sign your book to say you've got deliveries (Anisha).

This forced silence or feeling of impotence takes its toll on the student in terms of that individual's developing sense of ethics and professionalism;

So you feel very bad as a person because you stand by and you let these things happen, and you know theoretically they should never (Anisha commenting on 4th year).

Lynn relates that to her behaviour in her current circumstances:

[T]he first time that happens, it's the first time you compromise yourself, and I find this year I'm quite shocked when I do things or don't do things that I should've. And I think one place it started was in 4th year (Lynn commenting on 6th year).

For Anisha 6th year brought a sense of empowerment. The 'power' came from the student's new status as a member of the team and thereby a provider of aspects of the service. With that came a sense of control and the potential also to give or withhold something of value to other team members.

[T]here is a difference, you have power now. Because in the wards, you're now expected to, we're running the wards as well, they need you to help because they are short of staff, and you know, that...that sort of difference in how you're treated (Anisha speaking of 6th year).

This student now felt able to withstand the pressure from the nurse. In terms of the student's relationship with midwives the learner of 4th year in 6th year is able to express the new and developing role of doctor as clinician and supervisor.

You go back as a 6th year... You no longer need that nurse to sign the book for you. So I didn't have a problem saying 'you know look, she's not ready to push, give her some time. She pushes, it comes at 12 o'clock, so what?' (Anisha).

With that ability to say 'no' she expresses a renewed sense of professional identity and integrity. *"You don't feel like you're not doing the right things or you feel like you've compromised who you are"*.

At the other end of the spectrum where the student is still the junior partner in the medical hierarchy there is a sense of frustration because of a lack of respect and recognition as a contributing member of the team. *"It wasn't about the work per se. It was about the appreciation and acknowledgement of you being there as a worker as well"* (Rajesh). This same student experienced verbal abuse from an intern who, in his mind, as a recently qualified person, was only one step above him in the hierarchy. *"And at 3 in the morning he called me and started shouting at me ... he couldn't... He's an intern..."* (Rajesh). His frustration was compounded by the fact he could not speak out because, *"They were all contributing towards our mark, so whatever we said, was going to be to our jeopardy"*. The level of frustration was such that he had to seek support from faculty student support structures.

I hated Obstetrics this year with an undying passion... maybe it's because I felt I was helpless. I had to go to our undergrad office and sit there and be emotional with her, with the undergrad officer, because really, I couldn't... I didn't know what to do (Rajesh).

A fellow student indicates that other students shared these sentiments: *"I've heard a lot of people have had experiences like that, it's not just you"* (Lynn).

Would students come back to the discipline?

A lack of enthusiasm to come back to the discipline and/or the department was evident although feelings at the end of a hectic few years might not be regarded as representative. Rajesh notes that, *"There's a lot of confounding factors when it comes to Obstetrics and Gynaecology, and then the whole academic thing that deters people from it"*. In his opinion the internship and community service will influence things. *"So I feel a lot of people are going to recover and do O&G, but I think right now, people are unsure"*. Another student suggested there was an all or nothing *"polarised view of Obstetrics, people love it and some people hate it"* (Hazel). In his view Thulani felt the hours *"are just too long and you know, there's the situation, the current situation as it stands, I don't think it is actually worth it"*. His perception of broader opinion was that *"a lot of people, a lot of my friends they say Obstetrics is actually"*

the last, the really last thing that they would actually consider in specialising". Working in an obstetric environment as a Medical Officer for a season rather than "commit ourselves to 4 years of grind as a registrar" was seen as a real possibility for some (Hazel).

A final word

What came out of the focus group session was confirmation that the exposure to the obstetric discipline at various times and in various places affected the individual student at various levels from the deeply personal to the highest professional level (expressed as not wanting to come back to specialise). The transition from observer (as in legitimate peripheral participation) to full participation is documented in a variety of ways as is the change in Discourse. The language generally is that of the discipline which indicates change in identity together with both the acquisition (Gee, 1990) and now the dominance of the Obstetric Discourse. This is well illustrated in the case of Rajesh who in his commentary recorded how he coped initially by drawing on his primary Discourse (parental experience and advice). In the interview he cites "*the attainment of more knowledge and experience*" which indicates the influence of the newly acquired Obstetric Discourse. The process of change clearly impacts on future decisions about who to be (identity) and what to do (roles and responsibilities). This evolution of role and identity is demonstrated rather poignantly in this student's contemplation on her future:

I'm still really scared about having my own babies, to go and specialise in this, it's just , it's too close to what you want to eventually do to actually specialise in. But I agree with her, I would love to go, to go and do 6 months or 12 months as a SHO or as an MO somewhere, just to work in the environment. It's definitely going to contribute, you can get to stop the bad practices if you can, or you do good practices, it makes you feel better (Anisha).

Chapter 6

Conclusions and Recommendations

"A Classroom of Life"

Hazel

Introduction

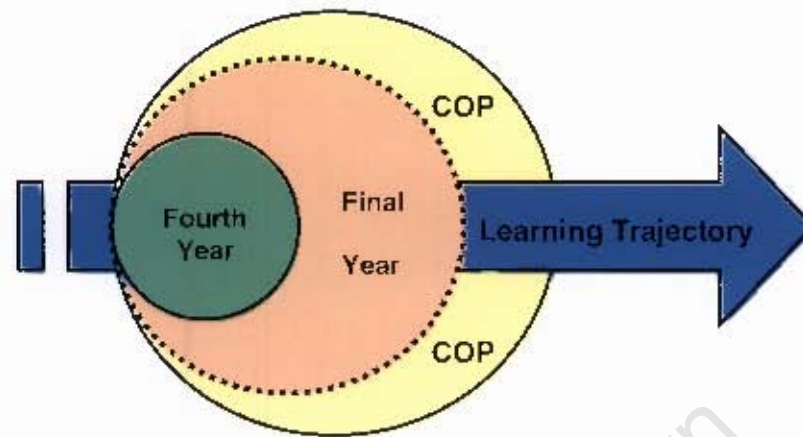
One of the students from the original group who submitted commentaries entitled her contribution "*My journey through the world of Obstetrics*". These few words provide a compact summary of the key theoretical frameworks used in this study and hint at some of its key findings. The 'world of obstetrics' represents the community of practice (COP) and the 'journey' captures the movement from legitimate peripheral towards full participation as well as the concept of learning trajectories as described by Lave and Wenger (1991). The title as a whole, but particularly the word 'through', gives a sense of a coming in and a going out, suggesting a peripheral rather than an inbound trajectory (Wenger, 1998). It also hints at the notion of a rite of passage. This sense of being in transit or transition draws attention to the concern that I have about students' perceptions of the 'world of obstetrics' (here the discipline and/or the Department of Obstetrics) and whether or not it is seen as an ultimate destination in terms of work or specialisation. In order to expand on these thoughts it is necessary to review the original research questions and the answers provided by this study.

Summary of important findings

As noted in the discussion of the theoretical framework, a COP is not always a single homogenous entity. In the situation described here the domains or spheres in which the fourth and final year students function overlap yet have distinct features. It is a factor that must be considered when interpreting the results. In essence the fourth year students' sphere of practice is largely confined to the labour ward whereas for final students it covers a much wider and varied field. Figure 10 illustrates how the two spheres of practice have a common origin and how both expand into the obstetric community of practice (COP) with the second year of exposure building on the first. The border of the final year field is dotted to indicate its lack of finality and the fact that it approaches but does not reach the limits of the community of practice. The blue arrow indicates a peripheral learning trajectory i.e. one that

passes through the COP. The answers to the research questions are presented below against this background.

Figure 9. Fourth and Final Year Spheres of Practice



Representations of roles, identities, relationships and issues of power.

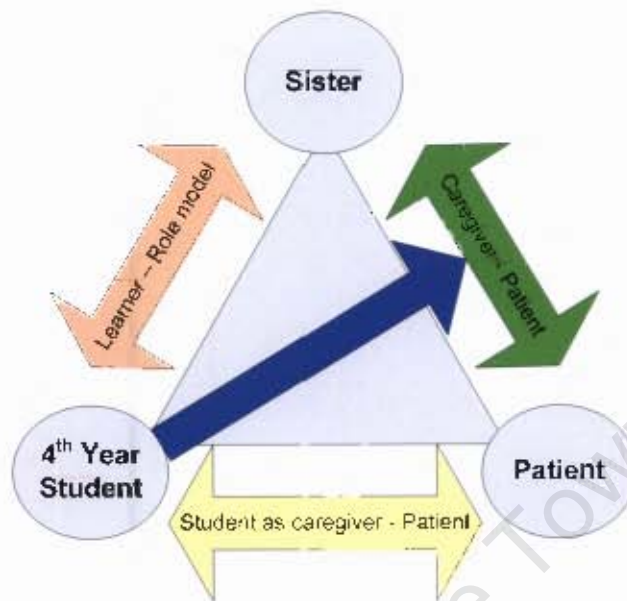
Students enter as newcomers who are naïve in terms of what they expect to happen and novices in terms of clinical knowledge and skills. Consequently they react almost as lay people and rely heavily on their Experiential Discourse to make sense of what they see and initially deal with the change required. Initially they show a poor understanding of childbirth as a social practice and are overwhelmed by the pain and suffering involved.

Patients play a key role in the student's identity formation. Whilst the student's goal is to become a doctor, in practical terms he/she first becomes a birth assistant (much like a midwife) and then a doctor. However, in the eyes of the patient and in terms of their own perceptions most students are seen as and 'feel' like a doctor. The relationship with a patient at an interpersonal level is very rarely portrayed overall in negative terms even if the initial contact is awkward.

The midwife plays a crucial role in the transfer of skills and scaffolding of student performance and development. In real terms she is the prime role model of 'caring' and students describe this both in terms of what to do/be or what not to do/be. Power issues also focus on the midwife. The issue of power as portrayed by students in the fourth year is located in the relationships between midwives and patients and students as depicted in figure 11. The midwife, as gate keeper or custodian of what happens to patients and students, wields disproportionate control or power. Disempowerment is experienced by both patients and students as not being able to object or express when circumstances or behaviour are not acceptable. Power is exercised by the withholding of what is requested or required by the person in the disadvantaged position. In the diagram the blue arrow indicates

the advocacy role that students intuitively want to fulfil on behalf of patients. However, they feel powerless to actually influence the situation or fear the consequences of trying to do so.

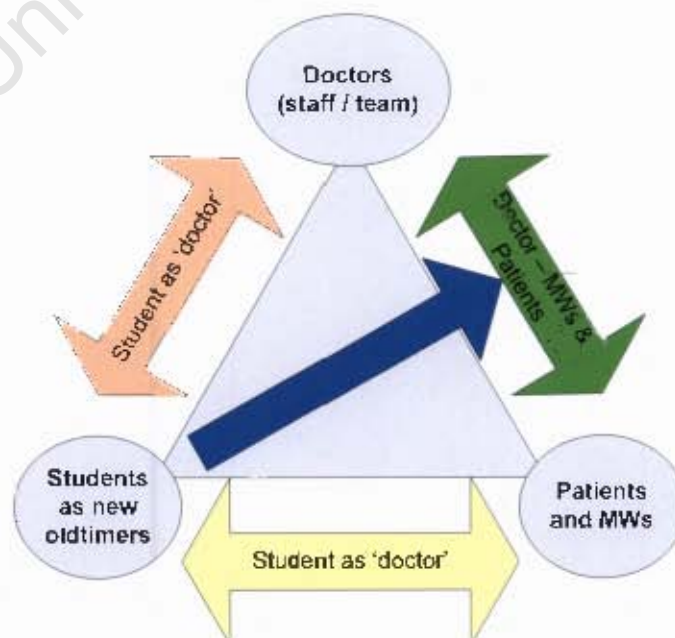
Figure 10 Key Relationships and Power in Fourth Year



Changes evident over time

The changes that are described are made evident by what the final year students say in the focus group session. The midwife is replaced by the doctor as the dominant role model (see figure 12) and the key role is seen as that of being a doctor. The student's relationships with

Figure 11 Key Relationships in Final Year



midwives and patients are described as being more detached and the paradigm is 'dealing with disease' i.e. cure rather than 'support' i.e. care. The student functions more and more in a 'doctor' type role both towards the patients and the other clinical team members.

Being 'part of the team' is experienced as having to share the work load whilst not being acknowledged as a member of staff (cf. the dotted line in figure 10). In terms of LPP students see full participation as being part of a team all the time and not just nominally when work needs to be done. In figure 12 the blue arrow indicates the points where the students as new old-timers at times feel excluded and seek entry and/or recognition.

The locus of power moves from the midwife to members of the medical staff and is independent of the member's level of seniority. Power is still perceived as the ability to withhold things. It is not clear whether the disempowerment stems from being a transient member of the team, not receiving a salary or from simply being a student whose status is still the subject of assessment. It may well be part of the 'commoditization' of unskilled labour as described by Lave and Wenger (1991) and highlighted in the discussion of the theoretical framework. Despite the in-between status vis-à-vis the doctors and more junior students, their status in respect of midwives changes. This is expressed in being able to say no, exercise options in terms of treatment and moving to a position of being able to withhold something that others need (especially nurses) without necessarily doing so.

Implications of the above for training and/or induction into the profession

If what has come out of the writing and reflections of these students is to have any lasting effect then it must impact on the following:

1. **A student support system** is needed with the capacity to recognise and manage students who are not coping with the change that takes place. This is premised on the fact that students will be better prepared on entry into the discipline.
2. The **quality of patient care** needs to be addressed as a separate issue.
3. The **quality of the learning environment** needs to be monitored continually. **Reflective writing** can play an important role but needs to be taken seriously in terms of providing feedback to students

Theoretical considerations

When appraising qualitative research Dixon-Woods et al (2004) indicate that it is crucial to recognise the theoretical perspective in which the research has been located. Against the background of earlier discussions in this regard only brief comments regarding situated learning, ritual theory and reflection will be made here.

It is worth reiterating that situated learning as described by Lave and Wenger (1991) is intended to be an analytical viewpoint or way of understanding learning and not an educational form or teaching strategy. Its value in understanding the dynamics of what is happening to students is clearly demonstrated here. The community of practice concept brings out important features of the learning / service environment whereas legitimate peripheral participation deals with the learning process. Issues that relate to the relationship between teacher and learner are also addressed. Two issues raised by Lave and Wenger need to be considered here. The first relates to their concept of a 'continuity-displacement contradiction'. This concept or a contextualised version thereof may explain some of the power issues between students and nurses. The second is their distinction between a teaching and a learning curriculum. In the case of the latter, learning is essentially situated. It is an approach that resonates with the problem oriented learning or task based approach currently applied within the faculty.

An aspect which situated learning does not address adequately relates to what is happening to the student at the level of personal change. Wenger's later work (1998) and his description of a social theory of learning moves in that direction and is helpful. Nevertheless the transformation in understanding and identity is probably better described in terms of ritual theory with the notions of separation, transition and re-integration being used to characterise the change taking place. The lack of a formal re-integration process is noted and is an area that needs to be addressed. Discourse has been another 'lens' through which to view the experiences of students. Separating the Experiential from the Obstetric Discourse has helped to track the both the learning trajectories and the changes in identity.

Reflection has been described as providing "*a window into the experience of students*" (Lichstein & Young, 1996). Quite apart from its role for the student as a learning tool reflective writing provides unique insights into the learning environment and the experience of the individual student. In many instances the revelations are quite intimate and personal which raises the question as to whether such writing should be subject to assessment. There is a great risk of students writing what they think would bring them additional marks rather than what would be valuable from an educational or support point of view.

Food for thought

There are some observations that are not adequately explained by this study. One of the more significant is the change in the relationship between students and patients when the two years of study are compared. The individual student's focus moves from involvement to detachment and from care to cure. The students comment on this and express a measure of concern. Is it inevitable or even necessary? Who or what is responsible and what role does the discipline of Obstetrics play in the process? To what extent is it a factor related to medical training in general or do certain disciplines contribute disproportionately to the change? The issues are raised. One can speculate. More research is needed to find adequate answers.

Where does this research fit in?

At the beginning of this thesis the point was made that context matters. That principle applies to the findings of this study and therefore it is appropriate to reflect briefly on where the findings must be placed when looking at the broader tapestry of research into medical education.

The comments made by students about the care of patients (or lack thereof) are vindicated by other local reports from Farrell and Pattinson (2004) and Jewkes et al (1998a) reporting on the obstetric students of Pretoria University and obstetric faculties in Cape Town respectively. In the case of the latter Jewkes et al (1998b) note that the physical abuse is reactive and even ritualised at times and cite several reasons for such behaviour. These go beyond a simple 'rotten apples in the barrel' explanation.

Obstetrics is often described as a discipline that makes a unique contribution to the training of medical students. That view is supported by the work of Sinclair (1997) who conducted a lengthy ethnographic study of a London medical school. Writing from both a medical and an anthropological perspective he makes several observations related to Obstetrics which could equally apply to the local situation. What it indicates is a remarkable stable training format which is labelled as an 'institutional apprenticeship' in the title of his book. It is so stable that it persisted largely unchanged for almost 150 years. It is only recent curriculum reform that has triggered change. It is a situation which finds an echo locally bearing testimony to the strong ties between the South African and the UK systems.

What is emerging from this reform process which by now is almost a global phenomenon, is awareness of the fact that what was thought to take place almost automatically in terms of

professional development is not actually happening or if at all then only in fragmented form. The issue of professionalism and professional development has become a key focal point. In this context, communities of practice, issues of identity, practice and community and many of the findings in this study assume a new relevance.

Regarding professionalism a number of key points are made in recent literature. Swick (2000) argues for a 'normative definition' of medical professionalism and identifies nine behaviours that constitute medical professionalism. The process at times is referred to as 'professional socialization'. Dornan and Bundy (2004) draw attention to the value of early clinical experience in initiating the socialization process whereas Pitkala and Mantyranta (2003) describe some of the problems encountered in the first clinical year. Broadhead (1983) highlights the cost to personal identity that was demanded in previous years. Boyask et al (2004) call for 'involved professionalism' which brings together knowledge, both personal and collective responsibility and responsiveness to society. The need for an explicit programme that is made known to both educators and learners is stressed by Chauvin (2002) and Swick et al (1999) while Kenny et al (2003) highlight the importance of role modelling.

Medicine is a profession and entering its communities of practice is part of becoming a professional or the professional socialization process. This study highlights gaps and deficiencies that need to be filled and / or rectified. What follows are some recommendations for doing so.

Recommendations

It is recommended that:

1. Regarding Training in Obstetrics and Gynaecology

- a) The insights gained must inform the future curriculum planning and implementation
- b) All the years of study should be integrated by mapping out not only what students should learn in terms of knowledge and skills but also their development as individuals and professionals. The concept of situated learning should inform this process.
- c) Students need to be given a meaningful 'voice' through the course evaluations, their reflective writing and any other means that will foster a sense of inclusion and show recognition of their contribution to the work of the department.

- d) Feedback (both positive and constructive negative) should be provided to nursing staff at the teaching sites.
- e) Attention must be given to the perceptions that students and potential future colleagues have of the discipline and steps taken to create an environment that will attract future medical officers and registrars.

2. Regarding Obstetric services steps should be taken

- a) to address the quality of care issues highlighted by the observations made by students. This should be done with due care to protect the working relationship between midwives and students.
- b) to improve the support of nurses working under extreme pressure due to the chronic shortage of nursing staff.

These activities should involve both the service providers (responsible for the service platform) and the relevant academic institutions (responsible for the teaching platform)

Prospects for future research

A number of options for further work have been created:

1. **A continuation of a longitudinal study involving the existing focal group members** could be considered. This would involve looking at other points in their trajectory of learning and membership of the obstetric community of practice.
2. **A comparative study involving students from the new curriculum** would provide insight into the effect of the new curriculum.
3. **Doing focussed research** on particular aspects such as reflection, professional development, narrative competence etc.

The possibility of employing an action research strategy with a multidisciplinary team that includes nurses, doctors, allied health professionals and professional educationalists should be considered.

A final word

The quote at the head of this chapter “*A classroom of life*” is the student’s way of summing up her Obstetric experience. It is a phrase that brings together two seemingly paradoxical ideas and creates a rich metaphor. It is the shortest sentence in her commentary. However its brevity fills it with meaning and power. It encapsulates her view of the obstetric block as a whole. “*A classroom of life*” suggests that she has learnt infinitely more than how to conduct a delivery. What is it that she wishes to convey? A classroom is a recognized space where learning takes place. By its nature and in its usual form it is a confining space and the associated learning is mostly planned, structured and formally delivered. “Life” on the other hand speaks of expanse and freedom (often coming at a cost), the unexpected and the frightening and most importantly reality. This student entered the classroom space and set about following the lesson plan. Reality took her down an entirely different path and her commentary describes very eloquently how the lesson plan changed. The lesson she learned is one that we should all learn and is best expressed in her own words:

“[W]hat it’s taught me most is that to be with someone in their pain, really with them, touches both mourner and comforter with a divine presence that reminds us what it is to be human”

“*A classroom of life*” is a message to us as academics and teachers that students, when doing their obstetric rotation, are learning and experiencing much more than how to catch a baby. Failure to see that is to fail our students, our patients, our medical and our nursing colleagues and ultimately ourselves.

A personal reflection

There have been many times when reading individual commentaries that I felt myself to be sitting in that same classroom learning about life. True to life there were moments of joy and those of sadness. There were also moments of anger and frustration because I felt young doctors had been robbed of experiences that could have altered their careers. There were those moments when I sensed the divine presence and felt intensely human.

To those students who allowed me into that private space to share their experiences I say thank you.

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APPENDIXES

University of Cape Town

Appendix A
Reflective Assignment

DEPARTMENT OF OBSTETRICS AND GYNAECOLOGY

4th YEAR OBSTETRICS COURSE - 2002

Becoming a reflective practitioner

Drawing on your recent experience, reflect and discuss how your first delivery experience has:

- a) Affected you as a person
- b) Shaped your understanding of the role of the midwife as teacher and model, and
- c) Given you insight into the needs of mothers in labour.

You are welcome to share any other insights that you have gained.

This assignment is not for marks. It is intended to make you stop and think about your experience in the knowledge that this facilitates learning.

Keep it simple – not more than 400 words.

George Draper

Course Convenor

Appendix B

Focal Group Commentaries

"THULANI"

When starting this block I did not know what to expect. Friends told me that this will be the best block ever in terms of feeling part of the medical profession and learning a lot of clinical skills. Thoughts were racing in my mind such as "what happens during birth", "will I be able to handle the baby properly", "will I faint" and "weather I will really enjoy the course?"

With my first delivery, the cord was around the baby's head. Thoughts were racing in my mind. The commentary you read to us came back to me. "Does this mean that my obstetric block will not be an enjoyable experience"? "How can I have a tragic first delivery"?

Sister Nani (at Somerset hospital) asked for the artery forceps and quickly clamped and cut the cord. She quickly delivered the baby and whisked the baby to resuscitate it. She instructed me to stay with the mother. All this time I was calmed by her calmness and professionalism and when the mother was asking for her baby I was able to reassure her that all was fine and that the Sister was helping baby to breath. When I heard baby crying I let out a sighed of relief knowing that all was well. From that moment on I knew that I had it in me to enjoy myself and to learn as much as I wanted to from every situation. A positive mind-set and an eagerness to make a difference, was for me the start of an enjoyable block.

It was a lot of hard work but the rewards where great. The mothers were always full of thanks afterwards. I had an opportunity to bond with the old and the new (mothers and baby). The look in their eyes and the sincerity of their thanks made me feel that I had made a positively contributed to their life and the hard work was forgotten.

I was part of an excellent management of a number of emergencies. With the aggressive resuscitation of a patient with a retained placenta, I saw how important it is to have people around who are cool headed and working together towards stabilising a patient and avoiding loss of life. The patient was successfully treated and well on her way to recovery. The other successful case is that of a patient coming in at 33 weeks gestation with an antepartum haemorrhage. She had two IV lines up and was wrapped up to keep her warm. She had classic signs of having had an Abruption (hard painful abdomen with signs of shock) and the registrar had to assess weather the fetus was still alive. An ultrasound was done and the fetal heart was present. Bloods were rushed for cross-matched and within four hours the patient was in theatre with a caesarean section being performed and being transfused. A 1,1-kg baby girl was successfully delivered and the mother was successfully transfused. The other emergency I assisted in was a case of impacted shoulders. I assisted in getting the patients knees on the chest while the sister rotated the baby's shoulders with successful delivery of the baby with no damage to mother or child. The baby weighed 4,2kg.

The only other aspect of obstetrics that I feel I was unable to contribute in was that of fetal loss. I wanted so much to be with a mother who had lost her child and be the one who comforts her. The closest I've been to this type of situation was when Anisha assisted in the delivery of an anencephalic fetus. The mother was counselled well before and she was accepting while the father did not know what to expect and he broke down. Anisha was there for them. The parents were given time to bond with the child and they named him Christopher. Baby Christopher lived for about 5 hours. I feel it's up to an individual, if they feel strong enough, to deliver a dead fetus or one that will not have a chance to survive outside the womb, giving comfort to the mother because most of the time I see them being isolated and left alone.

I can truly say that I have enjoyed this block. I have learnt a lot about obstetrics and myself. Giving birth is a natural process and having been a birth assistant I feel I'm in the right place. Thank you.

"HAZEL"

On reflection....

An experience that has shaped my life.

To me, obstetrics has been a kind of initiation rite into medicine. It's something that I entered into very naively; excited at the challenge and the romantic idea of birth – but actually quite clueless as to what the challenges really would be. I was unaware of the amount of conflict I would undergo. I suppose it's only through looking back that I can glimpse some of the growth that has taken place within me these past few weeks.

It hasn't been easy. It's been wonderful. It's been incredibly fulfilling. It's been the most amazing privilege. But it definitely hasn't been easy! Although, I suppose, it's tough experiences that teach us the most.

The most difficult experience for me was my second delivery. Bronwyn and I were in M... and the new night staff had come on duty. The previous night staff had been friendly and helpful and we were so disappointed by the aggression and off-handed rudeness of the new staff. Being real 'greenies' and new to the game, we didn't understand why they were being so awful when they didn't even know us. Not wanting to spend the rest of the week in a hostile environment we went out of our way to be helpful – cleaning up deliveries that weren't ours, fetching and carrying, booking patients so that that they could carry on watching 'Generations'.

Although we were bleak about how we were being treated, there was no comparison to how badly the patients were being treated. I was incredulous! For the week that we were there, M... was very quiet. Although we wanted to 'catch babies', it was actually valuable because it gave us the chance to spend a lot of time talking to the women and their families.

I met E..B.. as person, and spent a lot of time chatting to her about her 3 other children, her husband, her work, my work, how she was progressing, and how she was feeling. Her husband was outside waiting to be allowed in and we talked about how excited he was, and how grateful she was that he was there.

When she progressed to the active phase and was told to get up and go to the labour ward, I could feel the frowns as I helped her carry things there. I helped her up onto the bed and the sister sternly told me to leave her alone, she was fine. But E.. thanked me and smiled at me, and I knew I hadn't been out of place. By this time, her contractions were coming fast and furious, and not being used to this degree of physical pain, I was at a loss about what to do. I couldn't take it away. I couldn't fix it, I couldn't do anything! So I just let her hold me and I told her it would be alright, and breathed with her, mopped her face and snuck her little sips of water.

During one of her contractions, the sister in charge (my least favourite!) yanked open the curtain, put a glove on and stared at E... as if she'd crawled out from a piece of cheese. She stood there staring, as E.., sitting up, squeezed the blood out of my arm and concentrated on her breathing. At the end of the contraction, the sister said "So?" E.., exhausted, asked the sister what she wanted. The sister seemed annoyed that the patient didn't know the drill. "Lie down! Do you think I've got all night to wait for you?" (Yes, I was thinking, Yes! There is one other patient here, it's your job, and you're supposed to be providing CARE for this woman who is vulnerable and in pain, you stupid bag! You've got precisely all night to be there for her!) (... But I didn't say any of that.)

As E... began to ease herself down on the bed, another contraction began, and lying down on the bed was no longer first priority – getting through the pain was. The sister looked at her in a mixture between disbelief and disgust, snapped off her gloves and said, "If you don't want my help. I'm not going to help you. Your choice." And off she went.

I asked her if I could call E..'s husband in because she had started to ask for him, and she said 'no'. Apparently no one is allowed in to labour ward at night. I didn't understand because only the night before each mom was allowed one companion. I felt desperate because I knew how much it meant to both of them, and it was so frustrating not being able to do anything – no one would go against what she had said even though they knew it was wrong. When the moans of pain changed their tone to 'I mean business' moans I was torn between leaving E... and going and finding help. She REALLY didn't want me to go! I quickly ran to try and find one of the two midwives to help me. Neither of them

looked particularly concerned. Basically the message was, she's not my problem. I didn't get it. She wasn't even a difficult patient!

I went back, did my best, fumbling around on my second delivery, hoping I didn't mess things up. Fortunately the baby practically delivered himself, and my wealth of expertise (ha ha) wasn't needed; just a bit of perineal and emotional support. Even that I wasn't too good at because E... had torn, probably because the delivery was so uncontrolled. Eventually one of the midwives sauntered along to help stitch (without anaesthetic) and then my adrenalin rush turned into an anger that I could hardly control. I surprised myself at the strength of my feeling, and my desire to inflict pain on the so-called caregivers. I swore to myself that no matter how many patients I see, no matter how 'common' pain becomes, no matter how bad my day has been I will NEVER take that out on someone who is suffering and vulnerable. It is a privilege and a blessing to be able to help someone who needs you.

When the little boy was out and E... looked at me and said "I don't know what I would have done without you. I can't thank you enough;" I can't describe the emotion. It was one of the most meaningful moments of my life, and it's happened again since then. The time a woman opened up to me and told me how her husband rapes and beats her, and we cried together at the horror of it. The time an 18year old clung to me, streaked with vomit and blood as the truth that her stillborn really was dead sank in. It has been those moments when the ward is cold and smells. These moments when your feet are sore and you're so bored of taking blood pressures and pulses you could scream. It hasn't been pretty. It's been beautiful and ugly and bewildering and very, very real. A classroom of life. And what it's taught me most is that to be with someone in their pain, really **with** them, touches both mourner and comforter with a divine presence that reminds us what it is to be human.

"LYNN"

MY FIRST DELIVERY

As the time for my first night duty drew closer I became full of expectation. My partner and I were in the last rotation and each day we heard a fresh set of stories, new experiences, first deliveries, which sister to look out for and key Xhosa phrases. The night however, brought with it disappointment. There weren't even patients in second stage to monitor let alone deliver. We busied ourselves by helping the sisters in first stage but I couldn't help thinking that I was in for another week without having delivered a baby.

As the night drew on and the hours began counting towards morning I began to understand that obstetrics is not about catching your 15 babies. It was wonderful getting to know the sisters and watching them interacting with the patients both as birth companion and a teacher, explaining procedures and answering questions that most patients are afraid to ask the doctors. There have been many nights since when I have seen a nurse get a confused boyfriend up out of his chair to come and help the mother of his child as she goes through some of the most painful moments in her life. I have seen all the nurses stand round a patient, one hugging her talking constantly in hushed tones as she gives birth to an IUD. I have heard a nurse giving a fourth year level tutorials to a woman as she marvels at the birth of her twins. The most important part of the birth process is not the delivery but the quiet moments before and after when questions can be asked, doubts can be examined, fears can be faced and ultimately a woman can come to terms with moment that is going to change her life forever. In my personal life I have faced death and disease over the past year and to be surrounded by new life and old life mixing together I felt a sense of refreshment and the beginning of a paradigm shift.

Then at 6 o'clock exhausted and ready to face a new day I delivered my first baby. Everything happened so quickly, clamps and cords and hands were one blur in front of me. Then there on the bed was a new, bloody life that would one day sit just like her mother and wonder about choices she'd made and choices she'd have to make as she waited for a new life to come into the world.

"RAJESH"

I could not believe what I saw...the whole year of expectations and curiosity had come to its culmination and I was horrified. They were evil! They were terrifying! They screamed at the patients. They beat them on their thighs. And just as the mother couldn't bear the torture any longer, there it

was-the head was out. Within minutes the room was filled with the cries of a little baby boy. So overwhelmed by the whole sight, I forgot all about the cruel sisters. I began to wait in great anticipation for that feeling-that feeling you feel as the eager baby's head pushes against your supporting hand with that urge to jump out and take that leap into its mother's bosom.

The day went by, and St Monica's was so quiet. The young 18-year-old began to feel the pains get more and more severe, and yet with each pain, she began to grow weary of the inevitable agony she was about to endure when she would begin to bear down.

After 8 hours of observing her, she was ready. We could see the head! Afraid, I ran out the labour room to fetch a delivery trolley. "Did I get everything? Where are the clamps? Gloves? What size am I?" I stood there armed and ready with my swab supporting the perineum. But she would not push. The pains came and they went and she refused to push! The sisters began to scream louder, "Ncala! Ncala!"⁷ I could feel the anxiety in me rise as the tone of their voices became vicious! "Why doesn't she push?" Then they began slapping her on the thigh. With the fear levels reaching a high, she pushed and began to tear. The weary sisters pushed my hand aside as she brought the scissors and cut an episiotomy. Her screams were deafening. In that moment I felt my soul step aside from that bed as I began feeling dizzy from all the commotion. My mind became weary as I began to question the quality of care that is given in the public sector. I thought about my mother, who 21 years ago gave birth to me in a public hospital. I began to feel guilty that she would have had gone through the same horrifying experience in giving birth to me, all because they could not afford to go to a private hospital. I tried to picture her in that situation and I did not like it at all.

So much for first experiences... my mother always said that the only time you ever truly learn to drive is after you actually get your licence, and I can say the same for delivering babies. As I moved through the MOUs, I came across some of the most loving and caring nursing staff, whose major concern was to ensure that the mother's experience in child birth was a sacred time. I realised that the norms I established in my first week at St Monica's were actually unacceptable and that such evil practise is only confined to a few of the sisters at that MOU.

As my confidence has increased, I began to appreciate each and every moment of the mother's experience-each one being so different from the rest. From mother's who don't even want to look at their children to others who have no words to thank you for helping them bring their child into this world.

I am often asked why I became a Doctor, and for many a personal reason I always decline to tell anybody. I think one of the reasons affecting this decision is of fear that I am going to be a hypocrite and say things that in 15 years time I won't even remember why I said them. I want to experience each and everyday. I want to build on this calling that I had in life, and it is moments like these, when the mother's joy of holding her baby in her hand makes me realise how precious life is, and how much of responsibility I am taking on in my life. Thus far, throughout my degree, my study has always been on facts that can inevitable prevent death and disease, what the analysts call a positive negativity. For once, our study has been on "making" life-what the analysts will call a positive positivity. In the words of Dr Chris Warton, this experience (well, this whole block) definitely scores a high "WOW" score.

"ANISHA"

This entire 8wk block has been one of the best experiences of my life. For the first time since I started medicine I really felt like I was really involved with people. Trying to pick out a single experience during this block is tremendously hard... my biggest regret that it was only 8weeks.

Some moments to treasure forever:

My first delivery:

I had such a romantic idea of what it would be like. I thought the beauty of watching life come into this world would be an overwhelming experience, but in reality I wasn't thinking about the miracle of life, I was making my decision to adopt in the future.

The delivery itself went so fast, it was all just a blur of motion. The head, shoulders, body all came out at once and before I had a chance to watch for all those movements we had learned (restitution, etc)

⁷ The correct word in isiXhosa is actually "tyhala" or "tyala" which is a verb meaning "to push".

there was a baby boy giving his first cry. In subsequent deliveries I would get to see those movements and really get to marvel at the human creation, but not that first night.

So why will I always carry that first night so clearly in my memory?

I think it's because it was to be one of the most emotionally draining moments of my life. Here was a mother, who had just given birth, who should be enjoying the moment and instead she was crying her eyes out. She really tried to bear it but the pain was excruciating. She had such severe secondary tears that her insides were almost unrecognizable. The intern was too afraid to do the repair and it was left to the sister in charge.

During the repair I couldn't stop tears from escaping and my own voice had gotten very shaky. It was heart wrenching to hear her sobbing, to listen to her pleas for relief, to know that this was what had to be done...

After this I wasn't sure I could deliver again, I wondered, was it my fault she tore like that, did I not support the perineum enough? Just thinking back brings such a flood of emotion...

I owe an enormous debt of gratitude to the sisters at NSH who knew the fears/doubts I was having without me having to tell them. Their support and understanding is what got me through that first night and the rest of the block. It is often said that in order to understand it often helps to have experienced it...well if I ever see a woman wondering if its something she did/ did not to do which caused her complication – I know how powerful those feelings of self recrimination are. There is nothing anyone can say which removes all doubt but an understanding and sympathetic shoulder to lean on is invaluable and I just hope I can return the favour one day.

My anencephalic delivery:

Just before the delivery the sister pulled me aside and asked me if I was sure I wanted to deliver. I felt that I was strong enough and that I had a pretty good idea of what to expect so I assured her I would manage.

The delivery itself was amazing. I remember thinking God is All Great, All Merciful. Mrs M had no idea she was delivering, she couldn't feel any of it. A sister would feel for the contractions and tell her to push, she didn't even know when it crowned. For me that was tremendous that God could spare her the pain and trauma of the delivery as well.

My first shock : I didn't expect the baby to be so 'normal' from the face down. The parents initially did not want to see the baby but again thanks to the sister's patience and comforting care they agreed to see their son. We bandaged the head and dressed him as they asked and prayed he'd make it till we got him back to them.

Mother, father and baby bonded and they said their good byes. When they asked us to take him away they had already named him, Christian. They were so thankful for the time they had had.

For me it was a truly special experience.

Christian would lie in the labour ward for another 5hrs while they waited for an incubator to become available in high care. And every time I'd walk by the resus table I'd hear him cry softly or sneeze. When holding him he grasped my fingers so tightly, it left me wondering who said he won't survive? And I knew if I had such thoughts just imagine what his parents were thinking. Later his mother spoke to me, told me how much she was looking forward to her first child, how much her husband was looking forward to a son, how devastating this was to them. She had been so strong through the delivery, even when her husband started crying she had supported him, now she just needed someone to listen to her. I'll always be thankful that she gave me her trust, that I delivered her son for her, for as heartbreaking as it was, it was also tremendously special to have been allowed to get that close to her.

My final moment, my FIRST SOLO Delivery:

I was supposed to just be watching the patient as the sister stepped out for a second, when suddenly she started to crown. The mother was so quiet, so calm. I knew she was preterm, & was afraid for the baby. I shouted at the top of my lungs for help. Adrenaline rushed & I started to do what we normally do, support the perineum and the head as it came out. Another shout for help. And then I delivered the rest of the baby. By the time someone did come I already had my baby out, and breathing.

I never imagined I'd be able to do it on my own. The responsibility felt too much. I had been the one telling everyone I was so glad we only had to do "assisted deliveries". By the end of that night I was smiling from ear to ear. I was swelling with pride, overjoyed at my sense of accomplishment. It was one of those moments that turned out well so it was ok to enjoy it!

Thank you Dr Draper. I know this is longer than you wanted. Thank you also for this tremendous experience. I so often found myself in the wards on the nights I was off, just purely because there was no place I'd rather be. I did not want to miss one moment of it.

If I could I would thank all those mothers who let us in to their lives. Without their willingness to talk to us these 8 wks would never have been as touching and memorable as they were.

University of Cape Town

Appendix C

Documents relating to consent

UNIVERSITY OF CAPE TOWN



Department of Obstetrics and Gynaecology

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COMMENT ON REFLECTIVE COMMENTARIES

During your recent fourth year rotation through the Obstetric Department I had asked that, on a voluntary basis, you write a reflective commentary on your first delivery experience. Although not everybody chose to do the exercise I was absolutely amazed by the response that I got in terms of the content of the commentaries received. The insights gained by the participating students and the insight that it gave me regarding student learning and the teaching environment is something that I believe needs to be shared in an appropriate and sensitive manner with students and teachers alike. I would therefore request your permission to use anonymous extracts from your contribution for academic purposes. I undertake to protect the confidentiality of your submission.

Should you prefer that your commentary be excluded from such use I do understand and will respect your decision and would wish to assure you that this will not have any impact on your academic standing.

Could you please indicate your decision below in the appropriate block below.

CONSENT

I hereby freely give consent for extracts of my reflective commentary to be used for academic purposes provided that this is done on an anonymous basis and due care is taken to ensure that my academic standing is not adversely affected.

Signature:

Date:

I hereby wish to indicate that I would prefer not to have my reflective commentary used to provide descriptive material in the manner described above.

Signature:

Date:

Thank you for your consideration of this matter.
Yours sincerely

George Draper
September 2002



Department of Obstetrics and Gynaecology

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27 September 2004

Dear

RE: PARTICIPATION IN A STUDY

From the attached note you will see that I am requesting permission to use the reflective commentary that you wrote in 2002 during the fourth year Obstetrics block as the basis for a Masters degree in Higher Education that I am presently doing. Your particular commentary and the insights it gave were especially helpful. Because of that I would like to request your assistance in raising the study to a higher level. What I would ask you to do is the following:

1. To write an additional reflective commentary.
2. To participate in a focus group discussion.

Practical details

The reflective piece need not be more than 400 - 500 words. I shall provide a brief description of what is required.

The focus group will involve 6 – 8 people and will last about one hour. It will be a facilitated discussion and the idea is to use the discussion to explore some of the impressions gained from the commentaries. The session will be scheduled at a time that is convenient for the group. Refreshments will be provided.

In all cases the confidentiality of the participants will be respected. Participation is voluntary and participants are free to withdraw at any stage.

Your assistance would be greatly appreciated
Sincerely

George Draper



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28 September 2004

CONSENTING TO PARTICIPATION IN STUDY

I (name) hereby freely consent to participation in the research being conducted by Dr George Draper as outlined in the attached documentation. Furthermore I understand that:

- a) My involvement will in no way affect my academic standing and that the information given will be used for academic purposes only.
- b) Involvement includes the writing of a reflective commentary and participation in a focus group session.
- c) I am free to withdraw from the study at any stage and that this will not disadvantage me in any way.

I hereby confirm that my participation in this study is entirely voluntary.

Signature:

Date:

Appendix D

Guidelines for Focus Group Facilitator

Research Question

What discourses do medical students draw on to describe their apprenticeship into the obstetric profession?

More specifically:

- d) What themes emerge in their reflective comments?
- e) How are roles, relationships and issues of power represented?
- f) What are the implications of the above for training and/or induction into the profession?

Why do Focus Groups?

1. The case study methodology requires several sources of information. The focus groups would provide information not easily obtained in any other way.
2. It would provide validation of what had been determined from the earlier analysis. For example the themes identified included the student's own role in the management of patients, pain and suffering, the actual birth, midwife's role in caring for the patient, gender issues, life and death and coping with loss, identity issues, consideration of their own birth or whether to have children and an awareness of HIV.
3. It would provide a student perspective on what should be done to improve matters
4. Looking for clues as to why students are turned off from doing Obstetrics later in life.

NB Not only inquiring about the acquisition of knowledge and skills. It is also about being introduced into how to be a professional.

Possible trigger topics / questions

1. What comments would you make concerning your own or your class's introduction into obstetric practice in 4th year?
2. Who or what played a key role in shaping that experience?
3. Did you find writing the reflective commentaries helpful in dealing with critical issues at that time? What about the second commentary?
4. What would you say is the overall impression of Obstetrics in your class at this time? To what do you attribute that?
5. What recommendations would you make to change or improve that initial experience?

Appendix E

Quantitative Analysis of Data

Statistical Report compiled by the Dept of Public Health, University of CapeTown.

Aim

The aim of the analysis was to examine the relationship between the students' response to a request to submit a written reflective commentary on his or her first experience of conducting a delivery and their age, sex, first language, matriculation results and racial group.

Methodology

The study included the 159 students in the fourth year MBChB class of 2002 who had completed the obstetric component of that year. Of the original cohort, 159 cases were included in the analysis with the exception of the analysis involving matriculation results, where the sample consisted of 143 students due to the fact that 16 students had been schooled outside South Africa.

The outcome variable was a response to the request to write a reflective commentary on their first delivery experience, and was defined as a binary variable of a response or a non-response. The predictor variables were age, sex, English as first language, matriculation scores and racial group.

Statistical analysis

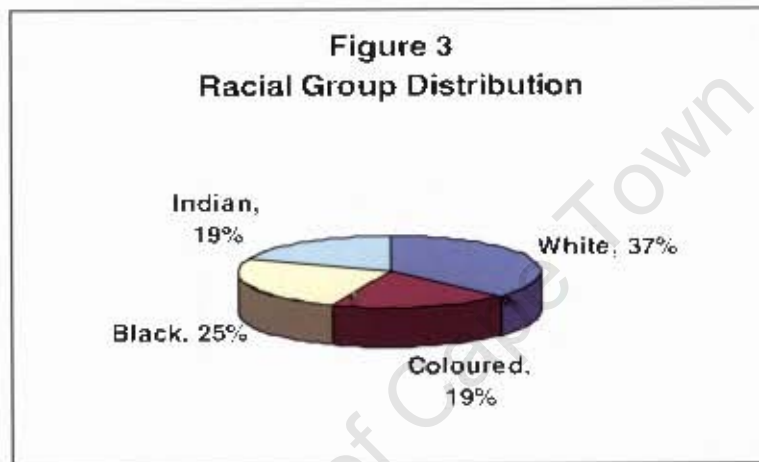
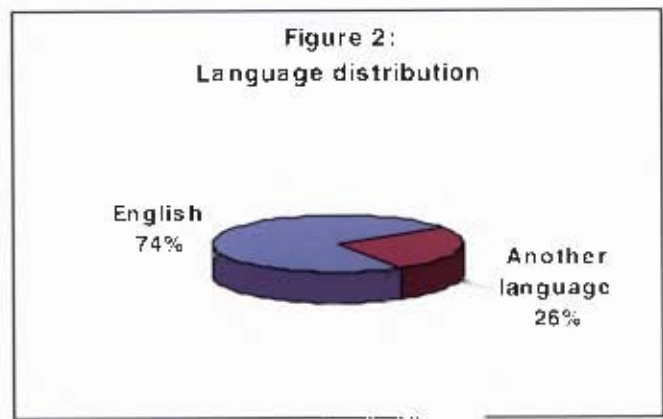
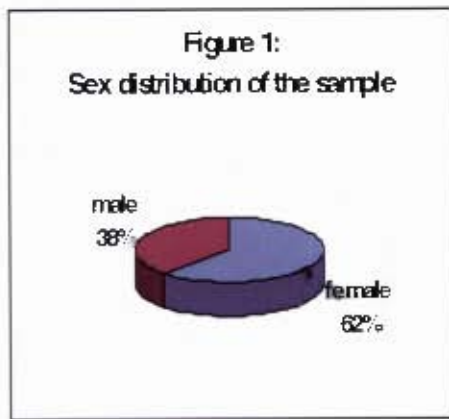
Both matriculation results and age were continuous variables: matriculation scoring was defined as a score out of 50, and age was defined in years. Sex and language were binary variables where language was defined as English first language or another language. Racial group was defined in four categories, namely Coloured, Black, Indian or White.

The data was analysed using the statistical package STATA 8. The cut off point for significance was set at $p = 0.05$

Descriptive statistics (mean, standard deviation, median, range and distribution) were calculated and histograms performed on the continuous variables age and matriculation score. The relationship between the outcome and the continuous variables was explored using the Wilcoxon sum rank test. The relationships between the variables of sex, language, race and the outcome were explored using the Pearson chi-square statistic. The predictor variables were also analysed for possible relationships between one another. The data was further analysed using logistic regression analysis. Possible interaction was explored for between possible confounders and the predictor variables.

Results

There were more female subjects than males, and the majority of students gave English as their first language. The distribution of the sample is shown below in figures 1 – 3



Both age and matriculation scores were found to have a skewed distribution (Figures 4 & 5). The first is explained by the fact that it represents a group that has completed secondary school and the second is an indication of the high level entry requirements of the medical school.

Figure 4: Age Distribution

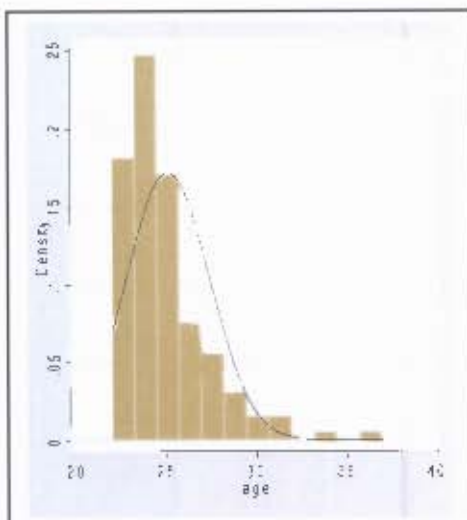


Figure 5: Matriculation Score Distribution

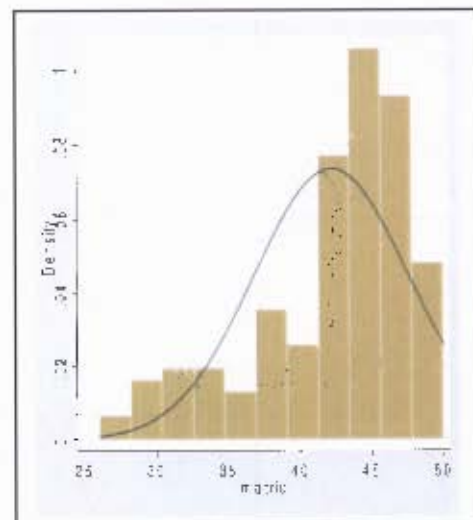


Table 1: Continuous variables

	Number of subjects	Median	Range
Age	159	24	23 – 34 years
Matriculation score	143*	44	27 – 50 points

* There were 16 students who were not schooled in the RSA

There were fewer responders (42%) than non-responders and the distribution according to the predictor variables is demonstrated in Table 2.

Table 2: Response data – Distribution of predictor variables

Response	Age in years	Matric score	Gender		Language		Racial group			
			M	F	English	Other	C	B	I	W
Yes (n = 66)	22.7	43.0	27%	73%	73%	27%	13%	26%	23%	38%
No (n = 93)	23.3	41.6	45%	55%	75%	25%	24%	24%	16%	36%

The results of the various statistical tests are shown in Table 3. Pearson’s chi-squared test indicated a significant difference in response according to sex ($p = 0.02$) and a non-significant response according to language group ($p = 0.72$). The Wilcoxon rank-sum test showed a significant difference between the response and non-response group according to age ($p = 0.01$), and a non-significant response according to matriculation score ($p = 0.22$).

Logistic regression analysis indicated no significant association between the response and sex, matriculation score, language or race group. In the regression analysis, age was the only variable that had a significant association with the response (OR 0.73, $p = 0.02$). Interaction and confounding were explored between age and the other predictor variables, but no significant associations were found.

Table 3: Association between response and variables

VARIABLE	RESPONSE			
	Individual		Logistic regression	
	Measure of association	P value	Measure of association (Odds Ratio)	P value
Age	Wilcoxon ranksum test	0.01*	OR = 0.73	0.02*
Sex	Chi squared test	0.02*	OR = 0.50	0.08
Matriculation score	Wilcoxon ranksum test	0.22	OR = 1.00	0.93
Language	Chi squared test	0.71	OR = 0.55	0.32
Racial group (x4)	**	-	OR = 1.22	0.25

* $p = <0.05$ i.e. the difference is significant

** Numbers too small – see logistical regression

It should be noted that there is a significant difference between the response and non-response groups when individual analysis is applied, but when logistic regression analysis is applied including all the predictor variables, then there is only a significant association between response outcome and age. One can conclude then, that for every 1 year increase in age, there is 27% decreased likelihood of response.

University of Cape Town

Appendix F

Thematic Analysis of all Reflective Commentaries

Introduction

As a background to the more detailed analysis of the five commentaries of the students who constituted the focal group, a brief thematic analysis of all the student commentaries was presented in chapter four. The methodology used was described at that time. What is reflected below is a more detailed and textured analysis of those commentaries. A list of the themes identified as well as the relative frequency with which they were mentioned is shown in table F.1.

Table F.1 Themes mentioned and relative frequency

THEMES	Number of Students (%) (N = 66)
BIRTH	
○ The actual birth as an event *	53 (80)
PATIENT	
○ Pain and suffering *	52 (79)
THE ROLE OF THE MIDWIFE	
○ Midwife's role in caring for the patient *	51 (77)
PERSONAL ISSUES	
○ Own role in the management of patients *	58 (88)
○ Personal Identity	23 (35)
○ Life and death and coping with loss	18 (27)
○ Own birth or whether to have children	13 (20)
CONTEXTUAL ISSUES	
○ Awareness of HIV	4 (6)

* Indicates that it was mentioned by more than half the group

Thematic Analysis

It may be helpful at this point to be reminded of the theoretical framework described in the literature review, more specifically Lave and Wenger's concept of situated learning. Students have indicated in their reflections that 'learning by doing' in the context of childbirth firstly involves infinitely more than simply delivering a baby and secondly that there is more to the

role of the midwife than being a mentor. As will become more evident in the discussion to follow, what is happening to the student is probably not fully covered by the notion of legitimate peripheral participation. The nature and extent of challenge demanded of the student is better explained or even supplemented by an understanding of 'transition' as outlined in the discussion on rites of passage.

1. The actual birth as an event

Responses to the birth varied. Some (33%) were positive - *"this was by far, the most beautiful experience I had EVER had...For me it was the realisation of the miracle of life and the precious nature of human existence"* (56PV). A similar number (33%) commented in more neutral fashion, *"I think I was too busy trying to get on top of all the technical aspects to get emotionally involved"* (3L5R). A smaller group (14%) were negative. The negative responses varied from disappointment that *"it was not a 'life changing'" event* (4M3N) to a more dramatic *"I found the labour experience to be quite humiliating and primitive"* (0A1C). The exposure for some, led to *"a new found respect for my mother and all mothers in general"* (1C7K).

2. Focus on the patient

The reality of the pain and suffering of childbirth came as a shock to most (79%). For some this evoked images of an uncontrollable force, *"I was thrown by how strong and violent the contractions were, (0A1C)"*, and even a battle field, *"Blood, guts and gore, screams of anguish and women writhing in pain became a familiar site for 6 arduous weeks (1C4C)*. Some were distressed by the fact that mothers often went through the experience alone: *"These patients were afraid and alone, and I don't think that anyone deserved to be treated like that"* (0B7J). Some however were able to process the experience by bringing the labour, the birth and post delivery situation into an integrated whole:

"I...left the room with three pictures. The first, the immense pain that the mum went through during labour (almost likened to violence). The second being the amazing birth process and the third being the culmination of the three ... mum breastfeeding. The violence and then peace, calm and serenity!" (3L3S).

3. The Role of the Midwife

The midwife, as the person supervising activities at the bedside plays a crucial role. Only slightly more than half of the students portrayed the midwife as teacher and role model in a positive light. Students with a more negative view noted that *"Instead of guiding and teaching*

me, she was screaming and making me feel like I knew nothing and will never learn anything" (4N8V). Another says "Some midwives' behaviour is a perfect example of what not to do or how to act" stating that difficult patients were not justification for poor practice, "...labouring mothers can be difficult, but shouting and threatening to do episiotomies without adequate analgesia is unacceptable" (5P5N). Other experiences were more positive. One recalls "The amount of information we received, both in practice and in theory, from the midwives was very valuable in helping us to understand the contents of the course" (2G1E) while another states that the midwife who assisted him "was very patient with both the patient and myself..." and that he was "very grateful for her tolerance and professionalism with which she handled the situation" (2GR2).

4. Personal Issues

Comments indicate that in this process of change their ability to manage patients, issues such as personal identity, personalising the birth experience and coping with issues of life and death all feature. The amount of personal work being done came as something of a surprise.

a) Their role in the management of patients

Contemplation of their own role in the management of patients featured very strongly (9 out of 10 students). Given the nature of the set reflective task this is not surprising. This took on a variety of forms. Most (74%) mentioned this aspect of care without making a strong value judgment. Being actively involved made a deep impact on many students. One was awed by the realisation the "first human being that ever touched him was me, what an awesome privilege..." and expressed the wish that, "I could see you grow, and appreciate the wonder of life" (5P3T). Others felt unsure even fearful, "My first night on call was drawing near and fear was welling up inside of me... What if I couldn't handle it?" (6S3V) whilst for others the feelings were even stronger, "I felt totally useless, inexperienced and inadequate" (59RC). For one particular student what he saw in labour ward of a mother's experience and how she was being treated was all too much. He could neither face nor challenge it. "Instead I got into my car and went home, vowing never to go back to Labour Ward even if it meant quitting medical school!" (1C7K). (Fortunately this student was able to process the experience and returned to complete the rotation and the degree).

Some (9%) were encouraged even affirmed by the experience and amazed at the level of patient trust. Feelings of "humility", being "useful" and "an intense human experience" were expressed. One student was enabled "to find my passion for this course again" (0A1C). A

few chose the option of detachment; *"One could become personally involved with much reward and risk becoming bitter or one could detach oneself. I think that detachment is the smart option"* (08BR).

a) Personal Identity

The issues of identity which came to the fore related to where students had come from personally and where they were going professionally. For some there was an awareness of coming from a privileged background; *"I was monitoring a 15 year old about to become a mother...It made me think of the opportunities and privileges that I have and sometimes take for granted"* (3K1I). For another, her early rural roots were recalled with a measure of guilt, *"She seemed to be asking, what went right with you? For the first time in my life, I truly felt guilty for being me. We had walked different paths, entirely"* (3M8B).

In terms of their developing sense of professional identity many students were challenged to think about their choice of doing medicine. For some the reality was difficult to deal with, *"I felt so small and insignificant amongst all the older medical students, interns, registrars, consultants and professors"* (0B9T). Others were affirmed, *"for the first time since I had started studying, I felt as if I myself actually did something to make a difference in someone's life, and to me this was a very rewarding experience"* (5P2Z).

b) Life and Death and Coping with Loss

Coping with obstetric loss was a new experience for some requiring adjustment, *"I felt like an intruder in someone else's private trauma...I had never felt our helplessness against Nature's will so acutely"* (3L4V). For some the loss was integrated at a much more personal level: *"In my personal life I have faced death and disease over the past year and to be surrounded by new life and old life mixing together I felt a sense of refreshment and the beginning of a paradigm shift"*

c) Own Birth and Whether to Have Own Children

For some the obstetric experience involved reflecting on their own birth: *"... the thought struck me, 'This may be the very room in which I took my first breath, 23 years ago!' Suddenly I saw in the patient, my mother"* (1B1G). Another also reflecting on his birth *"phoned home later that morning and said...'Mum, thank you!'"* (L3S3). Interestingly both are male students.

Various thoughts were expressed about whether to have children or not. Some were convinced not to, "*I was never keen to ever have children one day but now I know that I definitely don't want to go through what I saw that night*" (2J9C). Another expressed similar sentiments but changed her mind, "*I am now once again looking forward to having my own baby one day. I have come full circle and am the wiser for it*" (27IW). One of the male students had obviously gained insight into the role of the partner: "*As for my wife its hard to imagine that I will put her through this but most certainly I know ... the only place for a father is at the mother's side because at a difficult time like that nobody should be alone*" (51OM).

5. Contextual Issues

These contextual issues are included not because they were mentioned frequently but rather because they weren't mentioned frequently. This may reflect the influence of the prescribed task or simple that the childbirth process was all consuming in terms of the student's attention.

a) Gender awareness

References to the treatment of women in labour were based on considerations of what was basic compassionate care rather than as a feminist issue. There were new insights into how women were and should be treated: "*that night I came to realize how important mothers are, they bring babies into this world, they deserve all the respect and love*" (3K2T) and "*I appreciate womanhood and motherhood more profoundly*" (05BP). It is interesting to note that many of these comments are made by male students.

b) Awareness of HIV

The issue of HIV/AIDS is conspicuous by its absence. Most of the comments relate to the giving of the Nevirapine tablet during the course of labour. The comments however signal an understanding of the underlying issue namely that at the time of writing drugs were given for the benefit of the baby only. Antiretroviral drugs were not available to mothers and therefore the prospect of ultimately producing an HIV orphan was real. One student remembers: "*I heard the words... "Did you remember to take the Nevirapine tablets before labour?"..... Suddenly my excitement vanished to be replaced by a deep sense of disappointment and regret*" (3P6L). Another reflects on the underlying politics of providing antiretroviral treatment: "*I was however certain that I could do no harm. Much of the harm had been done already, and, according to the powers that be, nothing was to be done. The magic pill she had taken before birth would only protect one life*" (3M8B).

Appendix G

Examples of Coding and Discourse Identification

NOTES	TEXT	NOTES
<p>EXPECTATIONS Did not know / Friends to do = best block to feeling part of medical professional & learning clinical skills Q: birth / ability (skills & emotion) / enjoy course Feeling part = desire to belong</p>	<p>THULANI</p> <p>REFLECTION TO ACTION</p> <p>When starting this block I did not know what to expect. Friends told me that this will be the best block ever in terms of feeling part of the medical profession and learning a lot of clinical skills. Thoughts were racing in my mind such as " what happens during birth. will I be able to handle the baby properly", " will I faint" and "wonder I will really enjoy the course?"</p> <p>REFLECTION IN ACTION</p> <p>With my first delivery, the cord was around the baby's head. Thoughts were racing in my mind. The commentary you need to us came back to me. "Does this mean that my obstetric block will not be an enjoyable experience?" "How can I have a tragic first delivery?"</p> <p>Sister Nani (at Somerset hospital) asked for the artery toiceps and quickly clamped and cut the cord. She quickly delivered the body and whisked the baby to resuscitate it. She instructed me to stay with the mother. At this time I was calmed by her calmness and professionalism and when the mother was asking for her baby I was able to reassure her that all was fine and that the Sister was helping baby to breath. When heard baby crying I let out a sigh of relief knowing that all was well. From that moment on I knew that I had it in me to enjoy myself and to learn as much as I wanted to from every situation. A positive mind-set and an eagerness to make a difference, was for me the start of an enjoyable block.</p> <p>It was a lot of hard work, but the rewards were great. The mothers were always full of love's afterwards. had an opportunity to bond with the old and the new (mothers and baby). The look in their eyes and the sincerity of their love's made me feel that I had made a positively contributed to their life and the hard work was together.</p> <p>I was part of an excellent management of a number of emergencies. With the agony we resuscitation of a newborn with a retina net. Recently, I saw how important it is to have people around who are cool headed and working together towards stabilizing a patient and avoiding loss of life. The patient was successfully treated and well on her way to recovery. The other successful case is that of a patient coming in at 33 weeks gestation with an antepartum haemorrhage. She had two IV lines up and was wrapped up to keep her warm. She had classic signs of having had an Abruptio (large painful abdomen with signs of stroke) and the registrar had to assess whether the fetus was still alive. An ultrasound was done and the fetal heart was present. Bloods were rushed for cross-matched and within four hours the patient was in theatre with a caesarean section being performed and being successfully transfused. A 1.7-kg baby girl was successfully delivered and the mother was successfully transfused.</p> <p>The other emergency I assisted in was a case of impacted shoulders. assisted in getting the patient's knees, on the chest while the sister relaxed the baby's shoulders with successful delivery of the baby with no damage to mother or child. The baby weighed 4.2kg.</p> <p>REFLECTION ON ACTION</p> <p>The only other aspect of obstetrics that I feel I was unable to contribute in was that of fetal loss. I wanted so much to do with a mother who had lost her child and be the one who comforts her. The closest I've been to this type of situation was when Ayesha assisted in the delivery of an anencephalic fetus. The mother was counselled well before and she was accepting while the patient did not know what to expect and he broke down. Ayesha was there for them. The parents were given time to bond with the child and they named him Christopher. Baby Christopher lived for about 5 hours. I feel it's up to an individual, if they feel strong enough, to deliver a dead fetus or one that will not have a chance to survive outside the womb, giving comfort to the mother because most of the time, see them going isolated and left alone.</p>	<p>NOTES</p> <p>FIRST DELIVERY Complication = nuchal cord Unknown / related to commentary I read (#18FL) Q: Not enjoyable? Treat to expectation</p> <p>SAW SISTER IN ACTION Look care of mother & considered the mother (used / instructed student) Reassuring – calm & professional. Student related to mother Good outcome able to enjoy</p> <p>Asks Q then gives answer.</p> <p>Other aspects of professional behaviour = dealing with emergencies</p> <p>Excellent management / role modelling choices 1 Relaxed placenta – least effort 2 Abruptio - registrar 3 Impacted shoulders – sister and student (LPP to more central)</p> <p>Uses the jargon of the Obstetrics Discourse</p> <p>Ayesha was there for them I feel it's up to an individual, if they feel strong enough – wants to help / sees the need and feels it is not being met</p>
<p>Good example of professional in action</p> <p>Hard work outwards (Thanks) Bond with old (mother) and the new (baby) Interesting use of old & new</p> <p>Aggressive resus - shows insight i.e. severity and need for speed and lists NB actions</p> <p>Patient x 6 Patient vs mother (if + baby)</p> <p>Identified gap – mix fetal loss Desire to be the one who comforts Quotes an example of a fellow student – made strong impact and gives detail</p>		

<p>Enjoyed the block Learnt about Obs & self</p> <p>Q re birth – answer >>> Q re role – birth assistant</p>	<p>I can truly say that I have enjoyed this block. I have learnt a lot about obstetrics and myself. Giving birth is a natural process and having been a birth assistant I feel I'm in the right place. Thank you.</p>	<p>Unmet need</p> <ul style="list-style-type: none"> • Self • Patient <p>Want freedom to make decision</p> <p>OBSTETRIC Discourse</p>
<p>Discusses Block iso 1st Delivery</p> <p>Obstetrics = initiation rite into medicine i.e. identifies medicine as the larger Discourse</p> <p>Describes entry:</p> <ul style="list-style-type: none"> * Naively * Excited at challenge * Romantic idea of birth * Clueless into challenges <p>Unaware of conflict</p> <p>Gives an example of a difficult experience – the most difficult</p> <p>Highlights inexperience</p> <ul style="list-style-type: none"> > Greenies > New to the game <p>Disadvantaged Disempowered</p> <p>Compares to treatment of patients</p> <p>Not busy – chance to talk to patients & families</p> <p>Gives details of a specific patient & her husband</p> <p>Making her own judgment about the appropriateness of her own behaviour</p> <p>Confronted with pain – not sure what to do. Provides support</p> <ul style="list-style-type: none"> • Let her hold • Verbally reassured • Empathised • Comfort <p>Abuse brings forth a judgment and loss of respect</p> <p>Highlights what should be done</p> <p>Legitimate and appropriate to seek help</p>	<p>HAZEL</p> <p>On reflection... An experience that has shaped my life. } Summary</p> <p>REFLECTION ON ACTION</p> <p>To me, obstetrics has been a kind of initiation rite into medicine. It's something that I entered into very naively: excited at the challenge and the romantic idea of birth – but actually quite clueless as to what the challenges really would be. I was unaware of the amount of conflict I would undergo. I suppose it's only through looking back that I can glimpse some of the growth that has taken place within me these past few weeks.</p> <p>It hasn't been easy. It's been wonderful. It's been incredibly fulfilling. It's been the most amazing privilege. But it definitely hasn't been easy! Although, I suppose, it's tough experiences that teach us the most.</p> <p>REFLECTION IN ACTION</p> <p>The most difficult experience for me was my second delivery. Bronwyn and I were in M... and the new night staff had come on duty. The previous night staff had been friendly and helpful and we were so disappointed by the aggression and off-handed rudeness of the new staff. Being real 'greenies' and new to the game, we didn't understand why they were being so awful when they didn't even know us. Not wanting to spend the rest of the week in a hostile environment we went out of our way to be helpful – cleaning up deliveries that weren't ours, fetching and carrying, booking patients so that that they could carry on watching 'Generations'.</p> <p>Although we were bleak about how we were being treated, there was no comparison to how badly the patients were being treated. I was incredulous! For the week that we were there, M... was very quiet. Although we wanted to 'catch babies', it was actually valuable because it gave us the chance to spend a lot of time talking to the women and their families.</p> <p>I met F... as a person, and spent a lot of time chatting to her about her 3 other children, her husband, her work, my work, how she was progressing, and how she was feeling. Her husband was outside waiting to be allowed in and we talked about how excited he was, and how grateful she was that he was there.</p> <p>When she progressed to the active phase and was told to get up and go to the labour ward, I could feel the frowns as I helped her carry things there. I helped her up onto the bed and the sister sternly told me to leave her alone, she was fine. But E... hugged me and smiled at me, and I knew I hadn't been out of place. By this time, her contractions were coming fast and furious, and not being used to this degree of physical pain, I was at a loss about what to do. I couldn't take it away. I couldn't fix it. I couldn't do anything! So I just let her hold me and I told her it would be alright, and breathed with her, mopped her face and snuck her little sips of water.</p> <p>During one of her contractions, the sister in charge (my least favourite!) yanked open the curtain, put a glove on and stared at E... as if she'd crawled out from a piece of cheese. She stood there staring, as E... sitting up, squeezed the blood out of my arm and concentrated on her breathing. At the end of the contraction, the sister said "So?" E... exhausted, asked the sister what she wanted. The sister seemed annoyed that the patient didn't know the drill. "Lie down! Do you think I've got all night to wait for you?" (Yes, I was thinking, Yes! There is one other patient here, it's your job, and you're supposed to be providing CARE for this woman who is vulnerable and in pain, you stupid bag! You've got precisely all night to be there for her!) (... But, I didn't say any of that.)</p> <p>As E... began to ease herself down on the bed, another contraction began, and lying down on the bed was no longer her priority – getting through the pain was. The sister looked at her in a mixture between disbelief and disgust, snapped off her gloves and said "If you don't want my help, I'm not going to help you. Your choice."</p>	<p>No reflection to action – see title</p> <p>Uses the word experience to describe what happened to her = shaped her life</p> <p>As she reflects sees the growth</p> <p>Not easy</p> <p>Positive terminology</p> <ul style="list-style-type: none"> • Wonderful • incredibly fulfilling • Amazing privilege <p>Repeats not easy Tough >> teach most</p> <p>Compares different shifts Staff = aggressive, rude, off-handed</p> <p>Disappointed, couldn't understand – no grounds</p> <p>Student response</p> <ul style="list-style-type: none"> * Avoid hostility * Be helpful * trying to appease <p>Sister and patient</p> <ul style="list-style-type: none"> • Frowns when st helps • Does nothing to relieve pain • Non-verbal comms Yanked curtain / stared / seemed annoyed / look of disbelief and disgust / snapped off her gloves / left • Verbal comms 'So?' / Lie down! / Do you think I've got all night? If you don't want my help Your choice <p>Withheld husbands support</p> <p>Pattern of behaviour from midwives – similar lack of</p>

<p>Responds to need as best she can</p> <p>Patient has a fear that needs suturing</p> <p>Helping = privilege and a blessing</p> <p>Thank from pt = most meaningful moment - NB comes out of the most difficult</p> <p>It happened again</p> <p>Those moments</p> <p>Quote</p> <p>Contrasts / paradoxes</p> <p>Rediscovering humanity</p> <p>Divine presence = someone or something higher than us that transforms us</p>	<p>And off she went.</p> <p>I asked her if I could call E...s husband in because she had started to ask for him, and she said no. Apparently no one is allowed in to labour ward at night. I didn't understand because only the night before each mom was allowed one company. I felt desperate because I knew how much it meant to both of them, and it was so frustrating not being able to do anything – no one would go against what she had said even though they knew it was wrong. When the means of pain changed their tone to 'I mean business' means I was torn between leaving F... and going and finding help. She REALLY didn't want me to go! quickly ran to try and find one of the two midwives to help me. Neither of them looked particularly concerned. Basically the message was, she's not my problem. I didn't get it. She wasn't even a difficult patient.</p> <p>I went back, did my best, fumbling around on my second delivery, hoping I didn't mess things up. Fortunately the baby practically delivered himself, and my wealth of expertise (ha ha) wasn't needed: just a bit of perineal and emotional support. Even that wasn't too good at because E... had torn, probably because the delivery was so uncontrolled. Eventually one of the midwives sauntered along to help stitch (without anaesthetic), and then my adrenalin rush turned into an anger that I could hardly control. I surprised myself at the strength of my feeling, and my desire to inflict pain on the so-called caregivers. I swore to myself that no matter how many patients I see, no matter how common pain becomes, no matter how bad my day has been I will NEVER take that out on someone who is suffering and vulnerable. It is a privilege and a blessing to be able to help someone who needs you.</p> <p>REFLECTION ON ACTION</p> <p>When the little boy was out and F... looked at me and said "I don't know what I would have done without you. I can't thank you enough." I can't describe the emotion. It was one of the most meaningful moments of my life, and it's happened again since then. The time a woman opened up to me and told me how her husband rapes and beats her, and we cried together at the horror of it. The time an 18 year old clung to me, streaked with vomit and blood as the truth the her stillborn really was dead sank in. It has been those moments when the ward is cold and smells. These moments when you feel are sore and you're so boiled of taking blood pressures and pulses you could scream. It hasn't been pretty. It's been beautiful and ugly and bewildering and very, very real. A classroom of life. And what it's taught me most is that to be with someone in their pain, really with them, touches both mourner and comforter with a divine presence that reminds us what it is to be human.</p> <p>Hasn't been pretty > has been beautiful > ugly > bewildering > very, very real</p>	<p>concern</p> <p>Lack of concern - sauntering</p> <p>No anaesthetic - inhumane and unprofessional</p> <p>Provides a negative role model i.e. what not to be</p> <p>Makes a resolution</p> <p>No matter how.</p> <ul style="list-style-type: none"> • Many patients • Common pain • Bad my day <p>Will NEVER take it out on someone who is suffering and vulnerable</p> <p>Contrasts with what the student has discovered and experienced</p> <p>Something which the sister has lost</p> <p>Use of hasn't been & has been</p>
<p>Explores own personal space discovers a new life of her own</p> <p>As the time</p> <p>No patients in 2nd stage Disappointment – no deliveries. So we went to 1st stage – helped sisters</p> <p>As the night drew..</p> <p>New understanding of OD</p> <p>Defines:</p> <ul style="list-style-type: none"> • Getting to know srs • Elaborates on her growing understanding of sisters role • Understanding of birth • Implications of birth <p>Personal change in this context</p>	<p>LYNN</p> <p>MY FIRST DELIVERY</p> <p>REFLECTION TO ACTION</p> <p>As the time for my night duty drew closer I became full of expectation. My partner and I were in the last rotation and each day we heard a fresh set of stories, new experiences, fra deliveries, which sister to look out for and key Xhosa phrases. The night however, brought with it disappointment. There weren't even patients in second stage to monitor let alone deliver. We busied ourselves by helping the sisters in 1st stage but I couldn't help thinking that I was in for another week without having delivered a baby.</p> <p>REFLECTION IN ACTION</p> <p>As the night drew on and the hours began counting towards morning began to understand that obstetrics is not about catching your 15 babies. It was wonderful getting to know the sisters and watching them interacting with the patients both as birth companions and a teacher, explaining procedures and answering questions that most patients are afraid to ask the doctors. There have been many nights since when I have seen a nurse get a confused boyfriend up out of his chair to come and help the mother of his child as she goes through some of the most painful moments in her life, I have seen all the nurses stand round a patient, one hugging her talking constantly in hushed tones as she gives birth to an IUD. I have heard a nurse giving a fourth year level tutorials to a woman as she marvels at the birth of her twins. The most important part of the birth process is not the delivery but the quiet moments before and after when questions can be asked, doubts can be examined, fears can be faced and ultimately a woman can come to terms with moment that is going to change her life forever. In my personal life I have faced death and disease over the past year and to be surrounded by new life and old life mixing together I feel a sense of refreshment and the beginning of a paradigm shift.</p>	<p>Explores space & relationships of people who occupy the space</p> <p>Threads of time & space</p> <p>Not about catching your babies</p> <p>Boyfriend</p> <p>Context of birth</p> <p>Life & death</p>

<p>Then at</p> <p>First baby – very brief description New life x2 Circle of life</p>	<p>REFLECTION ON ACTION</p> <p>Ton at 6 o'clock exhausted and ready to face a new day I delivered my new baby. Everything happened so quickly; clamps and cords are hands were one blur in front of me. Then there on the bed was a new, bloody life that would one day sit just like her mother and wonder about choices she'd made and choices she'd have to make as she waited for a new life to come into the world.</p>	
<p>Very little reflection to action</p> <p>Watched delivery prior to doing a delivery</p> <p>Overwhelmed by birth so forgot about nurses</p> <p>Relates story of patient</p> <p>Questions about readiness</p> <p>Affected inwardly</p> <ul style="list-style-type: none"> • Questioned QOC in a public hospital • Guilt because he was delivered in such a situation • Could not afford private • Not happy with realization <p>Moved through the MOU system. Intro at VMOU not fully representative – needed to revise norms : evil practice confined to a few people & places</p>	<p>RAJESH</p> <p>REFLECTION TO and IN ACTION</p> <p>I could not believe what I saw...the whole year of expectations and curiosity had come to its culmination and I was horrified. They were evil! They were terrifying! They screamed at the parents. They beat them on their thighs. And just as the mother couldn't bear the torture any longer, there it was-the head was out. Within minutes the room was filled with the cries of a little baby boy. So overwhelmed by the whole sight, I forgot all about the cruel sisters. I began to wait in great anticipation for that feeling-that feeling you feel as the eager baby's head pushes against your supporting hand with that urge to jump out and take that leap into its mother's bosom.</p> <p>The day went by, and St Monica's was so quiet. The young 18-year-old began to feel the new get more and more severe, and yet with each beat she began to grow stronger of the inevitable agony she was about to endure when she would begin to beat down.</p> <p>After 8 hours of opposing her, she was ready. We could see the head! Afraid, I ran out the labour room to fetch a female nurse. "Did I get everything? Where are the clamps?" Clashes? What size are I?" I stood there armed and ready with my swab supporting the post-natal. But she would not push. The new came and they went and she refused to push! The sisters began to scream louder. "Naa! Naa!" I could feel the new in me rise as the tone of their voices became vicious! "Why doesn't she push?" Then they began slipping her on the thigh. With the new levels reaching a high, she pushed and began to tear. The new sisters pushed my hand aside as she brought the scissors and put an evil new. Her screams were drowning. In that moment I felt my soul stop aside from that bed as I began feeling dizzy from all the commotion. My mind became weary as I began to question the quality of care that's given in the public sector. I thought about my mother, who 21 years ago gave birth to me in a public hospital. I began to feel guilty that she would have had to go through the same horrifying experience in giving birth to me, all because they could not afford to go to a private hospital. I tried to picture her in that situation and I did not like it at all.</p> <p>REFLECTION ON ACTION</p> <p>So much for new experiences...my mother always said that the only time you ever truly learn to drive is after you actually get your licence, and I can say the same for delivering babies. As I moved through the MOUs, I came across some of the most daring and caring nursing staff, whose major concern was to ensure that the mother's experience in childbirth was a sacred time. I realised that the mother's establishment in my new week at St Monica's were actually unaccustomed and that such evil practice is only confined to a few of the sisters at that MOU.</p> <p>As my confidence has increased, began to appreciate each and every moment of the mother's experience-each one being so different from the rest. From mother's who don't even want to look at their children to others who have no words to new you for helping them bring their child into this world.</p>	<p>-horrified by behaviour of nurses Uses language of violence and abuse- Full / tear / crying / screamed / beat / torture / cruel</p> <p>Looked forward to the time when he would do the delivery</p> <p>Sisters response to patient</p> <ul style="list-style-type: none"> • Srs screamed louder • Tone became vicious • Slapping her thigh • Cut episiotomy without LA <p>Use of weary for patient > nurse and > student</p>
<p>Build on calling</p> <p>New understanding Facts – prevent death & disease (-ve negativity) Now focus "making life = +ve positivity"</p> <p>Decline to tell 'fear of not living up to that sid</p> <p>Why became a doctor</p> <p>Decline to tell 'fear of not living up to that sid</p> <p>Build on calling</p> <p>New understanding Facts – prevent death & disease (-ve negativity) Now focus "making life = +ve positivity"</p>	<p>I am often asked why I became a Doctor, and for many a personal reason I always decline to tell anybody. I think one of the reasons affecting this decision is of new that I am going to be a hypocrite and say things that in 15 years time I won't even remember why I said them. I want to experience each and everyday. I want to build on the calling that I had in life, and it is moments like these, when the mother's joy of holding her baby in her hand makes me realise how precious new is, and how much of responsibility I am taking on in my life. Thus far throughout my degree, my study has always been on facts that can revitalize prevent new and disease, what the analysts call a positive negativity. For once, our study highlighted on "making life" when the analysts will call a positive positivity. In the words of Dr Chris Watton, this experience (well, this whole block) definitely scores a high "WOW" score</p>	<p>Nonnamed mothers advice Analogy of licence</p> <p>Experiences of different mothers</p> <p>Seeing birth and interaction between mother and baby realises:</p> <ul style="list-style-type: none"> • How precious life is • How much responsibility <p>Draws on Chris Watton's WOW score</p>

	<h2 style="text-align: center;">AISHA</h2> <h3 style="text-align: center;">REFLECTION ON ACTION</h3> <p>This entire 8wk block has been one of the best experiences of my life. For the first time since I started medicine I really felt like I was really involved with people. Trying to pick out a single experience during this block is tremendously hard...my biggest regret that it was only 8weeks.</p> <p>Some moments to treasure forever</p> <p>My first delivery: I had such a romantic idea of what it would be like. I thought the beauty of watching me come into this world would be an overwhelming experience, but in reality I wasn't thinking about the miracle of me. I was making my decision to adopt in the future.</p> <p>The delivery itself went so fast, it was all just a blur of motion. The head, shoulders, body all came out at once and before I had a chance to watch for all those movements we had learned (restitution, etc) there was a baby boy giving his first cry. In subsequent deliveries I would get to see those movements and really get to marvel at the human creation, but not that first night.</p> <p>So why will I always carry that first night so clearly in my memory? I think its because it was to be one of the most emotionally draining moments of my life. Here was a mother, who had just given birth, who should be enjoying the moment and instead she was crying her eyes out. She really tried to bear it but the pain was excruciating. She had such severe secondary tears that her insides were almost unrecognizable. The intern was too afraid to do the repair and it was left to the sister in charge.</p> <p>During the repair I couldn't stop tears from escaping and my own voice had gotten very snaky. It was heart wrenching to hear her sobbing, to listen to her pleas for relief, to know that this was what had to be done... After this I wasn't sure I could deliver again, I wondered, was it my fault she tore like that, did I not support the perineum enough? Just thinking back brings such a flood of emotion...</p> <p>I owe an enormous debt of gratitude to the sisters at NSH who knew the fears/doubts I was having without me having to tell them. Their support and understanding is what got me through that first night and the rest of the block. It is often said that in order to understand it often helps to have experienced it... well if I ever see a woman wondering if its something she did/ did not to do which caused her complication - I know how powerful those feelings of self recrimination are. There is nothing anyone can say which removes all doubt but an understanding and sympathetic shoulder to lean on is invaluable and I just hope I can return the favour one day.</p> <p>My anencephalic delivery: Just before the delivery the sister pulled me aside and asked me if I was sure I wanted to deliver. I felt that I was strong enough and that I had a pretty good idea of what to expect so I assured her I would manage.</p> <p>The delivery itself was amazing. I remember thinking God is All Great, All Merciful. Mrs M had no idea she was delivering, she couldn't feel any of it. A sister would feel for the contractions and tell her to push, she didn't even know when I crowed. For me that was tremendous that God could spare her the pain and trauma of the delivery as well.</p> <p>My first shock: I didn't expect the baby to be so 'normal' from the face down. The parents initially did not want to see the baby but again thanks to the sisters patience and comforting care they agreed to see their son. We bandaged the head and dressed him as they asked and prayed he'd make it till we got him back to them.</p> <p>Mother, father and baby bonded and they said their good byes. When they asked us to take him away they had already named him. Christian. They were so thankful for the time they had had.</p> <p>For me it was a truly special experience.</p> <p>Christian would lie in the labour ward for another 5hrs while they waited for an incubator to become available in high care. And everytime I'd walk by the resus table I'd hear him cry softly or sneeze. When holding him he grasped my fingers so tightly, it left me wondering who said he won't survive? And I knew if I had such thoughts, just imagine what his parents were thinking. Later his mother spoke to me, told me how much she was looking forward to her first child, how much her husband was looking forward to a son, how devastating this was to them. She had</p> <th data-bbox="1249 136 1524 2078"> <h3 style="text-align: center;">REFLECTION to ACTION</h3> <p>At the start of each case description Expectation - to be really involved with people</p> <p>Romantic idea Would be overwhelming instead personalized and thought of giving birth herself - decided to adopt</p> <p>Why such an impression?</p> <p>Patient tore - had pain after birth which detracted from her ability to enjoy baby Severity</p> <p>Impact of failure on the first attempt</p> <p>Questions her own role in producing the situation Able to deliver again Fear of failure</p> <p>Self recrimination</p> <p>Makes a resolution for the future</p> <p>Reflection to action Expectation Questions from the sister regarding preparedness</p> <p>? had epidural Caring on the part of caregivers (Drs)</p> <p>Management of delivery and abN. Role of sisters perceived positively</p> <p>NB Alternates what happened to parents with what is happening to her</p> <p>Links her thoughts with what she imagines theirs to be = empathy</p> <p>Saw baby as a person just like the parents - speaks of his mother and uses his name Realises the importance of</p> </th>	<h3 style="text-align: center;">REFLECTION to ACTION</h3> <p>At the start of each case description Expectation - to be really involved with people</p> <p>Romantic idea Would be overwhelming instead personalized and thought of giving birth herself - decided to adopt</p> <p>Why such an impression?</p> <p>Patient tore - had pain after birth which detracted from her ability to enjoy baby Severity</p> <p>Impact of failure on the first attempt</p> <p>Questions her own role in producing the situation Able to deliver again Fear of failure</p> <p>Self recrimination</p> <p>Makes a resolution for the future</p> <p>Reflection to action Expectation Questions from the sister regarding preparedness</p> <p>? had epidural Caring on the part of caregivers (Drs)</p> <p>Management of delivery and abN. 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<p>One of the best experiences Experience is a key word</p> <p>Chooses 3 'first' experiences to illustrate</p> <p>Fast - couldn't do the academic thing - baby giving its first cry.</p> <p>Marvelled subsequently</p> <p>One of the most emotionally draining moments</p> <p>Support from sisters</p> <ul style="list-style-type: none"> • Practical • Emotional <p>Has her feelings understood allows her to do so later Translates experience into empathy for others in the future NB Relates it to women and not colleagues</p> <p>A more difficult delivery</p> <p>Supervision from sister Extending boundaries</p> <p>Not what she expected Part of dealing with parents</p> <p>Experience = very positive</p> <p>Mature approach</p> <p>Thankful:</p> <ul style="list-style-type: none"> • Patient's trust • D/d delivery • Even though 		

<p>heartbreaking special because she got close to the patient</p> <p>Expecting to just watch Sister out for a moment</p> <p>Started to crown & delivered with her assistance before staff returned</p> <p>Did not expect she could deliver on her own – the responsibility was too great</p> <p>Acknowledges the contribution of those who made it possible</p>	<p>been so strong through the delivery, even when her husband started crying she had supported him, now she just needed someone to listen to her. I'll always be thankful that she gave me her trust, that I delivered her son for her, for as heartbreaking as it was, it was also tremendously special to have been allowed to get that close to her.</p> <p>My final moment, my FIRST SOLO Delivery: I was supposed to just be watching the process as the sister stepped out for a second, when suddenly she started to crown. The mother was so quiet, so calm, I knew she was preterm, & was afraid for the baby. I shouted at the top of my lungs for help. Adrenaline rushed & I started to do what we normally do: support the perineum and the head as it came out. Another shout for help. And then I delivered the rest of the baby. By the time someone did come I already had my baby out, and breathing.</p> <p>I never imagined I'd be able to do it on my own. The responsibility felt too much. I had been the one telling everyone I was so glad we only had to do "assisted deliveries". By the end of that night I was smiling from ear to ear. I was swelling with pride, overjoyed at my sense of accomplishment. It was one of those moments that turned out well so it was ok to enjoy it!</p> <p>Thank you Dr Draper. I know this is longer than you wanted. I thank you also for this tremendous experience. I so often found myself in the wards on the nights I was off, just purely because there was no place I'd rather be. I did not want to miss one moment of it.</p> <p>If I could I would thank all those mothers who let us in to their lives. Without their willingness to talk to us these 6 wks would never have been as touching and memorable as they were.</p>	<p>Listening</p> <p>Did what she had been taught</p> <p>Moment of pride and achievement</p> <p>Back in the wards at other times – not because she had to be there but because she wanted to</p>
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Obstetric vs Experiential Discourse

THULANI

1 When starting this **block** I did not know what to expect. Friends told me that this will be the best **block** ever in terms of feeling part of the **medical profession** and learning a lot of **clinical skills**. Thoughts were racing in **my mind** such as "what happens during birth", "will I be able to handle the baby properly", "will I faint" and "weather I will really enjoy the course?"

2 With **my first delivery**, the **cord** was around the baby's head. Thoughts were racing in **my mind**. The commentary you read to **us came back to me**. "Does this mean that **my obstetric block will not be an enjoyable experience**?" "How can I have a tragic first delivery?" Sister Nani (at Somerset hospital) asked for the artery forceps and quickly clamped and cut the cord. She quickly delivered the baby and **whisked** the baby to resuscitate it. She **instructed me to stay with the mother**. All this time I was calmed by her calmness and professionalism and when the mother was asking for her baby I was able to reassure her that all was fine and that the Sister was **helping baby to breathe**. When I heard baby crying I let out a **sigh of relief** knowing that all was well. From that moment on I knew that I had it in **me to enjoy myself and to learn as much as I wanted to from every situation**. A positive mindset and an eagerness to make a difference, was for **me** the start of an **enjoyable block**.

3 It was a lot of **hard work** but the **rewards were great**. The mothers were always **full of thanks** afterwards. I had an **opportunity to bond** with the old and the new (mothers and baby). The **look in their eyes** and the **sincerity of their thanks** made **me** feel that I had **made a positive contribution** to their life and the **hard work was forgotten**.

4 I was part of an excellent **management** of a number of **emergencies**. With the **aggressive resuscitation** of a patient with a retained placenta, I saw how **important it is to have people around who are cool headed and working together towards stabilising a patient and avoiding loss of life**. The patient was successfully treated and well on her way to recovery. The other successful case is that of a **patient** coming in at **33 weeks gestation** with an **antepartum haemorrhage**. She had two IV lines up and was **wrapped up to keep her warm**. She had classic signs of having had an Abruption (**hard painful abdomen with signs of shock**) and the **registrar** had to **assess** whether the **fetus was still alive**. An **ultrasound** was done and the **fetal heart** was present. **Bloods** were rushed for **cross-matched and within four hours the patient was in theatre with a caesarean section being performed and being transfused**. A **1.1-kg baby girl** was successfully delivered and the mother was successfully transfused. The other **emergency I assisted in** was a case of impacted shoulders. I **assisted in getting the patients knees on the chest** while the sister rotated the baby's **shoulders** with successful **delivery of the baby with no damage to mother or child**. The **baby weighed 4.2kg**.

5 The only other aspect of **obstetrics** that **I feel I was unable to contribute** in was that of **fetal loss**. **I wanted so much** to be with a mother who **had lost her child and be the one who comforts her**. The closest I've been to this type of situation was when Ayesha **assisted** in the **delivery** of an **anencephalic fetus**. The mother was **counselled** well before and she was accepting while the father did not know what to expect and he broke down. Ayesha was there for them. The parents were given time to bond with the child and they named him Christopher. Baby Christopher **lived for about 5 hours**. **I feel it's up to an individual**, if they feel strong enough, to **deliver a dead fetus** or one that will not have a chance to **survive** outside the **womb**, giving comfort to the mother because most of the time **I see them being isolated and left alone**.

6 **I can truly say that I have enjoyed this block**. I have **learned a lot about obstetrics** and myself. Giving birth is a **natural process** and **having been a birth assistant I feel I'm in the right place**. Thank you.

HAZEL

On reflection...

An **experience** that has shaped **my** life.

1 **To me, obstetrics** has been a kind of initiation rite into **medicine**. It's something that **I entered into very naively**, excited at the challenge and **the romantic idea of birth** – but actually quite **clueless as to what the challenges really would be**. **I was unaware** of the amount of conflict **I would undergo**, **I suppose it's only through looking back** that **I can glimpse some of the growth** that has taken place within **me** these past few weeks.

2 **It hasn't been easy. It's been wonderful. It's been incredibly fulfilling. It's been the most amazing privilege. But it definitely hasn't been easy!** Although, **I suppose, it's tough experiences that teach us the most**.

3 The most difficult **experience for me** was **my second delivery**. Bronwyn and **I were in M...** and the new **night staff** had come on **duty**. The previous **night staff** had been **friendly and helpful** and **we** were so disappointed by the aggression and off-handed rudeness of the new **staff**. **Being real 'greenies' and new to the game, we didn't understand** why they were being so awful when they didn't even know us. Not wanting to spend the rest of the week in a hostile environment **we went out of our way to be helpful** – **cleaning up deliveries** that weren't ours, fetching and carrying, **booking patients** so that they could carry on watching 'Generations'.

4 Although **we** were **bleak** about **how we** were being treated, there was no comparison to how badly the **patients** were being treated. **I was incredulous!** For the week that **we** were there, **M...** was very quiet. Although **we** wanted to **'catch babies'**, it was actually valuable because it gave **us** the chance to spend a lot of time talking to the women and their families.

5 **I met E.B., as person, and spent a lot of time chatting to her** about her 3 other children, her husband, her work, **my** work, how she was progressing, and how she was feeling. Her husband was outside waiting to be allowed in and **we** talked about how excited he was, and how grateful she was that he was there.

6 When she progressed to the **active phase** and was told to get up and go to the **labour ward**, **I could feel the frowns** as **I helped her** carry things there, **I helped her up onto the bed** and the **sister sternly told me** to leave her alone, she was fine. But E... thanked **me** and smiled at **me**, and **I know I hadn't been out of place**. By this time, her **contractions** were coming fast and furious, and not being used to this degree of **physical pain**, **I was at a loss** about what to do. **I couldn't take it away, I couldn't fix it, I couldn't do anything!** So **I just let her hold me** and **I told her it would be alright, and breathed with her, mopped her face and snuck her little sips of water**.

7 During one of her **contractions**, the **sister in charge** (**my** least favourite!) yanked open the curtain, put a **glove** on and stared at E... as if she'd crawled out from a piece of cheese. She stood there staring, as E... sitting up, squeezed the blood out of **my** arm and concentrated on her **breathing**. At the end of the **contraction**, the **sister** said "So?" E... exhausted, asked the **sister** what she wanted. The **sister** scowled annoyed that the patient didn't know the drill. "Lie down! Do you think I've got all night to wait for you?" (Yes, **I was thinking**. Yes! There is one other **patient** here, it's your job, and you're supposed to be **providing CARE** for this woman who is vulnerable and in pain, you stupid bag! You've got **precisely** all night to be there for her!) (... **But I didn't say any of that!**)

8 As E... began to ease herself down on the **bed**, another **contraction** began, and lying down on the **bed** was no longer first priority – getting through the **pain** was. The **sister** looked at her in a mixture between disbelief and disgust, snapped off her **gloves** and said. "If you don't want **my** help, I'm not going to help you. Your choice." And off she went.

9 **I asked her if I could call E.'s husband** in because she had started to ask for him, and she said 'no'. Apparently no one is allowed in to **labour ward** at night, **I didn't understand** because only the night before each mom was allowed one companion. **I felt desperate** because **I knew how much** it meant to both of them, and it was so frustrating not being able to do anything – no one would go against what she had said even though they knew it was wrong. When the moans of **pain** changed their tone to 'I mean business' moans **I was torn** between leaving E... and going and finding help. She REALLY **didn't want me to go!** **I quickly ran to try and find one of the two midwives** to help me. Neither of them looked particularly concerned. Basically the message was, she's not **my** problem **I didn't get it**. She wasn't even a difficult **patient!**

10 I went back, did my best, tumbling around on my second delivery, hoping I didn't mess things up. Fortunately the baby practically delivered himself, and my wealth of expertise (ha ha) wasn't needed; just a bit of perineal and emotional support. Even that I wasn't too good at because F... had torn, probably because the delivery was so uncontrolled. Eventually one of the midwives sauntered along to help stitch (without anaesthetic) and then my adenalin rush turned into an anger that I could hardly control. I surprised myself at the strength of my feeling, and my desire to inflict pain on the so-called caregivers. I swore to myself that no matter how many patients I see, no matter how common pain becomes, no matter how bad my day has been I will NEVER take that out on someone who is suffering and vulnerable. It is a privilege and a blessing to be able to help someone who needs you.

11 When the little boy was out and F... looked at me and said "I don't know what I would have done without you. I can't thank you enough." I can't describe the emotion. It was one of the most meaningful moments of my life, and it's happened again since then. The time a woman opened up to me and told me how her husband rapes and beats her, and we cried together at the horror of it. The time an 18-year-old clung to me, streaked with vomit and blood as she told me her stillborn really was dead, sank in. It has been those moments when the ward is cold and smells. These moments when your feet are sore and you're so bored of taking blood pressures and pulses you could scream. It hasn't been pretty. It's been beautiful and ugly and bewildering and very, very real. A classroom of life. And what it's taught me most is that to be with someone in their pain, really with them, touches both mourner and comforter with a divine presence that reminds us what it is to be human.

LYNN

MY FIRST DELIVERY

1 As the time for my first night duty drew closer I became full of expectation. My partner and I were in the last rotation and each day we heard a fresh set of stories, new experiences, first deliveries, which sister to look out for and key Xhosa phrases. The night however, brought with it disappointment. There weren't even patients in second stage to monitor let alone deliver. We busied ourselves by helping the sisters in first stage but I couldn't help thinking that I was in for another week without having delivered a baby.

2 As the night drew on and the hours began counting towards morning I began to understand that obstetrics is not about catching your 15 babies. It was wonderful getting to know the sisters and watching them interacting with the patients both as birth companion and a teacher, explaining procedures and answering questions that most patients are afraid to ask the doctors. There have been many nights since when I have seen a nurse get a confused boyfriend up out of his chair to come and help the mother of his child as she goes through some of the most painful moments in her life. I have seen all the nurses stand round a patient, one hugging her talking constantly in hushed tones as she gives birth to an IUD. I have heard a nurse giving a fourth year level tutorial to a woman as she marvels at the birth of her twins. The most important part of the birth process is not the delivery but the quiet moments before and after when questions can be asked, doubts can be examined, fears can be faced and ultimately a woman can come to terms with moment that is going to change her life forever. In my personal life I have faced death and disease over the past year and to be surrounded by new life and old life mixing together I felt a sense of refreshment and the beginning of a paradigm shift.

3 Then at 6 o'clock exhausted and ready to face a new day I delivered my first baby. Everything happened so quickly, clamps and cords and hands were one blur in front of me. Then there on the bed was a new, bloody life that would one day sit just like her mother and wonder about choices she'd made and choices she'd have to make as she waited for a new life to come into the world.

RAJESH

1 I could not believe what I saw... the whole year of expectations and curiosity had come to its culmination and I was horrified. They were evil! They were terrifying! They screamed at the patients. They beat them on their thighs. And just as the mother couldn't bear the torture any longer, there it was, the head was out. Within minutes the room was filled with the cries of a little baby boy. So overwhelmed by the whole sight, I forgot all about the cruel sisters. I began to wait in great anticipation for that feeling-that feeling you feel as the engendered baby's head pushes against your supporting hand with that urge to jump out and take that leap into its mother's bosom.

2 The day went by, and St Monica's was so quiet. The young 18-year-old began to feel the pains get more and more severe, and yet with each pain, she began to grow weary of the inevitable agony she was about to endure when she would begin to bear down.

After 8 hours of observing her, she was ready. We could see the head! Afraid, I ran out the labour room to fetch a delivery trolley. Did I get everything? Where are the clamps? Gloves? What size am I? I stood there armed and ready with my swap supporting the perineum. But she would not push. The pains came and they went and she refused to push! The sisters began to scream louder, "Natal Natal!" I could feel the anxiety in me rise as the tone of their voices became vicious! "Why doesn't she push?" Then they began slapping her on the thigh. With the fear levels reaching a high, she pushed and began to tear. The weary sisters pushed my hand aside as she brought the scissors and cut an episiotomy. Her screams were deafening. In that moment I felt my soul step aside from

that bed as I began feeling dizzy from all the commotion. My mind became weary as I began to question the quality of care that is given in the public sector. I thought about my mother, who 21 years ago gave birth to me in a public hospital. I began to feel guilty that she would have had gone through the same horrifying experience in giving birth to me, all because they could not afford to go to a private hospital. I tried to picture her in that situation and I did not like it at all.

3 So much for first experiences... my mother always said that the only time you ever truly learn to drive is after you actually get your licence, and I can say the same for delivering babies. As I moved through the MOUs, I came across some of the most loving and caring nursing staff, whose major concern was to ensure that the mother's experience in childbirth was a sacred time. I realised that the norms I established in my first week at St Monica's were actually unacceptable and that such evil practise is only confined to a few of the sisters at that MOU.

4 As my confidence has increased, I began to appreciate each and every moment of the mother's experience- each one being so different from the rest. From mother's who don't even want to look at their children to others who have no words to thank you for helping them bring their child into this world.

5 I am often asked why I became a Doctor, and for many a personal reason I always decline to tell anybody. I think one of the reasons affecting this decision is of fear that I am going to be a hypocrit and say things that in 15 years time I won't even remember why I said them. I want to experience each and everyday, I want to build on this calling that I had in life, and it is moments like these, when the mother's joy of holding her baby in her hand makes me realise how precious life is, and how much of responsibility I am taking on in my life. Thus far, throughout my degree, my study has always been on facts that can inevitable prevent death and disease, what the analysts call a positive negativity. For once, our study has been on "making" life-what the analysts will call a positive positivity. In the words of Dr Chris Warton, this experience (well, this whole block) definitely scores a high "WOW" score.

ANISHA

1 This entire Bwk block has been one of the best experiences of my life. For the first time since I started medicine I really felt like I was really involved with people. Trying to pick out a single experience during this block is tremendously hard... my biggest regret that it was only 8weeks.

Some moments to treasure forever:

My first delivery:

2 I had such a romantic idea of what it would be like. I thought the beauty of watching life come into this world would be an overwhelming experience, but in reality I wasn't thinking about the miracle of life. I was making my decision to adopt in the future.

The delivery itself went so fast, it was all just a blur of motion. The head, shoulders, body all came out at once and before I had a chance to watch for all those movements we had learned (prostitution, etc) there was a baby boy giving his first cry. In subsequent deliveries I would get to see those movements and really get to marvel at the human creation, but not that first night.

3 So why will I always carry that first night so clearly in my memory?

I think its because it was to be one of the most emotionally draining moments of my life. Here was a mother, who had just given birth, who should be enjoying the moment and instead she was crying her eyes out. She really tried to bear it but the pain was excruciating. She had such severe secondary tears that her insides were almost unrecognizable. The intern was too afraid to do the repair and it was left to the sister in charge.

4 During the repair I couldn't stop tears from escaping and my own voice had gotten very shaky. It was heart wrenching to hear her sobbing, to listen to her pleas for relief, to know that this was what had to be done... After this I wasn't sure I could deliver again. I wondered, was it my fault she tore like that, did I not support the perineum enough? Just thinking back brings such a flood of emotion...

5 I owe an enormous debt of gratitude to the sisters at NSH who know the fears/doubts I was having without me having to tell them. Their support and understanding is what got me through that first night and the rest of the block. It is often said that in order to understand it, often helps to have experienced it...well if I ever see a woman wondering if its something she did/ did not to do which caused her complication - I know how powerful those feelings of self reprimination are. There is nothing anyone can say which removes all doubt but an understanding and sympathetic shoulder to lean on is invaluable and I just hope I can return the favour one day.

My anencephalic delivery:

6 Just before the delivery the sister pulled me aside and asked me if I was sure I wanted to deliver. I felt that I was strong enough and that I had a pretty good idea of what to expect so I assured her I would manage.

7 The delivery itself was amazing. I remember thinking God is All Great, All Merciful. Mrs M had no idea she was delivering, she couldn't feel any of it. A sister would feel for the contractions and tell her to push, she didn't even know when it crowned. For me that was tremendous that God could spare her the pain and trauma of the delivery as well.

8 My first shock : I didn't expect the baby to be so 'normal' from the face down. The parents initially did not want to see the baby but again thanks to the sisters patience and comforting care they agreed to see their son. We bandaged the head and dressed him as they asked and prayed he'd make it till we got him back to them.

9 Mother, father and baby bonded and they said their good byes. When they asked us to take him away they had already named him, Christian. They were so thankful for the time they had had.

10 For me it was a truly special experience.

11 Christian would lie in the labour ward for another 5hrs while they waited for an incubator to become available in high care. And everytime I'd walk by the resus table I'd hear him cry softly or sneeze. When holding him he grasped my fingers so tightly, it left me wondering who said he won't survive? And I knew if I had such thoughts just imagine what his parents were thinking. Later his mother spoke to me, told me how much she was looking forward to her first child, how much her husband was looking forward to a son, how devastating this was to them. She had been so strong through the delivery, even when her husband started crying she had supported him, now she just needed someone to listen to her. I'll always be thankful that she gave me her trust, that I delivered her son for her, for as heartbreaking as it was, it was also tremendously special to have been allowed to get that close to her.

My final moment, my FIRST SOLO Delivery.

12 I was supposed to just be watching the patient as the sister stepped out for a second, when suddenly she started to crown. The mother was so quiet, so calm. I knew she was preterm, & was afraid for the baby. I shouted at the top of my lungs for help. Adrenaline rushed & I started to doing what we normally do, support the perineum and the head as it came out. Another shout for help. And then I delivered the rest of the baby. By the time someone did come I already had my baby out, and breathing.

13 I never imagined I'd be able to do it on my own. The responsibility felt too much. I had been the one telling everyone I was so glad we only had to do "assisted deliveries". By the end of that night I was smiling from ear to ear I was swelling with pride, overjoyed at my sense of accomplishment. It was one of those moments that turned out well so it was ok to enjoy it!

14 Thank you Dr Draper. I know this is longer than you wanted. Thank you also for this tremendous experience. I so often found myself in the wards on the nights I was off, just purely because there was no place I'd rather be. I did not want to miss one moment of it.

15 If I could I would thank all those mothers who let us in to their lives. Without their willingness to talk to us those 8 wks would never have been as touching and memorable as they were.