

Medical students' response-ability to unjust practices in obstetrics: A relational perspective

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Relational ontology

Responsibility

Response-ability

The logo of the University of the Western Cape, featuring a stylized classical building with a pediment and six columns.

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DECLARATION

I declare that *Medical students' response-ability to unjust practices in obstetrics: A relational perspective* is my own work, that it has not been submitted for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Veronica Ann Mitchell

27th April 2019

Signed



VAMITCHELL



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Bruno and Kelly (photo taken by Sue Gredley while dog-sitting)

This text emerges from many intra-actions¹ both locally and abroad. Below I include a collage of photos depicting special times spent with colleagues and a few of the theorists who speak in and through my thesis.



Collage of different times, places and people merging as timespacematter emerged

Departmental colleagues:

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Karen Barad

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¹ *Intra-action* is a concept introduced by Karen Barad (2007). It refers to the idea that entities come into being through relationships with human and other bodies. It differs to interactions that are relationships between individuals where there is an assumption of pre-existing entities.

GLOSSARY OF TERMS²

Posthumanism and feminist new materialism (FNM) are emerging theoretical frameworks that use different terms as well as old theoretical terms with new and different meanings.

Posthumanism brings diverse theoretical positions that include critique of, as well as a challenge to established human-centred or anthropocentric beliefs with their binary distinctions and processes involving humans and nonhumans. Through posthuman knowledge, there can be a multi-dimensional, multi-layered and multi-directional opening up of our thinking “to build on the generative potential” of posthumanism (Braidotti, 2019, p. 9). To use posthumanism as a practice of inquiry, is considered more ethical because such a practice enacts and is more accountable to enquiry processes that enact a non-essentialist ontology (Mauthner, 2018a)

Along with posthumanism, the growing interest in thinking with and through matter began with the emergence of new materialism in the late 1990s, which brought a philosophical approach that is not just anti-linguistic, however there is no unified account of new materialism. Matter takes on different meanings. In my thesis I follow Barad's (2007) relational ontology which brings into account the relationships that are enacted, and which co-constitute every encounter thereby refuting any assumption of individuals as given, rational and bounded entities.

Below I give a brief description of key words used in my text to avoid them appearing as “theoretical jargon” but rather as tools for new ways of thinking about relationality in medical education.

Affect

Affect is the “*perception of one's own vitality, one's sense of aliveness, of changeability*” (Massumi, 1995, p. 97, italics in original). Affect is defined by Massumi (1987) as “a prepersonal intensity corresponding to the passage from one experiential state of the body to another and implying an augmentation or diminution in that body's capacity to act” (p. xvii). This Deleuzian interpretation of affect drawn from a Spinozist or monist

² Thanks to Natasha Mauthner who recommended that a glossary would be helpful for readers.

philosophical view rather than a psychological perspective brings a focus on the intensities and capacities that power the body to move or be moved (Colebrook, 2002).

Affective attunement

Affective attunement is a term used to denote a sensitivity to the complex affective differences flowing in an assemblage.

Affective forces

Affect is considered as a life-force that “happens in and between and through bodies and things” with different and differing intensities related to time, speed and heat (Ringrose & Renold, 2014, p. 773). Affective forces can be reactive or active, tacit or performed, enabling or constraining (Coleman, 2010).

Agency

Agency, according to Barad (2007) is “doing” or “being” in its intra-activity” (p. 178). Such a conception of agency moves beyond conventional ideas of human-centred agency where there is an assumption of individuals as intentional, rational and bounded entities. Barad states that agency is “*a matter of intra-acting, it is an enactment, not something that someone or something has*” (p. 178, italics in original).

Agential realism

Agential realism is Karen Barad’s (2007) new theoretical framework that recognises the ongoing relationships which are materialising to enact what is happening with us and around us. It provides a performative understanding of worlding in which knowledge-making practices “*are specific material engagements that participate in (re)configuring the world*” (p. 91, italics in original). It uses a relational ontology that “investigates the material-discursive boundary-making practices that produce “objects” and “subjects” and other differences out of, and in terms of, a changing relationality” (p. 93).

Assemblage

An assemblage is a collective formed by different components, however there are several different interpretations of assemblages. Jackson and Mazzei (2012) claim that an assemblage “isn’t a thing— it is the process of making and unmaking the thing” (p. 1). I draw on assemblage thinking as an alternative way of engaging with the troubling aspects of student learning and their ability to respond to the injustices they witness. I

refer to congealing assemblages as students are becoming-with others in their learning events.

Discursive

Discursive practices are not simply humanist activities “but specific material (re)configurings of the world through which boundaries, properties, and meanings are differentially enacted” (Barad, 2007, p. 183). Discourse is more than a representation of an action or a thought as it is what “constrains and enables what can be said” (Barad, cited in Kuby, Spector & Thiel, 2018, p.146).

Diffraction

Diffraction is a crucial aspect of Barad’s philosophical approach of agential realism. It refers to thinking about or reading insights through each other where the effect of the differences matters. I do not refer to diffraction in my text as I felt that it would divert attention from the issues at hand and perhaps confuse readers.

Event

An event is always “dynamic, and in re-formation” (Massumi, 2015, p. 58). It is an intersection of becomings in which there is a nexus of unpredictable flows and interferences of forces. Events are complex as they create and generate new openings and potentials. In my study, events can be seen to produce environments that actually produce habits of practice that sustain disrespectful practices in obstetrics.

Forces

Stagoll (2010) describes force as “*any* capacity to produce a change or ‘becoming’, whether this capacity and its products are physical, psychological, mystical, artistic, philosophical, conceptual, social, economic, legal or whatever” (p. 111, italics in original). I refer to multiple forces that include the non-intentional force of the birthing body, agentic forces of nature, cultural forces, material forces and others that are interacting and intersecting through each event.

Matter

Matter is conceived differently by different theorists. For instance, Jane Bennett (2010) claims that entities of matter are actants with vitality that she refers to as “thing power”,

and that there is an overlapping relationship of humans and “thinghood” as well as a movement of “slip-slide into each other” (p. 4). While Barad (2007) notes that matter is “not a fixed essence; rather, matter is substance in its intra-active becoming - not a thing but a doing, a congealing of agency” (p. 183-184).

Materialisation

Materialisation is an iterative, ontological process which is dynamic and unpredictable, and according to Barad (2007) needs to take into account the discursive practices as well as material phenomena. Thus, Barad opens up a broader viewpoint of materialisation than previous theorists such as Foucault (1970) and Butler (1990) whose focus was on more on human interactions.

Rhizome

The rhizome is a figuration conceived by Gilles Deleuze and Félix Guattari that contrasts with static, structured linear processes. A rhizome has no beginning or end as it has a multiplicity of connections and dimensions. It is anti-genealogical and refers to a process that “acts on desire by external productive outgrowths” (Deleuze & Guattari (1987, p. 14).

Intra-action and Interaction

Intra-action is a term conceived by Barad (2007) to signify the multiple forces and relationships that are enacted between human and nonhuman bodies. Intra-actions assume that entities come into being through their mutual entangled relationships, while interactions relate to entities that pre-exist relationships, acting as separated units (Barad, 2007).

ABSTRACT

This study is located in the fourth-year obstetrics curriculum that undergraduate medical students at the University of Cape Town, South Africa, traverse, and in which they are initiated into the knowledge and skills of practical obstetrics practices in local birthing facilities. I investigate student learning and what contributes to students being rendered in/capable when they find themselves immersed in the high levels of prevailing injustices to women in labour. Disrespect during the intrapartum period is a local as well as global problem which has actually reached epidemic levels.

Drawing on the theoretical frameworks of posthumanism and feminist new materialism, and using post-qualitative inquiry and non-representational methods, I put forward a novel perspective for interrogating responsibilities in terms of students' ability to respond to unjust practices they observe, I discern what matters for student learning, exploring the troubled practices that emanate through/with/from the curriculum-student relationships in the past/present, and what it means for the future. Assemblage thinking provides a relational tool to understand the impact of the curriculum, assessment processes and other materialising forces that have agency as students are becoming-with human and more-than-human bodies. An initial survey was followed up with interviews and focus groups with students, midwives, educators and administrators.

My study revealed hidden aspects of student engagement with their curriculum in obstetrics. What emerged was that students are entangled in a mesh of forces influencing their ability and capacity to respond to the injustices they witness. These forces arise from the discursive and material practices and the in-between relationships that are generated in the learning processes. The study also brought to the fore the intensive forces of affect that appeared to be obfuscated in terms of students' response-abilities.

My findings foreground how reciprocal relationships matter and that a relational ontology can provide helpful insights to engage with responsibility, response-ability and social justice. Students' capacity to respond to the injustices they witness is limited by multiple forces that include the curriculum itself and other materialising forces generated, for instance by floors, beds, curtains and the student logbook. Time is also a crucial issue amidst the tensions emerging in the complex and risky process of birthing. What matters to students, such as their assessment needs, appears to undermine their efforts to offer

care and to promote social justice. Affect plays a powerful part in shaping students' actions, yet there are few opportunities for acknowledgement of affect.

I used drawings as data-in-the-making. The process of drawing contributed an extra material force to the study illuminating the power of an affective pedagogical approach for fostering students' capability to respond to injustice. This socially just pedagogy as well as classroom performances and online collaborative engagement contributed to a collective effort to engage with obstetric disrespect in an innovative and empowering manner that gave voice to students' experiences and the emerging forces.

My study contributes to the field of medical education by opening up a relational perspective to issues of social justice and responsibility that moves beyond individualist and human-centred conceptions of student learning. Through a relational ontology, students' clinical encounters can be conceived as enactments of the multiple prevailing forces. Each moment matters.



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CHAPTER 1 - STUDENT LEARNING IN MEDICAL EDUCATION

1.1 Introduction

Students entering undergraduate medical programmes are academic achievers. Their success in managing the demands of their studies through secondary education and possibly other academic programmes will have enabled them to enter into medical training and to progress through the rigorous curricular tasks. The earlier theoretical years in the medical curriculum lead into clinical rotations between the different disciplines which include obstetrics. These practical learning blocks enable students to learn and work as a doctor, bringing a level of excitement as well as anxiety as students develop a sense of becoming 'real' doctors. They take on practical responsibility to use their newly acquired knowledge and skills. What they find in the birthing units, is sometimes very different to their expectations, leaving them unsettled and at times, unresponsive.

Birthing facilities are complex environments. Students are required to observe and practice their skills to birth a neonate, which provides a departure point for their future practice. Yet, their actual learning experiences in these settings are not well known. In 2012, after facilitating health and human rights education workshops with students for four years in the Department of Obstetrics and Gynaecology (Dept O&G) at the University of Cape Town (UCT), I was asked to address the issue of abuse in maternity care. What transpired was more than I expected. I learnt that it is not only women in labour who are in an intensely vulnerable position during the intrapartum period, but also that medical students themselves are vulnerable, as they are located in a system of knowledge production that limits their options and actions.

Obstetric experiences attract a wide interest partly due to the many controversial issues involved in the process of birthing. There are different choices for childbirth for mothers-to-be, as well as different medical interventions to be determined by certain criteria that are evaluated by healthcare professionals. The choice of actions and inactions by healthcare providers are not immune to controversies. Medical students learn amidst these uncertainties.

In this thesis I explore a perspective of the medical training curriculum that takes students into their initial practical clinical learning in obstetrics. In this curricular space there is an unexpected prevalence of disrespectful practices by healthcare providers which have tended to be invisible yet are directly witnessed by students. I do not attempt to find reasons or solutions for the poor behaviours of those who ought to care. I rather explore a relational perspective for engaging with the reality of practice and issues of responsibility in order to develop pedagogical processes that can foster students' capability to respond to issues of social injustice they may find in these curricular encounters. I consider this as an ethical move to offer an innovative approach to current practices.

1.2 Student learning in medicine

Medicine as a scientific discourse is governed by facts and evidence-based practices. For students learning to be and become doctors, they are progressively immersed in the knowledge culture of medical discourse and associated epistemic practices for knowledge production. The medical curriculum can be conceived as the “machinery of knowledge construction” when viewed as a mechanistic-type process leading to the production of graduates who can work as doctors (Nerland & Jensen, 2012, p. 103). In terms of healthcare, the systems are more than delivery processes for a health service offering medical interventions but rather “complex socio-political institutions” (Gilson, 2003, p. 1463).

While the core objectives of medical training are geared towards developing competent and safe physicians with the requisite knowledge and skills needed for practising medicine, there is a growing movement to engage with healthcare needs in a more holistic manner (Bleakley, 2006; Mennin, 2010). These shifts in focus bring an expansive perspective to medical education beyond the previously narrow biomedical, evidence-based approaches. There are increasing efforts to engage with the complexity of relationships with patients and healthcare in general, bringing more attention to the different individual needs, as well as collective needs such as those related to societal priorities. As a result of these shifting interests, there are consequences impacting on student learning.

The seminal Lancet report by Frenk, Chen, Bhutta et al. (2010) explains the three generations of reform identified in health education. Through the 20th Century, the initial first generation reform was a science-based curriculum which then moved into problem-

based instructional processes. Now the third generation shifts to systems based performances with a vision that entails

all health professionals in all countries should be educated to mobilise knowledge and to engage in critical reasoning and ethical conduct so that they are competent to participate in patient and population-centred health systems as members of locally responsive and globally connected teams. The ultimate purpose is to assure universal coverage of the high-quality comprehensive services that are essential to advance opportunity for health equity within and between countries. (p. 2-3)

Efforts to promote health equity are situated within and through the knowledge culture of medical training where there are political, economic, and social dimensions that set up certain structures with related interests (Knorr Cetina, 2005, p. 74). The acquisition and sharing of knowledge and skills is not a neutral process. There are agendas to be addressed from different stakeholders and vested interests that place value judgements on particular aspects of the educational system (Freire, 2000). Certain outcomes are valued more than others. In South Africa, higher education institutions are under pressure to improve the success rate of disadvantaged students (Department of Education, 2006).

For training institutions, student achievement and throughput are essential goals for their graduate programmes especially in medicine. However, there is increasing awareness of the multiple forces that drive medical students' individual achievement and professional development such as their motivation to be and become doctors, their emotional well-being as well as their resilience to cope with their professional and personal challenges (Howe, Smajdor & Stöckl, 2012; Kumagai & Lyson, 2009; Prayson, Bierer & Dannefer, 2017)). Furthermore, the importance of addressing and responding to the broader societal needs is gaining momentum as a concern for higher educational institutions (Case, Marshall, Mckenna, & Mogashana, 2018).

In terms of social justice, institutional responses are moving beyond the need to focus on wider student admission to open up access for previously disadvantaged students. Medical training facilities are now making efforts to become socially accountable through curricular matters (Boelen, Dharamsi & Gibbs, 2012; Green-Thompson, McInerney & Woollard, 2018). Social accountability of medical schools is defined as "*the obligation to direct their education, research and service activities towards addressing the priority*

health concerns of the community, region, and/or nation they have a mandate to serve authorization" (Boelen & Heck 1995, p. 3. Italics in original). This paradigm shift from medicine as a service to cure diseases to meeting wider societal needs and in so doing, addressing health disparities, involves broadening the scope of healthcare training (as well as widening the access to a more diverse group of students). Although there are moves for social justice and social accountability to be taken into consideration in medical curricula, there are no clear indications that substantial shifts in pedagogical practices have occurred, indeed, Coria, Mc Kelvey, Charlton, Woodworth and Lahey (2013) contend that these shifts are not common.

Indicators to demonstrate institutional commitment to social accountability and responsibility are now used by many training facilities in the health sciences (Boelen, Dharamsi & Gibbs, 2012; Hassan, Abolghasem & Mahast, 2015). These indicators play a significant role in a strategic move from an instrumentalised learning system closely associated with standardised performances towards an attentiveness to relationships and issues of social justice. It is a response to calls of concern about "the dehumanization of medicine and disempowerment of patients" (Engel in Suchman, 2004, p. 256). However, what is measurable does not necessarily show the whole picture. An example in terms of obstetrics, is the widely referred to statistics of maternal mortalities that reveal the progress or deterioration of important life-saving efforts. However, these quantifiable measurements do not illuminate the many detrimental relational practices that occur. Disrespect in maternity care can have significant health consequences for mothers, their families, as well as those present in the birthing process who are not unaffected by such behaviours. Hence, a global³ response to disrespectful/abusive care during childbirth in facilities (DACF) is the International Federation of Gynecology and Obstetrics guidelines, known as FIGO guidelines (2015) provides an audit mechanism towards certification for mother and newborn friendly facilities (Miller & Lalonde, 2015). The document details the need for accountability and governance, continual support with supervision, and that maternity facilities need to demonstrate efforts to promote quality of care for all.

Relationships between different actors, including undergraduate medical students, contribute to and shape practices in the different spaces in the health sector. Training institutions and health facilities are organised with varied arrangements in terms of their

³ A collaboration between FIGO, the International Confederation of Midwives, White Ribbon Alliance, International Pediatric Association and the World Health Organization.

processes and principles in what Knorr Cetina (2005) terms the “knowledge society” (p. 65). For medical students in South Africa, learning takes place in the formal spaces of institutional facilities where they learn from mostly clinicians, as well as in the workplace where they gain their clinical skills and insights from multi-disciplinary teams. The clinics, including the Midwife Obstetrics Units (MOUs) fall under the auspices of the national health system (NHS). Therefore, there are social and political implications in terms of issues of governance and responsibility for both the healthcare workers in the facilities, as well as the students moving into those facilities where they learn. Within these epistemic environments where knowledge is produced and enacted upon, there is an e/mergence⁴ of forces and worlds that matter in the present, in the future as well as drawing from the past.

1.3 Location of this study

South Africa is ranked as the most unequal society in the world, with a Gini coefficient of 0.63 (World Bank estimate in 2014). The Gini coefficient provides a measure of income inequality, where 1.0 indicates and represents total inequality. As noted by Adjaye-Gbewonyo, Kawachi, Subramanian, and Avendano (2018) in their study on cardiovascular disease, South Africa provides a unique setting for understanding the health outcomes related to income inequality. Furthermore, the country is challenged by a high level and prevalence of violence which has reached epidemic proportions. Inequality, poverty and the vulnerability of women, all contribute to the operational challenges in obstetrics units, including the high incidence of unintended pregnancies. There is a complex interplay of forces related to the country’s quadruple burden of disease, which includes “the colliding HIV and tuberculosis epidemics, a high burden of chronic illness, mental health disorders, injury and violence-related deaths, as well as a silent epidemic of maternal, neonatal, and child mortality (Le, Connolly, Yu, Pinchevsky & Steyn, 2015, p. 24). My study is situated in the silent space of the adverse obstetrics experiences.

Included in the wide-reaching acts of violence are “violent crimes against women, such as sexual assault, [that] increased dramatically between 2015/16 and 2016/17” (Statistics South Africa, 2018). In their study, Statistics South Africa’s (2018) findings noted that hitting a woman for arguing was deemed acceptable by both men and

⁴ The forward slash denotes that both words may be used or a combination of both words, thereby avoiding a binary of one or the other. I later refer to Karen Barad’s work where she regularly uses this form of text.

women. Such beliefs and behaviours have relevance for my study. Kim and Motsei (2002) claim that in our “political, social, and economic environment, a prior or ongoing situation of abuse may make it difficult or impossible for a nurse to effectively deal with this issue within her professional capacity” and the same is true for students who may feel incapacitated to respond to poor behaviours as a result of their own personal circumstances (p. 1251).

Chivaugn Gordon (2016), an educator and colleague in the Dept O&G at UCT points out that “[h]ealth professionals have enormous power and influence to either re-empower or further disempower women” (p. 965). Gordon and myself have spent many hours together deliberating how we can translate these troubling issues into medical training. How do we promote responsibilities and social justice, taking cognisance of students’ troubling encounters in medical training and practice, yet keeping in mind that students choose to study medicine, not necessarily wanting to become activists for social justice?

Where does responsibility lie for students, educators and the training institution? Whether or not medical students in South Africa choose to be activists for social justice, they are still immersed in a burdened health system with vast disparities in quality of care and access (Mayosi & Benatar, 2014). In this study, I will examine how responsibility involves relationships that enable and constrain students’ responses. I refer to the term response-ability, “the ability to respond” which has ethical and political implications (Barad, interview with Kleinman, 2012a, p. 81).

My work and study are located at the University of Cape Town (UCT), noted as a historically advantaged higher education institution in South Africa (Cooper, 2015; Leibowitz & Bozalek, 2015). This research is focused on medical student learning in the Health Sciences Faculty (HSF), an elite space with the status and power that medicine carries universally and for which each student has competed for acceptance. Once in their clinical years, medical students in the Western Cape learn in healthcare settings that are used primarily by impoverished communities who have access to public health facilities without any choice or opportunity for private health care which is financially unreachable. These communities have to rely on local primary healthcare facilities and the established referral system. In acknowledging that the health system is in crisis, Mayosi and Benatar (2014) noted the many operational challenges for patients, healthcare workers and medical students-in-training. How we respond to the many challenges is an important component to issues of responsibility.

1.3.1 Rationale for this study

Students' stories, and particularly those related to difficult experiences in their clinical encounters, tend to remain invisible, especially to educators. This study explores these frequently silenced students' experiences that tend to be hidden behind the larger learning outcomes that are directed by institutional imperatives. I note the conflict of responsibility for students who face competing interests when they have a strong need to comply with curricular imperatives in order to get their due performance (DP) certification but are confronted with dilemmas and fear in terms of reporting the poor patient care that they witness.

It is important to recognise that educators also have sensitive histories that impact on classroom engagement (Zembylas, 2012). As educators, we too are subject to the politics of emotions and carry silent burdens that might well impact on the way we teach or engage with students. In my own personal experience, my parents were German child immigrants who escaped the horrors of the Holocaust by moving to South Africa. Family discussions on their past only began to open up as they reached their older years and end stages of life. Anne Marilyn Lucas' one-act play titled, "From Silence" performed in 2016, visually portrays how wartime stories have frequently remained hidden from future generations (Prince, 2012). The silencing of women's birth stories has recently become more public with social media⁵ providing a public medium for the outpouring of women's troubling birthing experiences.

My role as an educator, as a facilitator of student learning at different levels and in diverse spaces within the undergraduate medical curriculum at UCT was strongly influenced by my own positionality and experiences as a mother of a daughter doctor moving through the struggles of the South African health system. The medical undergraduate curriculum has affected me in different ways. At times I felt overwhelmed by what I heard from my daughter and other medical students and young doctors. For instance, recent and ongoing news reports and posts on social media continue to raise alarm about the long hours spent working with detrimental consequences to students and young doctors (Petersen, 2016). When I first shared concerns about the possible harmful impact of certain work experiences on students themselves, a Faculty member normalised my concerns with a justification that long hours and certain poor practices

⁵ The Twitter hashtag #violence_in_obstetrics was initiated following an article in the Guardian (Gimson, 2018).

were part of the learning process, I was struck by her resignation to unjust practices. What are the ramifications of such a lack of responsiveness and normalisation of poor practices? Is the curriculum acting to separate knowledge production and operational obligations from individual well-being (for both students and their patients) in the process of being and becoming a doctor?

As a facilitator of student learning at UCT, I wondered what the curriculum was doing and/or not doing in knowledge production. This wondering led me along unexpected yet connecting paths. Rosi Braidotti's (2011) concept of nomadic thinking and the nomadic subject contributed to my experimentation in thinking and teaching towards new potentials and new becomings, also termed a molecular becoming by Deleuze (1994), where "becoming is about the in-between, the middle" (Coleman & Ringrose, 2013, p. 15) I found myself affected by lines of connections and the tensions that rupture them, where cracks emerged. Deleuze (1994) claims that "[s]omething in the world forces us to think. This something is an object not of recognition but of a fundamental encounter" (p. 176). As I worked with and through students learning, the forces from these encounters enabled me to break through into new spaces, a disruptive process in the middle/in-between spaces (Coleman & Ringrose, 2013). I began to question established boundaries, power mechanisms and dualities. Most significant were the "magic moments" that revealed the fragility of my thinking and acting leading to my becoming-researcher (Ohlsson, 2008).

Historically my unresponsiveness as a person living and working during the closed apartheid years in South Africa is startling. I moved through the gross violations and disparities in the health system working as a physiotherapist, although feeling unsettled at times, I did not respond. This inaction was partly due to family encouragement to be silent on political matters, a cultural consequence of my family's hasty departure from Germany during difficult times. During the birth of my three children, I was fortunate to have access to private healthcare where respectful relationships contributed to my compassionate experiences of birthing.

My study takes a move away from measurements and issues of safety, to the underlying contributing factors and relationships that tend to remain hidden and not measurable, and that impact on student responses in their learning in birthing facilities.

1.4 Responsibility as my research problem

In the medical profession, responsibility is a key component of healthcare and an integral aspect of student learning in terms of professionalism. The notion of responsibility generally equates to obligations, as well as accountability mechanisms that are put in place through policies and programmes to ensure collective and individual responsibility. Conventional professional responsibility has necessitated regulatory approaches and surveillance with objectives directed towards preventing any wrongdoings and associated adverse consequences. Facts and evidence provide the driving forces for disciplinary and professional training. Yet, such knowledges can conceal other factors that may be neglected, such as the quality of care. Bruno Latour (2004) implores us to give more priority to matters of concern rather than taking meaning solely from quantifiable facts. Maria Puig de la Bellacasa (2011) takes this concern further to question matters of care. Responsibility is an element of care (Tronto, 1993).

There are different conceptions of responsibility, in terms of institutions and individuals. More recently there is an emerging awareness that medical educational practices ought to be more responsive to diverse societal needs (Kumagai & Lybson, 2009). This social responsibility can take on many forms. Medical training faculties are demonstrating their social responsibility through their institutional commitment and concern for the welfare of society, showing evidence of their responsive roles, largely related to underserved communities (Faulkner & McCurdy, 2000). Training institutions in the health sciences, in many countries are working towards curricular reforms that include pedagogical opportunities for engagement with social responsibility which include providing health services to underserved communities, such as outreach projects that involve the development of satellite campuses in rural areas. An example of such a project at UCT is the extended learning platform for HSF students in the town of Vredenburg, approximately 150 Km north of the Cape Town campus. Since 2011, medical students travel to the Saldanha Bay Sub-District to work there in their rural academic programme (University of Cape Town. Public Health Care Directorate, 2019). In such alternative settings, medical students are learning different skills to provide healthcare to and for marginalised patients (Coria et al., 2013).

These kinds of expressions of integrating social responsibility into routine clinical teaching and assessments were incentivised by a university wide review at UCT (2009) in which Steve Reid⁶ noted:

the extent to which UCT graduates practise in a socially accountable manner, will be seen in the differences that they make in the communities in which they operate. Since health outcomes as measured by health status or mortality figures are determined by a multitude of factors, this is much more difficult to measure (Favish et al, 2012, p. 225).

However, there are concerns that separating students out into distanced and different contexts may be contributing to a form of othering. There are calls to work more at integrating social justice topics into core curricular tasks in order to avoid students marginalising or placing less value on rural health needs (Coria et al., 2013).

To further demonstrate institutional commitment to social responsibility, training facilities are aiming to become socially accountable by developing graduates who can be advocates for change “with capacity to work as well on health determinants and contribute to adapting the health system” (Boelen, Dharamsi & Gibbs, 2012, p. 181). Students are encouraged to go beyond the acquisition of knowledge and competence, to develop a concern for ethical engagements and responsiveness towards societal needs. There are also moves for the inclusion of social justice curricula as evidenced in the addition of multicultural education to curricula, with the objective to support medical students to develop cultural competence and sensitivity (Kumagai, Kakwan, Sediqe & Dimagno, 2010). Personal stories are used as a motivating force in these programmes and as a pedagogical technique in medical training to raise students’ critical awareness of social injustices (Kumagai & Lypson, 2009).

In reformed curricula, interprofessional teamwork is encouraged with an emerging and deepening focus on connections, relationships and interdependence. Institutional responsibility to promote a high quality comprehensive health service, necessitates that training curricula need to be changed to foster transformative learning and the kind of doctors who can become change agents (Frenk, Chen, Bhutta et al. 2010). Three essential moves are noted, firstly, “from isolated to harmonised education and health systems”, secondly, “from stand-alone institutions to networks, alliances, and consortia”

⁶ Professor Steve Reid is the Director of the Primary Health Care Directorate at UCT.

and thirdly, “and from inward-looking institutional preoccupations to harnessing global flows of educational content, teaching resources, and innovations” (Frenk, Chen, Bhutta et al. 2010, p. 3).

These moves suggest the need for more connections and networking that incorporate the importance of relationships for working with and through issues of responsibility. For instance, the systems structures are deeply implicated in the nexus of healthcare justice issues and student learning.

Both social responsiveness and social accountability are now linked to medical schools’ accreditation processes to measure the effectiveness of institutional responses to social injustices. In 2012, the journal, *Medical Teacher*, published a Special Edition on this theme following the report on the *Global Consensus for Social Accountability of Medical Schools* (2010) and the related *Lancet Report* (2010). It was noted that universal and homogenised viewpoints can be problematic as each local area has specific needs. In addition, indicators and measurements can offer a certain perspective and leave others out (Mol, 2002; Barad, 2007).

Post-conflict societies like South Africa face many questions about responsibility, some of which are haunted by troubled knowledge where feelings such as shame, anger and guilt persist as a result of traumatised pasts, yet also impact on present practices (Jansen, 2009; Zembylas, 2013b). When troubling matters arise, using legal and moral reasoning, and sourcing guilt is not necessarily helpful. The judgement and blaming of individuals in these so called “liability models” provides a limited insight (Young, 2011). Accountability mechanisms like inquiries, tend to look back at the past. For instance, a public inquiry into access to healthcare, a constitutional right that ought to be progressively realised in South Africa, explains how the delivery of quality healthcare is undermined by many factors including the inaccessible resources, both human and material (South African Human Rights Council, 2009). This report in its current form is useful, although it is also relevant to note what it leaves out or backgrounds. For instance, the healthcare providers efforts to overcome the many challenges appear to be sidelined.

There are powerful interconnections that take issues of responsibility beyond individual commitments. Iris Marion Young (2011) puts forward “the social connection model of responsibility” that refers to an individual’s interdependencies with the structural

processes that produce injustices (p. 105). Within health systems there are a multiplicity of forces connecting with past, present and future practices, some of which are harmful, undermining responsibilities. Current behaviours of neglect and disrespect are emerging from such systemic and structural forces (Rucell, 2017). Questions of *privileged irresponsibility* (Tronto, 2013) also arise in terms of benefitting at the expense of others by “being in superior positions in a hierarchical system” (Zembylas, Bozalek & Shefer, 2014, p. 207).

Relationships matter in terms of responsibilities. In this study I move beyond human-centred relationships to explore how multiple other forces act in shaping issues of responsibility. Moving beyond human-centred agency and the assumption that this exists within bounded individuals gives recognition to the wide array of forces and relationships that influence pedagogical practices and students’ response-ability. I take up the call that curricula for social responsibility need to be “innovative, collaborative, participatory, and transformative” according to Dharamsi, Ho, Spadafora and Woollard (2011, p. 111). Medical educators and their institutions have a social responsibility to raise social awareness.

In this research study and my connected pedagogical intervention, I draw on the work of philosophers who take responsibility further than the humanist and individualistic notions of obligations and accountability that are outlined above. The works of Karen Barad and Donna Haraway examine mutual relationalities between, and with, different bodies. Barad (2007) is a physicist and philosopher whose theoretical insights from quantum physics experiments bring a scientific/philosophical perspective. She warns us about measurements, which have a tendency to give only a certain perspective, separating away from other important connections. What is measured, and what is left out? The tensions, dilemmas and forces influencing the emerging practices may remain concealed when measurement is prioritised. Donna Haraway (2000) is a biologist and feminist philosopher whose explanations of our “webs of relatedness” are profound and relevant to student learning for exploring multiple perspectives (p. 82). She encourages us to seek out the more-than-human connections in processes. There is a “making-with” others that she calls, “sympoiesis” (Haraway, 2016). She aligns this affirmative process to composting; a notion of flourishing together to produce something better. There is a mixing and coming together with others (Haraway 2016). Any problem or person cannot be examined in isolation.

In this study I move outwards, beyond the individual and beyond interpretations of social interactions with related questions about choice, intention and contribution, in order to examine connections and webs of relationships enacted and emerging in students' learning encounters. I acknowledge that students' responses and their capacity to respond is an integral part of their responsibilities. The term response-ability is used to describe the capability to respond, especially pertinent in troubling encounters (Haraway, 2016). It acknowledges the more-than-human forces acting in dynamic relationships that constitute events, such as learning moments (Bozalek, Bayat, Gachago, Motala & Mitchell, 2018). These forces include the relationships with matter thus constituting material-discursive forces that play a vital role in medical education and will be discussed in more detail in Chapter Three.

1.5 The in-between spaces of student learning

Much has been written about what matters in the doctor and patient relationship with an increasing concern for improving safety and avoiding adverse incidents. The relationship between students with their educators and their patients is less visible, however there are a growing number of publications for medical training on this topic (Bin Abdulrahman, Mennin, Harden & Kennedy, 2015; Brown, Noble, Papageorgiou & Kidd, 2015; Norman, Vleuten & Newble, 2002). But there appears to be a paucity of information on students' experiences in terms of the medical curriculum-student relationship, particularly around their responsibilities and dilemmas (Hicks, Lin, Robertson, Robinson, & Woodrow, 2001). As a teacher and researcher, I listened to students' personal narratives, often shocked, feeling disheartened at what they were being exposed to in their efforts to address curricular needs. These moments catalysed this research study.

Clinical training spaces tend to rely on a three phase apprenticeship approach where students observe practices to learn the procedures, then mimic and perform procedures with their newly acquired skills, finally followed by opportunities to teach others. This apprenticeship process, originating in the earlier generations of medical training associated with William Osler and Abraham Flexner (Dorman, 2005) is dependent on trust, good collegial support and accountable role models. It is widely used and founded on the belief that healthcare providers in the workplace are good role models and that current systems are representative of what the students ought to do and to become, with assumptions of highly regarded professionalism. However, there are currently many limiting factors that reduce the effectiveness of the apprenticeship model such as time

constraints, large student numbers, and the fragile personal dis/connect between teachers and learners.

Recent shifts to alternative ways of learning include a move from immersion and exposure in the discipline to a more integrated “cognitive apprenticeship” in which “novices do not simply learn how to do the job as they gain expertise – they also learn how to think and recount the job (Bleakley, 2006, p. 154). This individualistic mode of learning that dominates the present thinking and doing in medical education is a concern (Bleakley, 2006). Even connectivist thinking is considered inadequate as it does not adequately account for the complex, fluid and uncertain situations in which medical students learn (Bleakley, 2006). Connectivism is a relatively recent learning theory conceptualised by George Siemens (2005). It brings an epistemological perspective focused on connections made with different nodes of knowledge in different spaces such as the social and digital. The role of the “environmental cues” has been acknowledged as an untapped potential for student learning to “indicate how we could respond with a view to other elements in our surrounds” (Bleakley, 2006, p. 155). These cues suggest the need to engage with a wider awareness that takes medical training beyond the limitations of the human interactions in an apprenticeship model where relationships are only considered between the novice and the experienced professional but in terms of feminist new materialism (FNM), do not go far enough as it only takes into account the human forces and not those emanating from other actors. FNM and posthumanist theories (discussed in detail in Chapter Three) acknowledge that our actions emerge through multiple forces and relationships rather than confined to human intentionality.

In this study I focus on problematic relationships in the learning environment. For instance, student dilemmas arise in their clinical encounters and are not uncommon (Caldicott & Faber-Langendoen, 2005; Hendelman & Byszewski, 2014; Hicks et al., 2001; Wear, Zarconi & Dhillon, 2011). Associated with these dilemmas is the recognition of the erosion of trust in the medical profession itself (Cruess & Cruess, 2008; Gilson, 2003). Despite highly organised and structured learning processes and environments, what is apparent is that the complexity of clinical practice challenges the boundaries of regulatory governance and accountability structures. As students move into their senior years, they become aware of the structural fault lines, resulting in an “erosion of empathy” that influences their willingness to respond to dilemmas or injustices (Hojat, Vergare, Maxwell, Brainard et al., 2000, p. 1182).

Bleakley (2015) refers to “sensibility capital – how the senses must be used clinically and how sensitivity is acquired and professionalised” (p. 960). While relevant for medical training, Bleakley notes that this capital is not well distributed by medical educators, even to the extent that it is “withheld or distorted such that the production of insensibility in medical students is more common” which includes “objectifying of patients, teaching by ritual humiliation, empathy decline, emotional - moral erosion and cynicism, intolerance of ambiguity, paternalism, poor self-care and heroic individualism” (Bleakley 2015, p. 960).

1.5.1 The South African context

In South Africa there is a strong need for the eight national medical schools to produce competent graduates to improve the provision of healthcare in the currently under-resourced public health service. At UCT the reformed medical undergraduate curriculum is designed to graduate students who are “fit for purpose” (Burch & Reid, 2011, p. 25). However, from anecdotal evidence (Phalime, 2014) it appears that this outcomes-based approach largely ignores individual and collective students’ experiences.

Moreover, the legacy of apartheid with unjust discriminatory practices persists and plays a vital role in the current delivery of health services. Vast disparities continue between public and private health facilities reflecting our unequal society. Benatar (2013) asserts that:

A priority must be to strengthen existing facilities and to strive for high-quality teaching, conditions of service and an ethos of care in clinical services that would encourage dedication by healthcare professionals to excellence, rather than merely having job security and a salary (p.155).

There are increasing challenges to reach equitable healthcare for all amidst a wider context where “much of the public healthcare infrastructure [is] run down and dysfunctional as a result of underfunding, mismanagement, and neglect” (Mayosi & Benatar, 2014, p. 1346). Our health system is in crisis, according to Mayosi⁷ and Benatar (2014). In July 2016, a National Health Assembly was organised by a collective of civil society action groups, comprising the People’s Health Movement, SECTION 27

⁷ Professor Bongani Mayosi was Dean of the Health Sciences Faculty at UCT during the duration of this study until his untimely death in July 2018.

and the Treatment Action Campaign where it was announced that South Africa's public health system is "broken" (Furlong, 2016, n.p.).

Integral to the brokenness of the health system, is the widespread prevalence of discrimination and neglect. The public inquiry by the South African Human Rights Commission (SAHRC) in 2007 into the access to health care services noted:

the lamentable state of many public hospitals in the country due to many factors, including a shortage of trained health care workers, a lack of drugs in clinics, lengthy waiting periods that patients endure before receiving treatment, poor infrastructure, a disregard for patients' rights, a shortage of ambulance services and poor hospital management (SAHRC, 2009, p. 4).

South African medical students learn from within this brokenness, and later as graduates and junior doctors, work in the same settings. Their experiences in this fractured environment stay with them, influencing their future professional development and their actions. The student protests that began in March 2015 at South African universities have given voice to students' experiences and foregrounded the prevailing challenges and disparities in education and healthcare (Costandius et al., 2018; Doherty & McIntyre, 2015; Rivers, 2017). The #FeesMustFall movement (that was triggered by #RhodesMustFall when human excrement was thrown at a statue of Cecil John Rhodes to protest against multiple issues of colonisation at UCT) amplified previously hidden students' voices. Relevant to this thesis, is that the bucket of faeces acted as a powerful and sensational force that actually initiated the nationwide movement with calls for wide institutional transformation and renewed responses towards decolonisation. There was an unanticipated collective action that shifted policies and fostered actions for change. However, it was not without great tension and contradictions (Langa, 2016).

My research study foregrounds medical students' voices and experiences within the broader concept of material-discursive practices that are generated through curricular activities. I investigate a small slice of students' early clinical learning, their initial obstetrics encounter. Within the "broken" South African health system, students are exposed to injustices (Mitchell 2016). According to Vivian et al. (2011) the training system for doctors is not predicated on the context in which students frequently find themselves, despite the rigorous set of knowledge, skills and values acquired for their future professional practice. During students' practical clinical learning rotations, they confront many troubling encounters that tend to be backgrounded and kept invisible as

hidden truths such as rudeness and disrespect to patients. Students learn to hide the reality of their experiences, which is a local as well as a global trend, particularly in obstetrics where widespread disrespect for women is witnessed (Wear, Zarconi & Dhillon, 2011; Kruger & Schoombie, 2010). In other words, students learn how the reality differs from the ideals and that advancing human rights is easier in theory than in practice

Medical students learn about South Africa's progressive Constitution (1996) and human rights laws that include reproductive rights. Human rights provide an idealistic framework especially for poor people who do not have resources to seek redress (SAHRC, 2009). A rights-based approach places a focus on the State's responsibility to uphold individual's human rights, yet there are difficulties in operationalisation and implementation processes (Gruskin & Daniels, 2008). All UCT's first year health sciences students receive a hard copy of the Constitution which contributes to institutional efforts to implement a human rights-based approach (London, Baldwin-Ragaven, Kalebi, Maart et al., 2007) to healthcare. Although there has been some progress towards achieving quality health for all, the reality of continuing violations in educational and health institutions is problematic. In their clinical learning encounters, students confront the many obstacles to the realisation of human rights objectives leading to conflicting messages for these students. The legalistic mechanisms of human rights appear to be insufficient to change practices (Zembylas & Bozalek, 2014). Legislation is not enough to ensure that rights are protected, promoted and fulfilled (SAHRC 2009). Alternative insights, practices and perspectives are needed.

The public health facilities are the spaces where medical students in South Africa learn their clinical skills. What, where, and how they learn is largely influenced by the available placements, the infrastructure and their educators who act as role models in terms of their apprenticeship, as has been described above. Different practices are used and demonstrated at the different workplaces, as well as differing attitudes among staff and different levels of communication skills. While the acquisition of knowledge and skills takes priority for students to pass their assessments and to progress through the curriculum, there are other influences that play out through multiple pathways that impact on students' relationships and connections. Figure 1.1 (below) illustrates how the building blocks of professionalism, human rights, and ethical practices are put in place through curricular design, yet also shows how cracks and breakages appear in the in-between spaces.

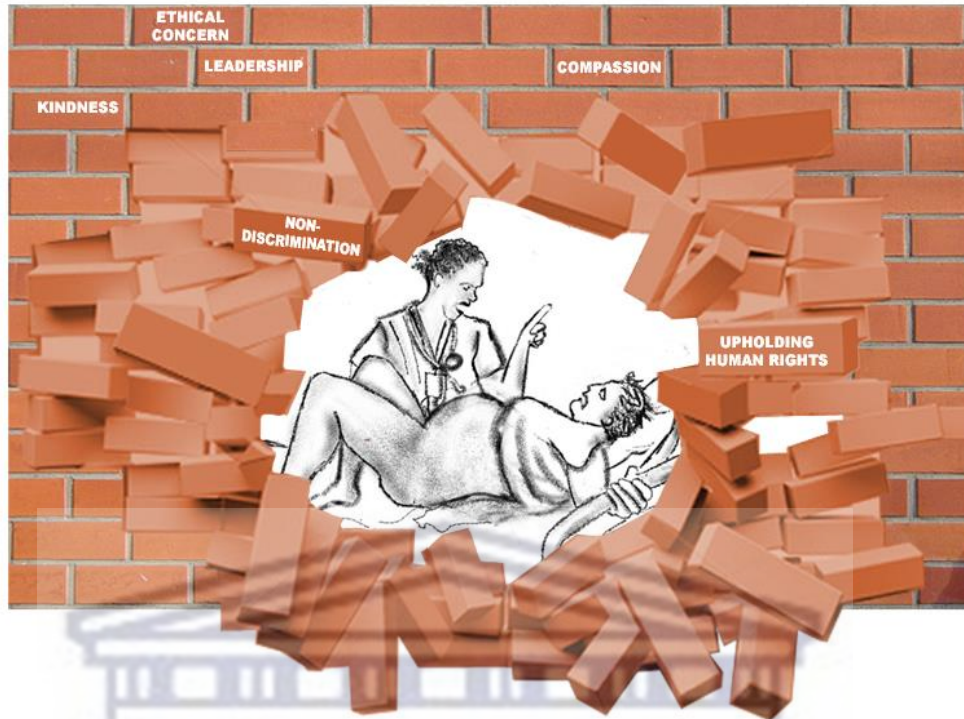


Figure 1.1: Crumbling wall of professional practice (Illustration by Stacey Stent)

1.5.2 What about obstetrics?

Obstetrics is a curricular area of deep concern, holding a position in these cracked spaces. Expectations of nurturing, kindness and care to vulnerable women in labour are disrupted by multiple instances of injustice and violence (WHO, n.d.). The vision of a joyful birth filled with excitement, as depicted in the media, is at times, erased by poor professional practices that tend to remain silenced and hidden. In Chapter Two, I expand on these notions.

My own connections with one health sciences faculty in Cape Town, South Africa and medical students within that Faculty at different levels, triggered this research study. As I made efforts to build up the blocks of professionalism with students, colleagues and others, I too felt pulled into the cracks and crevices of a relatively sealed and separated portion of medical training. While listening to students' narratives both in formal and informal spaces, I was struck by the enormity of issues they frequently confront in our public health sector.

The medicalisation of the natural process of childbirth is a controversial topic in itself. Although there has been a significant reduction in maternal mortality and neonatal deaths, other less measurable consequences have arisen. For instance, obstetric

medicine appears to privilege “masculine values, perspectives and definitions” (Rothman in Chadwick, 2007, p. 24) adhering to the “*patriarchal* ideology that also underpins medicine” (p.23, italics in original), where “the birthing process is abstracted from the bodies of women to become a series of medically sanctioned ‘stages’, timetables and norms” (p. 24). To a certain extent, patriarchal influences have contributed to the pathologisation of pregnancy and birth (Cahill, 2001) involving specialist clinicians (many of them men) becoming powerful actors and policy makers in the field of obstetrics (Johanson, Newburn & Macfarlane, 2002). Rucell (2017) notes that midwifery “has been subordinated within the field of medical practice by male doctors, in order to secure their control over women’s knowledge, health, bodies”, and even refers to control over what midwives earn (p. 109).

Of particular relevance to this study is the issue of professional lapses or disrespect in obstetrics. Concerns about the medicalisation of obstetrics are shifting to these deeper issues. For instance, in Mexico, Dixon (2015) reports on the movement around “*violencia obstetrica*”, which refers to the inherent violent practices in childbirth and wider structural concerns of gendered inequality as indicated by the collective phrase “that *violencia obstetrica es violenciade genero*—obstetric violence is gendered violence” (p. 238).

The *violencia obstetrica* movement positions specific obstetric practices within a broader framework of historical and ongoing patterns of social inequality, especially related to gender, race, and class. How women are treated in labor and birth, the midwives argue, mirrors how they are treated in society in general. For many midwives, this means that women are set up from the beginning to be treated poorly in public hospitals—because of their status as lower class and/or indigenous” (p. 447).

In line with moves in Mexico and Venezuela, in South Africa, there are efforts to criminalise obstetrics violence (Pickles, 2015). Yet, the violence continues to be generated and perpetuated with limited responses (Rucell, 2017). Power and hierarchical relationships and authoritative rigidity are closely associated with the culture of medicine (Cottingham, Suchman, Litzelman, Frankel et al., 2008; Goer, 2010) thus influencing different responses. The QR code in Figure 1.3 below refers to Professor Lynette Denny’s description of the disgrace of obstetrics violence.



Figure 1.2: Disgrace of disrespect in maternity care (QR code to be scanned for video clip)

In this research project I examine relationships. I interrogate the interface between the different and multiple actors and confront what matters in the troubled waters of student learning in obstetrics. I turn to issues of responsibility, particularly what enables and limits students' ability to respond to the injustices they witness. My research questions that follow on here indicate that I move on to explore affect as an integral component of students' encounters. Affect is understood as "our power to affect the world around us and our power to be affected by it, along with the relationship between these two powers" (Hardt, in Clough, 2007, ix).

1.6 Research questions

The research question framing this study is below followed by the three sub-questions:

What forces render students in/capable in their responses to injustices they may witness in obstetrics?

1. What matters in the obstetrics curriculum in terms of undergraduate medical students' experiences and responsibilities?
2. How does the curriculum as a material-discursive practice render students' in/capable⁸ in their response-abilities?
3. How can an affective attunement work towards rendering students capable in their response-ability to unjust practices in obstetrics?

In order to answer these questions I explore how a relational ontology can be put to use to consider the enactments that emerge and are revealed through the connections between the curriculum and students' experiences, and what this can mean towards fostering students capacity to respond to the injustices they may witness. I refer to my

⁸ in/capable is a Baradian (2007) way of using a forward slash to avoid binaries. It implies here that there is a continuum of capability, not either capable or incapable or both, but an indeterminacy regarding capability.

efforts to develop a socially just pedagogy which relates to “what sort of knowledges are valued and devalued, and whose voices are prominent in education” in order to reconceptualise curricular matters (Bozalek, 2018, p. 296). Different patterns of relationality are highlighted to focus on how pedagogical possibilities and curricula can render students in/capable in their responses to unjust practices in obstetrics. My intention is not to evaluate current practices but to enlighten a future for student learning in obstetrics that can develop response-abilities in/through students becoming-with others, also understood as processes of mutual becomings. A relational perspective provides an alternative way of engaging with responsibility or “re(con)figuring responsibility” as suggested by Higgins and Tolbert (2018) in their work on decolonising science curricula (p. 274).

1.7 Significance of this study

We are responsible for the world of which we are a part, not because it is an arbitrary construction of our choosing but because reality is sedimented out of particular practices that we have a role in shaping and through which we are shaped (Barad, 2007, p. 390).

In this study I take up an ethical concern around issues of responsibility. Although this project is primarily based in the Department of Obstetrics and Gynaecology at UCT, the findings may contribute to re-imagining and reconceptualising medical curricula to transform current practices of responsibility that may foster students’ ability to respond and their responsiveness to unjust practices. This project is concerned about what might best facilitate possibilities for enhancing mutual flourishing for students who are becoming doctors, their teaching institutions, and for the public good in terms of public health outcomes, through providing improved quality of care for all. My research outcomes are intended to be productive and illustrative of new insights through a theoretical lens that moves beyond human-to-human interactions.

Obstetrics is a key component of all medical training curricula. My project is located at the nexus of the obstetrics curriculum with student learning where curricular tasks intersect with student engagement. This is where students are emerging from their encounters with/in/through obstetrics. Issues of responsibility are foregrounded as students face multiple dilemmas in terms of their responses within a health service that is currently undermined by multiple cases of poor practices. My research asks questions about how a traditional curriculum based on set learning outcomes can actually disrupt

student learning. I propose that an exploration into relationships and notions of affect may offer innovative potentials for medical education. Students' experiences are a central focus for interrogating their responses to their intensive curricular moments.

By investigating the learning context in terms of what the curriculum is doing and not doing and how that matters to students, I illuminate students' responses to unjust practices that they encounter. I avoid any effort to interpret meanings behind the students' troubling experiences or to find solutions to the identified problems. Todd May (2005) refers to Deleuze's concept of the *actual* which pertains to the fixed nature of solutions, as compared to the *virtual* of problems that open up fields of possibilities. I explore these fields to ascertain what is valued and devalued in the process of knowledge production and how that can contribute towards a reconceptualised curriculum for promoting responsiveness of students to the injustices they may face. I acknowledge Barad's (2007) claim that justice:

is not a state that can be achieved once and for all. There are no solutions: There is only the ongoing practice of being open and alive to each meeting ... so that we might use our ability to respond, our responsibility, to help awaken, to breathe life into ever new possibilities for living justly (p. x).

The curriculum is intended to equip students with the necessary skills and knowledge to provide a quality health service and engage empathically with patient care. I question what else the curriculum is doing. Does it empower or constrain students in their responses to unprofessional behaviours and practices that they may observe?

I surface the tacit curriculum to work with previously hidden dialogues, particularly difficult ones. My thesis puts forward theoretical concepts and practical initiatives that have the potential to possibly promote institutional change in the discipline of obstetrics and beyond. Olsson (2009) contends that "you cannot put a theory onto a practice" but that it is more productive to work in between practices and theories to enable newness to emerge (p. 97). Alternative thinking and doing is deemed necessary to shift curricular design away from technical, linear and static processes that do not reveal some important and hidden influences in student learning such as affect.

Through this study I propose that medical training may benefit from a more inclusive approach that respects the multiple relational forces (including the material) emerging in and through students' learning encounters. I examine how feminist new materialism

(FNM) can generate a different viewpoint of subjectivity and responsibility. Such a theoretical framework works through an open-ended process in which vital forces move across boundaries of established categories and domains, not reduced or confined to the human species, but in generative processes with other elements, both human and non-human⁹ (Braidotti, 2013a).

I examine how both human and more-than-human relationships constitute what matters and does not matter for both students and the curriculum. I look beyond the acquisition of knowledge in terms of epistemology, to explore relational matters in students' becoming-with the curriculum and the events that play out as they traverse their curricular encounters. This ontological perspective takes into account the ethical issues of responsibility and responses to injustices. It proposes that we move beyond notions of separation but that we rather interrogate the relationships embodied and embedded in ethico-onto-epistemologies, a concept put forward by Barad (2007) to help rethink our response-abilities (St. Pierre, Jackson & Mazzei, 2016). Banerjee and Blaise (2013) contend that "becoming-with practices open[s] up new ways for rethinking" issues that we're grappling with for our futures and in the present (p. 244). Relationships are difficult to measure and assess and tend to go unrecognised. I draw on FNM theorising to explore how human interactions with non-humans and the more-than-humans can play a significant role in what matters in student learning.

Specific curricular moments are highlighted which influence students' power to affect and be affected by their curricular experiences. Affect is an important component of a movement that can shift and open up spaces of silence, that have been hidden. In this thesis I argue for an appreciation of affect which refers to more than emotions and differs from the psychological perspective of affect that "individualizes it" (Massumi, 2015, p. 206). Affect is pre-personal and pre-individual, emerging through relations. It is a charge with intensity that has a force, known as an affective capacity, that moves us through a threshold, making a transition to something different (Massumi, 2015).

There's an affect associated with every functioning of the body, from moving your foot to take a step to moving your lips to make words. Affect is simply a body movement looked at from the point of view of its potential – its capacity to come

⁹ While non-human is widely used, I continue with the concept of more-than human to include animals and matter. The term *more-than-human* helps to avoid the binary assumptions that could be associated with other more commonly used terms in FNM such as *nonhuman* and *inhuman*. However, when quoting from theorists in FNM, these latter terms will be included.

to be, or better, to come to do. It has to do with modes of activity, and what manner of capacities they carry forward (Massumi, 2015, p. 7).

When a culture allows for disrespectful and violent practices to occur, there are possibilities for change when we take time to examine belief systems and “unspoken emotional investments” (Boler, 1999, p. ix) and contemplate new becomings. In medical education there is an acknowledged need to relook at what is valued and to broaden perspectives to “begin seriously exploring the role of emotion in learning” (Artino & Durning, 2011, p. 275). In this study I go beyond emotions to explore affect, taking a positive affirmative stance to find new potentials and possible activism towards a different understanding of student responsibility. I avoid placing judgement or being prescriptive on what has been and continues to be present in obstetrics practices. I take up the spaces where a theoretical untangling of practice can be productive (Haraway, 2016), finding value in depathologising negative feelings to unpack with hope rather than demean (Cvetkovich, 2012).

1.8 Limitations of this study

The topic of this study is a sensitive issue. Therefore, the project has involved risks as it cuts into a silent space where the dominant discourses and established practices have tended to conceal issues of abuse and neglect that prevail in public birthing facilities where UCT students learn their skills and their responsibilities towards patient care. There is a possibility that my study may be viewed defensively by the healthcare professionals connected to student learning at UCT. My thesis is about the unexpected, where process has mattered more than product. The non-traditional nature of this study could be problematic and may be criticised for taking a path away from evidence-based practices that are the traditional benchmarks for scientific research. The data are neither measurable nor replicable. My post-qualitative study moves beyond repeating what is currently known, a form of representation (explained in detail in Chapter Four). Furthermore, the concept of affect that emerged in the research is not quantifiable, not available for measurement or the usual types of analysis, as noted by Ducey (2007) in her study with allied health care workers. Findings are emergent, situational and indeterminate.

Although medical students are our future doctors and possible change-makers, their focus tends to be “on relatively short-term goals, and specifically competencies and outcomes necessary to qualify and become a practicing physician” (Mennin, 2016, p.

356). I agree with Jessica Rucell's (2017) comments in her doctoral thesis which also researched obstetrics violence in the Western Cape, that the rule-bound ethics which we agree to uphold, where anonymity and confidentiality are assured, forces us as researchers to be complicit bystanders in the events we hear about and encounter. Although I was able to initiate departmental, and at times provincial responses, trends of disrespect at certain facilities remain hidden in my text.

1.9 Concluding with what follows

My research project investigates issues of responsibility and students' capacity to respond to unjust practices. Chapter One offered a brief overview of my study situated within the obstetrics learning component of the medical undergraduate curriculum. My focus is on curricular matters in an effort to discern what matters in terms of students' responses and ability to respond to injustices they may witness in the birthing facilities where they learn their practical skills.

Chapter Two outlines how the obstetrics curricular tasks necessitate a need for fourth-year students at UCT to spend time in the clinical placements in public health birthing facilities, where they learn from others. I illuminate how disrespect and abuse in maternity care is rampant both locally and globally, and how there is a growing movement of activism to promote respectful maternity care through numerous channels of engagement. However, students' immersion in the curriculum is entangled with multiple forces that appear to constrain or facilitate their responses to injustice.

Chapter Three provides an explanation of the theoretical frameworks that I use to offer an innovative relational approach to these pressing matters affecting students in their learning to be and become doctors. I take up concepts from feminist new materialism and posthumanism that include Barad's (2007) agential realism, to bring a very different affirmative perspective to issues of responsibility and response-ability.

Chapter Four describes the different processes taken for this research study that include my post-qualitative inquiry and non-representational approach giving an explanation of how this differs to conventional human-centred methodologies. I give details to clarify the steps taken in my study to ensure that it adheres to the standards and requirements for institutional ethics and administrative processes

In Chapters Five, Six and Seven the study findings are described together with theory that highlights the entanglements of students becoming-with others. Chapter Five takes a focus on what matters in the curriculum and how that influences students' responses. Chapter Six foregrounds the agency of matter to illustrate how it matters in student learning and contributes to limiting students' responses to unjust practices. Chapter Seven brings a focus on affect with its intensity and forces and how the affective flows emerged to make a mark in my study. In concluding I put forward that the study has not provided a solution to the current wave of abuse and disrespect in obstetrics but that a relational perspective can open up new ways of engaging in this pressing issue. It can contribute to promoting and fostering students' capability to respond to injustices they may witness.



CHAPTER 2 - WHAT ABOUT RESPONSIBILITY IN MEDICINE?

2.1 Introduction

In the previous chapter I introduced the topic of response-ability, explaining that this study is based on students' experiences in their obstetrics learning. I pointed out how abuse in obstetrics is prevalent yet has been a hidden and silenced aspect of the medical undergraduate curriculum. It was noted that in higher education in general, conversations about troubling pasts (Zembylas, 2012) and "troubled knowledges" (Jansen, 2009) are not comfortable hence often avoided. Zembylas, (2012) contends that:

classrooms are not homogeneous environments with a common understanding of oppression, but deeply divided places where contested narratives are steeped in the politics of emotions to create complex emotional and intellectual challenges for educators (p.118).

What follows in this chapter is a more detailed description of the contextual landscape in which this research took place and in which students learn their obstetrics skills. I explore institutional responsibility and mechanisms used to engage with troubling encounters with measures to address issues of accountability. I then move on to focus on obstetrics to explain how the ongoing practice of mistreatment of women in labour is entangled with multiple other forces that contribute to the current apparently limited responses that appear to perpetuate these practices (Rucell, 2017).

2.2 Curricular imperatives

The goals of higher education institutions are demonstrated in their graduate attributes which according to Barrie (2012) "seek to articulate the nature of the education the university offers to its students and through this an aspect of the institution's contribution to society" (p. 80). In health sciences faculties such as at the University of Cape Town (UCT), students also promise to adhere to an oath pronounced by them at their graduation. The oath is also chanted aloud by student groups at their orientation sessions in each of their clinical years. Included in this document is a commitment to uphold and defend human rights even under threat. What is missing in commitments such as repeating oaths and promises is the emotional power and capacity for students to adhere to these ideals. Zembylas (2013a) writes about memorial practices and

performances at schools in Cyprus. While such ceremonies invoke a binding culture among communities, these ritual practices involve emotional power at micro and macro levels that mark expectations that may not be attainable. What may be more valuable are pedagogical approaches with theoretical underpinnings that encapsulate emotions and power (Zembylas, 2013a).

I question the assumptions made by such ideals. The expectation that students can uphold and defend human rights with an ability to respond to unprofessional practices or injustices they may witness is uncertain especially when they may feel distanced from the real issues of discrimination and injustice. In the previous chapter I noted the limitations of a rights-based approach to healthcare challenges. Defending human rights is fraught with multiple challenges such as the vulnerabilities of human rights defenders as well as those whose rights are being violated. From my own experiences in the Health Sciences Faculty at UCT, I observed that one of the most impactful curricular interventions in the first year programme was a lecture delivered by Wendy Orr, who recounted her ordeals and dilemmas with personal narratives as a young doctor during the apartheid years. She described how her professional responsibility led to her promoting the human rights of her incarcerated patients, despite the many challenges she faced at the time, and afterwards (Orr, 2002).

2.2.1 Becoming a doctor

Writing about her experiences as a student and junior doctor in an award-winning book, *Postmortem: The doctor who walked away*, Maria Phalime (2014) explains her shift away from the profession of medicine on May 3rd, 2004 as being “swift, a surgical cleavage” (p. 59). Despite her passion for caring and her sense of competence in being a doctor amidst the high tensions that prevail in South Africa’s health system, she cut a new career path for herself. She is not alone. In several personal interactions with me, Maria has expressed her alarm at how her book has motivated a tsunami of responses, especially from many doctors, keen to share their experiences that resonate with her own. What is unusual is Maria’s openness. She uses many personal anecdotes that depict the gap between the ideals of medical training and the reality of the difficulties experienced in practising medicine in South Africa. Reflecting on her ten years as a student then as a junior doctor, Phalime (2014) recognised an uncomfortable change in herself, admitting “I didn’t like the person I was turning into. I felt disconnected from the very people I was meant to be serving” (p. 42). In medicine there is an acknowledged culture of learning to cope and developing a resilience despite the long hours and work

pressures as well as the exposure to “gruesome pathology and trauma” (p. 94). Students are expected to push through the difficulties to become the doctors many have dreamed of being and becoming and to provide a service in a country with dire health needs. Being and becoming “fit for purpose” is a key theme for students moving through South Africa’s medical training institutions (Burch & Reid, 2011; Mennin, 2016).

Multiple efforts are in place to assist students and to promote institutional throughput of students with the objective to “produce graduates who are able to engage reflexively and critically as socially responsive health practitioners within the South African health delivery system (Hartman et al., 2012, p. 480). Furthermore, recent curricular reforms aim to allow for flexibility to enable differently positioned students, with the recognition that some are ill-prepared for the arduous workload. However, the move towards prioritising the primary health care approach has led to some curricular disconnects between the earlier pre-clinical theoretical years and later years when clinical disciplinary input is structured differently (Reid & Cakwe, 2011).

Maria Phalime (2014) claims that many unforeseen encounters happen while students are traversing the curriculum, yet, “[w]e didn’t talk about what was going on for us. There wasn’t time, and the institutional culture didn’t allow for it” (p. 42). James Dwyer (1994) refers to the silent retreat away from ethical dilemmas that are witnessed by students and considers it to be a failure for learning and for care. There is an acknowledged mismatch between bioethics curricula taught to medical students and the reality of the dilemmas that they face in clinical practice (Caldicott & Faber-Langendoen, 2005, p. 866). A Canadian study into the ethical dilemmas of students in clinical clerkships suggested that feminist pedagogical approaches that engage with relationships could contribute valuable insights into these challenging and complex moral issues.

2.2.2 The unexpected dilemmas of responsibility

Despite the great wonders of best-practice medicine, medical practices in the past (and present) reveal many instances of abuse inflicted by a few doctors and other health care professionals, both individually and collectively (Mann, Gruskin, Grudin & Annas, 1999). Such misuse of power over patients highlights the disruptions of trust that challenge healthcare and related training institutions. Questions pertaining to responsibility, responses, and ethics in the training programmes in the health sciences are relevant for exploring how such harmful practices arise and more importantly for this study, are perpetuated. There appears to be a lack of responsiveness or incapacity to respond that

enables unprofessional practices to occur, and at times to be perpetuated. Much remains invisible or kept within private domains of communication.

In South Africa, the Truth and Reconciliation Commission's hearings (1998) made public the many incidents of abuse of power, torture and other unethical behaviours led by and practised by local doctors supporting the apartheid regime. The demanding challenges faced in responding to both past and present injustices are highlighted in the case of Wouter Basson, a cardiologist, currently practising as a private specialist in Cape Town despite being found guilty of chemical warfare atrocities (London, 2010). Basson's case is an extreme form of unethical practice involving gross human rights violations. However, it does illustrate how violence is endemic in our society, with the banality of evil permeating into different contexts in a system that justifies it and allows for the continuation of it (Arendt, 1963). Basson has claimed that his murderous actions took place in doing his duty as a soldier, arguing that he separated his roles and responsibilities as a doctor and soldier. While murder is very different to unjust practices in obstetrics, I use Basson's case to demonstrate how professional and ethical dilemmas plague medical professional practices and training in the health sciences. Lifton (2004) admits that "[p]hysicians are no more or less moral than other people" recommending the need for speaking out as an important response and way forward (p. 416).

Unlike Basson's case where his interests were clearly aligned to the State's apartheid practices, other doctors have struggled with dual loyalty where there is a conflict of interest between the employer and the patient. Dual loyalty is pertinent when "the subordination of the patient's interests risks violating that patient's human rights" (London, Rubenstein, Baldwin-Ragaven & Van Els, 2006, p. 382). Such dilemmas illustrate the complexities of practice when multiple forces impact on the agency, decision making and practice of healthcare professionals. I propose that medical students have similar, though different dilemmas when their need to graduate conflicts with their loyalty to patients. Reporting wrongdoing is commendable and encouraged yet it is entangled with many connected factors that include fear and failure, which are as relevant for practising doctors as for students in training.

When questioning how and whether responses to shocking professional practices and behaviours are possible, the limitations of regulatory laws, policies and oaths become evident as these legal channels have not curbed the prevalence of abuse by those in positions of power. Abusive actions in the health system occur despite South Africa's

healthcare regulations that are guided by the National Health Act, No. 61 of 2003, and policies laid out by the Health Professionals Council of South Africa (HPCSA) under the overriding legal precedents set by international and local conventions and protocols. In terms of knowledge production, there are important systemic and structural factors that contribute to the global challenges, related to poor quality of care, a problem of health service delivery by providers at all levels within health systems. Nerland and Jensen's (2012) report on research in Norwegian hospitals where "the quality of procedures was found to be poor, many were outdated, and others that simply could not be followed in clinics were identified" (p. 109). Despite the good intentions in governance procedures, many different problematic nursing practices were occurring. Findings focused on acquiring knowledge indicated that knowledge was accessed and circulated through different relationships, which proved problematic at times. Contributing factors noted were the multiple approaches in different facilities that led to confusion as different epistemic practices were used for the same treatments. This has implications for student learning in obstetrics too as they move between several facilities.

Further to different ways of teaching, in developing countries like South Africa there are additional burdens on medical training. Not only are there resource limitations but also the quadruple burden of disease where four concurrent epidemics are affecting patients and health professionals. Included in these groups of health conditions placing a burden on healthcare are maternal and child illnesses, infectious diseases like HIV and tuberculosis, non-communicable diseases like diabetes, and lastly violence and injuries that are recognised as "perhaps the most neglected component" (South African Health Review, 2016, p. 295), with acknowledgement of related mental health issues. These burdens add to the tensions and complexity of maternal care and student learning in obstetrics. For instance, special treatment and care is needed for a pregnant woman with HIV in order to protect the unborn baby. The global movement towards millenium development goals (MDG) which included improving maternal health provides motivation and incentives to change current practices.

2.3 Mechanisms of accountability as a response to responsibility

Questions of responsibility and accountability present themselves with every possibility; each moment is alive with different possibilities for the world's becoming and different reconfiguring of what may yet be possible (Barad, 2007, p. 182).

In what follows I refer to legal avenues for redress, curricular matters and then lead onto a focus on reporting processes at UCT before giving a more detailed description of responsibilities in terms of the context of student learning in obstetrics. After the 1994 elections in South Africa, political transition was marked by substantial legislative changes to support the new democracy including the right to access quality healthcare with the stated inclusion of reproductive rights in the Bill of Rights (1996, Section 27). National policies that aim to promote, protect and respect human rights in the health system include the Policy on Quality in Health Care for South Africa (Department of Health, 2007), the Patients' Rights Charter (Department of Justice) and the Batho Pele principles (Department of Health). However, social inequities and alarming levels of national violence as reported in the Medical Research Council policy brief (Jewkes et al., 2009) reflect how societal norms and values resonate in the health system representing the social fabric of a society (Gilson, 2003, p. 1461).

As mentioned in Chapter One, the public health system is in a lamentable state (SAHRC, 2009). Among the many efforts to address the difficulties in the health system is the Rural Health Advocacy Project's (RHAP) publication by their Voice Project (2017). This online resource aims to promote the reporting of incidents of poor care, to move away from silence and fear of such actions. It focuses on the health workforce crisis, providing a guide to reporting healthcare challenges. "There's really no such thing as the 'voiceless'. There are only the deliberately silenced, or the preferably unheard" says Arundhati Roy on the website of RHAP. This notion of voice will be expanded on in the next chapter when I acknowledge that reporting wrongdoing is not a straightforward linear process.

Another outlet for responding to harmful practices in healthcare (and the workplace in general) is the Open Democracy Advice Centre (ODAC) which supports whistleblowers. The ODAC (2015) promotes accountability and transparency as a positive act to bring political and social change but acknowledges that it can be risky with unintended consequences for the whistleblower.

Good intentions for institutional responses through transparent complaints procedures and incident reports are not necessarily straightforward, as they are frequently hampered by other factors and forces influencing individual's responses. Even the implementation of the Patients' Rights Charter in South Africa and its wide exposure through posters and pamphlets has not led to anticipated outcomes (London et al.,

2006). Research findings indicated that patients' rights were foregrounded at the expense of their responsibilities. Patients were labelled as irresponsible and seen to take advantage of the power given to them by the Charter. Furthermore, it was noted that the healthcare providers used the power afforded to them by their status and authority to enforce top-down changes that highlighted issues of poor management in the established hierarchical health system (London et al., 2006).

Processes for responding to complaints frequently involve punitive actions substantiated by evidence of individual's fault or guilt. This deficit approach to accountability affirms blame in an effort to pave a way for improvement. Such linear liability models are critiqued by Iris Marion Young (2006) as backward-looking. She reminds us to be cognisant of the structural processes that can produce injustices, recommending a shift towards a forward-looking perspective that involves a shared, collective responsibility towards social change, promoting justice. Rucell (2017) highlights problematic structural processes in her recent doctoral thesis related to obstetrics in the Western Cape. Rucell (2017) coins the term, *structural obstetric violence* to name "how the public health system reproduces violence" (p. 20). There are harmful consequences on patients and staff resulting from the current resource constraints and weak managerial systems and practices in the public health birthing facilities. These limitations appear to actually contribute to the societal "continuum of violence" which is fueled by power differentials and unjust discriminatory practices (p. 154)

Finding alternative approaches to respond to these violences is key to change. For instance, Gilson (2003) recommends mechanisms to develop trust expressing the value of "openness, solidarity, fairness, truth-telling" to promote quality of care (p. 1462), pointing out that conventional forms of "measurement and performance monitoring" are characteristic of low trust systems. Diminished trust undermines the quality of care (Gilson, 2003, p. 1460).

In her doctoral study on mother's birthing experiences in South Africa, Rachelle Chadwick (2007) admits that it was challenging for her to take up the women's birth stories "beyond an individualist framework" (p. 324), acknowledging that most studies follow "realist modes of representation in which the stories and talk of women were reproduced as static, uniform and decontextualised blocks of quotations" (p. 325). Chadwick (2017) identified the importance of assemblage thinking in terms of the "emergent dynamic involving multiple relations of power, affective flows, bodily energies,

structural and material configurations, and discursive repertoires” (p. 492), While engaging with theories of feminist materialism, Chadwick (2007) stressed the contradictions, with her thesis titled, *Paradoxical Subjects*.

Healthcare accountability in maternal health has tended to focus on the consequences of negative birthing experiences and the impact this has on the woman’s health and future health seeking behaviour (Goer, 2010; Chadwick, Cooper & Harries, 2014). Efforts to promote accountability with intentions to improve quality of care or to seek redress for individuals have not fulfilled expectations to halt unprofessional practices (Rucell, 2017). It appears that new alternative insights are needed to bring change to current practices.

2.3.1 Curriculum matters at the University of Cape Town

Revised policies and objectives towards implementing a Comprehensive Primary Health Care (CPHC) approach were put forward in the White Paper for the Transformation of the Health System in South Africa (1997). It included a mission to provide and to promote caring and effective services that would reach all people in South Africa. Included in transformative moves for the health system, were curricular reforms at health professionals’ training institutions. Apart from providing more access to previously disadvantaged students, changes included the introduction of curricular content that could promote and advance more equitable health services, giving attention to the needs of the population and to address the vast disparities from the apartheid era. Recent student protests countrywide (mentioned in Chapter One) have challenged the degree of curricular transformation. Emerging from the protest action in the HSF at UCT, was a student collective known as #OccupyFHS¹⁰, and a curriculum change working group (CCWG) that has been established to engage deeply with transforming and decolonising the current curriculum so that it can become more Afrocentric. Furthermore, an undergraduate oversight task team was established to address the demands made by the students. Included in these demands were requests for more oversight in institutional processes (such as oral assessments) to prevent abuse of power by educators, an indication of the lack of trust in institutional processes. The reformed curricula have proven insufficient, not going far enough to support and work through the power struggles of traditional established practices that are ingrained in a strictly hierarchical

¹⁰ #OccupyFHS is the Twitter hashtag that refers to the student protest in the HSF at UCT which involved students occupying the Dean’s suite for several days in 2016.

culture and system.

Relationships between different entities in the health and education systems are complicated and complex. For instance, some clinicians have joint mandates with the university and the provincial health department resulting in split functions to teach students and to manage clinics. There are tensions and resultant dilemmas in terms of which entity takes responsibility for these doctors' actions. For the doctors themselves, they face conflict in prioritising their time and tasks between their students' needs and those of the patients under their care. A multilateral agreement with State health authorities in the Western Cape between the four Higher Education Institutions, (Stellenbosch University, the University of Cape Town, the University of the Western Cape and the Cape Peninsula University of Technology) "has been a bone of contention for several decades" (Western Cape Government, 2012), although the agreement was perceived to be an important bridge towards collaboration and cooperation. The necessity for such an agreement is explained in the quote below:

The relationship ... needs to be governed due to resource limitations and finding a balance to deliver two mandates - academic activities and service delivery. The sharing of resources requires clear arrangements for proper accounting (Western Cape Government, 2012).

These organisational structural challenges seem distant to students who are immersed in their curricular tasks; the tensions are not made explicit to the students, yet they do influence student relationships with unintended consequences. Students are affected by these conflicts, picking up what is valued through the unspoken and unwritten messages they discern in their learning. These actions are components of the hidden curriculum¹¹ in which there are multiple tacit forces acting on/with the curriculum. Erin Manning (2019) urges us to think beyond the bounds of the explicit curriculum and the institution, to value "what is in excess of curriculum, the unknowable" (p. 44).

The use of the term *hidden curriculum* is criticised by Lawrence et al., (2017). In their scoping review of 197 articles, they assert that it is too ambiguous, without clear conceptual boundaries, and limited in terms of the different needs for different cultures and areas. They recommend more research on the hidden curriculum in southern contexts such as Africa. Hafferty and Martimianakis's (2017) response to these criticisms

¹¹ The hidden curriculum represents what students learn through traversing the curriculum as opposed to the designed curriculum that they are formally taught (Hafferty, 1998).

is to suggest that the hidden curriculum ought to be “an entry point for studying the interstitial space between the formal and a range of other-than-formal domains of learning” (p. 15). This study emerges from a space in the hidden curriculum, responding to Draper and Louw’s (2007) recommendation for the hidden curriculum at UCT to become explicit and open in order for “staff and students to engage in ongoing communication about both their sets of values, beliefs and priorities around the medical profession” (p. e106).

A hidden component and force in the implicit undergraduate medical curriculum is fear. Students’ own curricular experiences tend to be silenced. In difficult situations, their fear of victimisation appears to limit their responses. In 2011, Vivian et al. surveyed 223 senior students in the HSF at UCT. The majority of students chose not to report unprofessional behaviours. They offered care and support to their patients to compensate for the poor treatments observed, citing their sense of helplessness and intense fear related to possible victimisation that could limit their academic progress, as well as fear of senior educators. The study findings noted that 130 (71%) students had witnessed human rights abuses and professional lapses during their clinical learning encounters that included physical and verbal abuse and undermining the dignity of patients, as well as inadequate information provided to patients regarding their treatments.

A definitive response to this in-house research was for the HSF at UCT to establish a Professional Standards Committee (PSC). In the online guide to professional behaviour for health science students at UCT there is an expectation that students will “[r]aise concerns with the relevant authorities when clinical standards that could compromise patient or others safety are not upheld” (n.d., Section 6G, p. 272). Yet, responding to unprofessional practices is difficult, as acknowledged in the incident report form of UCT’s HSF Professional Standards Committee which states:

Reporting of unprofessional behaviour, although difficult, can help to improve the quality of care to patients, to prevent the recurrence of particular incidents, to improve the learning experience for students, and ultimately to strengthen ethical and accountable practice (University of Cape Town. Faculty of Health Sciences, 2019).

In 2015 there were 718 viewers to the PSC site on Vula. Repeat visits were reflected by the total of 1083 views. The site has a Question & Answer tool that was not used. The

incident report form was downloaded only five times. However, although downloaded, incidents were not reported through this mechanism which involves completing the form then submitting it to the chairperson of the committee who then initiates a response. This lack of uptake and apparent unresponsiveness by students has been and continues to be a deep concern for the PSC. Even though anonymous reporting is acceptable, few students draw on this option which resonates with Vivan et al.'s (2011) findings where fear was noted to be a barrier for reporting, no matter what mechanisms have been put in place. Even the option of anonymity has not yielded more response. Perhaps it signifies a lack of trust within the institution or an unwillingness to 'rock the boat', or that students possibly feel that it is not their responsibility to care about the consequences of poor treatment by supposedly competent professionals. As a person appointed on the PSC committee from the time it was initiated, I draw on my insights throughout this research project.

In my efforts to engage with issues of responsibility and responsiveness in my teaching, I have used a visual image¹² to highlight the pathways that are available for students' responses at UCT (Figure 2.1). Using this visual tool, I encourage students to respond and to report poor practices by following due process. The image highlights the importance of facts and evidence, and the value of working through existing channels with others rather than alone.

The logo of the University of the Western Cape, featuring a stylized classical building with columns and a pediment above the text "UNIVERSITY of the WESTERN CAPE".

UNIVERSITY of the
WESTERN CAPE

¹² Stacey Stent is a local illustrator.



Figure 2.1: Visual guide for students to respond to unprofessional practices in the HSF, UCT (Illustration by Stacey Stent)

2.3.2 Sensitivities of responses and silencing of stories

Silence is not uncommon in educational spaces. Jackson and Mazzei (2012) refer to silence as “an enactment of desire”, claiming that “silent discourses serve to maintain a status quo” with an illusion of sameness and belonging” (p. 100). Jonathan Jansen (2009), as the then Vice Chancellor of the University of the Free State, challenged the silences in South African society and Higher Education Institutions (HEIs). He transformed problematic racial practices and cultures through engagement and dialogue arguing against the established culture that has prioritised silence over dialogue. Although silence can be productive, such as in passive aggressive behaviours, he opened spaces for mutually engaging with troubling knowledges.

Below I take a closer look at the discipline of obstetrics with reference to the past, future and present practices of injustices. I draw on the limited but growing number of publications around disrespect in obstetrics, and then lead into what this means for

student learning. Obstetrics is an essential learning space and curricula element for all undergraduate medical training programmes.

Pregnancy is between an act and a state. It is conscious and unconscious within an intimate involvement with the world to come. Being with child is being with the always not-yet of the world (van der Waal, 2018, p. 369).

2.4 A focus on obstetrics: intrapartum¹³ care/lessness

As mentioned in Chapter One, saving lives during childbirth has become a top priority globally. However, there are massive disparities of maternal mortality across the globe reflecting the multiple factors that play out in the birthing process. An example from Peru, where there has been a significant drop in maternal mortality rates (Bowser & Hill, 2010), demonstrates the many, often unexpected forces that drive an individual's choices and shape health care practices. Few women were attending the Emergency Obstetric Care (EmOC) facilities and there also appeared to be a clash between the predetermined practices by medical personnel acting as Public Health authorities, and women's cultural beliefs. In the facilities women were forced to stay in a horizontal position. To avoid this imperative, women stayed at home in a space where they could uphold and respect their cultural tradition of taking up a vertical position during labour. These indigenous women feared being faced with the regulations connected with the public health facilities. However, once these issues were identified and the challenging relationships acknowledged, change was enabled. The Peruvian Health Ministry adopted new policies to facilitate alternative positioning. As a result, more women had a desire to attend the services of public facilities, which led to reduced mortality rates (Vertical birth, 2019).

The above example offers a glimpse into the complexities and invisible sensitivities involved in obstetrics. There are so many beliefs, opinions, and uncertainties adding to the tensions of a critical moment in people's lives and in student learning. My study moves into these tensions to specifically explore harmful and disrespectful practices in obstetrics and the resulting consequences on students in training. The sparse amount of literature on the topic illustrates the hidden nature of maternal disrespect. However, in late 2018, the publication of the *12 Steps to Safe and Respectful MotherBaby-Family Maternity Care* marked a decisive international move to highlight and guide a collaborative interdisciplinary effort to bring change to the current global epidemic of

¹³ *Intrapartum* refers to the time period from the onset of labour to the delivery of the placenta.

intrapartum disrespect (International Childbirth Initiative, 2018). Even the title of the document demonstrates a shift from separating the needs of mother, baby and family towards the impact of their entanglement.

Language used to denote disrespectful behaviours in birthing facilities vary with behaviours and attitudes that are described variously as professional lapses (Vivian et al., 2011), obstetrics violence (D'Gregorio, 2010), negative birthing experiences, mistreatment (Gan & Snell, 2014), inhumane treatment (Goer 2010), abuse, neglect and disrespect (Bowser & Hill, 2010), disrespect, and abuse (D&A) (Sando et al., 2017). In order to promote respectful maternal care Freedman et al., (2014) recognised the need for a definition, suggesting disrespect and abuse in childbirth “as interactions or facility conditions that local consensus deems to be humiliating or undignified, and those interactions or conditions that are experienced as or intended to be humiliating or undignified” (p. 916). Goer (2010) claims that the mistreatment of women in pregnancy and labour “opens up new categories of abuse not falling under conventional definitions” (p. 37).

Abuse in obstetrics has a surprisingly long history as a global problem. It has been referred to since the 1950s when issues of cruelty and inhumane treatment to women in labour were made public (Schultz, 1958). Sadism in delivery rooms and cruelty in maternity wards were reported in the Ladies Home journal in November 1957 and May 1958 (Goer, 2010). Incidents included the immobilisation of women in the lithotomy position, having their legs tied together to stop the birth process while the obstetrician had his dinner, women receiving slaps if they seemed unco-operative, being threatened with the possibility of a damaged baby, receiving cuts or episiotomies without local analgaesic or receiving insults and remarks regarding conception, for example, “you enjoyed it then, so...”

Current practices continue to present inhumane treatments, despite many reforms in process and management (Goer, 2010). The same, similar and different practices are still prevalent today both internationally and locally (Bohren et al., 2015; Caldicott & Faber-Langendoen, 2005; Chadwick, Cooper & Harries, 2014; Kruger & Schoombie, 2010, Vivian et al., 2011; Warren et al., 2013). The vast prevalence of disrespect in childbirth is demonstrated in the research report of the Kenyan Heshima Project finding that nine out of ten healthcare providers were familiar with (had heard or witnessed) inhumane treatment by their colleagues (Population Council, 2014).

Mistreatment of women in labour is not confined to the developing countries. In British Columbia, Canada, there have been reports of violations of maternity care leading to the formation of a non-profit organisation called Humanising Birth, now campaigning for “respectful, peaceful and humane birth” (Humanize birth, 2014). This organisation is linked to the Women’s Global Network for Reproductive Rights (WGNRR) who, supported by 36 partner organisations, have declared May 28th as the International Day of Action for Women’s Health. Included in their campaigns is the action against obstetrics violence with an infographic campaign poster designed as an educational resource to highlight the multiplicity of factors contributing to obstetric violence such as the disregard of the needs of women and their pain during labour.

Bowser and Hill’s (2010) report for the United States Agency for International Development’s Translating Research into Action (USAID-TRAction) Project describes the many forms of disrespect and abuse that are prevalent in birthing facilities which they divided into seven categories, namely; physical abuse, non-consensual care, non-confidential care, non-dignified care, discrimination based on specific patient attributes, abandonment of care, and neglect and inappropriate demands for payment (p. 9-15). A systematic review (Bohren et al., 2015) that included 65 studies across 34 countries presents an evidence-based typology of mistreatment of women during childbirth. A follow up systematic review (Sando et al., 2017) of five studies in four sub-Saharan African resource-restricted settings that included Kenya, Tanzania, Nigeria, and Ethiopia sought to measure the prevalence of specific categories of disrespect and abuse (D&A) named as “physical abuse, non-dignified care, non-consented care, non-confidential care, abandonment, and detention” (p. 2). The wide range of measures in the reported findings indicate how complex the issue is, and how difficult D&A is to define and operationalise into researchable categories. The complexity of researching D&A is amplified by many other factors that are particularly relevant to student learning which include:

the normalization of mistreatment of women in societies, structural inequalities and power differentials within the culture of medicine and the broader culture in which the health system resides, and health system constraints that may impact perceptions of what constitutes acceptable service and treatment of patients (Sando et al., 2017, p. 16).

Disrespectful and undignified care of women during facility-based childbirth was identified by Kruk et al. (2018) in their study in Tanzania, as an indicator of the broader problem of a health system in crisis. Although there have been global efforts to address disrespect and abuse in maternity settings with buy-in from policy makers, staff on numerous programmes, activists in civil society organisations and communities, Warren et al. (2013) contend that much more is needed to address these issues, and have implemented research projects in Kenya.

This Heshima project in Kenya in 2014 was a collaborative response to D&A supported by the USAID-TRAction project. By confronting the problem of disrespectful maternal care in Kenya, the many and different drivers of abuse were identified as arising at three different levels, notably at policy and government level, health facility and provider level, and at the community level. An outcome from this project was the development of the Respectful Maternity Care Resource Package (Population Council, 2015).

Only since the beginning of the 21st Century have health professionals' taken up the issue of obstetrics violence, however more in terms of a quality of care perspective than in the relationships that matter. Vogel, Bohren, Tuncalp and Gülmezoglu (2016) have called for the development of evidence-based interventions and evaluations "so that health systems can effectively manage this problem" (p. 673). The multiple forces that constitute obstetric disrespect are coming to light, particularly when perceived beyond individual behaviour and binary conceptions such as guilt/innocence, perpetrator/victim. Lokugamage and Pathberiya (2017) refer to activist Milli Hill, the founder of the Positive Birth Movement, who has pointed out the vast and deep polarities present in birthing such as between obstetricians and midwives, midwives and doulas, etc. suggesting that bridges be built to facilitate more trusting relationships. The so-called "factory line conditions within health facilities" exacerbate the denial of rights, such as when women are forced and restrained to lie on their backs for many hours and give birth in that position (Lokugamage & Pathberiya, 2017).

There is increasing attention being given to disrespect in obstetrics, with the term obstetric violence (OV) becoming more commonly used and recommended as an appropriate label for the pervasive actions of abuse and neglect (Pickles, 2015). A growing movement of collaboration is giving visibility to the associated challenges with the opening up of "channels for denunciation and accountability of the different actors involved - institutions, managers, health professionals, Public Prosecutors, and Public

Defenders” (Jardim & Modena, 2018, p. 9). However, these moves are human-centred with limited attention being given to the materialising forces generated in relationships with women during the birthing period.

Problems that have distressed patients in their intrapartum care have been identified in four categories namely, poor interpersonal relations with those who ought to provide care, inadequate information, different forms of neglect, and frequent loneliness felt by some women when their companions were either not present or prevented from being present (Chadwick, Cooper & Harries, 2014). Alongside my own research, Jessica Rucell’s (2017) doctoral thesis (mentioned earlier in this chapter) entitled, *Obstetrics violence and colonial conditioning in South Africa’s reproductive health system* (University of Leeds) researched disrespect in seven local birthing facilities in the Western Cape, from a policy and sociological perspective. She coined the term “structural obstetric violence” to denote the wide impact of systemic influences that exacerbate poor birthing practices.

In South Africa, the exact prevalence of maternal disrespect is not measured or measurable. Poor practices continue despite the country’s progressive constitution and numerous policies related to quality of care (Abrahams, Jewkes & Mvo, 2001; Rucell, 2017). Disrespect appears to be normalised thereby contributing to an apparent culture of legitimisation within the health system and beyond (Abrahams, Jewkes & Mvo, 2001). In 2011 Human Rights Watch published their report on research in the Eastern Cape between August 2010 and April 2011, which revealed shocking practices and related distressing personal narratives of abuse and neglect in an inaccessible health system. How well obstetrics services are performing is usually indicated by ratios of maternal mortality and live births. For instance, South Africa’s high rates of maternal mortality are noted as “unacceptable” by Amnesty International (n.d.). Moreover, these statistics indicate limited success with reaching the Millennium Development Goal (MDG) no 5¹⁴. An improvement in health worker training is noted as one of the five specific recommendations to achieve improved outcomes, as well as health system strengthening (Statistics South Africa, 2015). While there has been a significant reduction in maternal deaths (South African Department of Health, 2018) the seventh report on confidential enquiries into maternal deaths in South Africa notes that 61% of maternal deaths were “potentially preventable indicating mostly poor quality of care

¹⁴ MDG 5 aimed to reduce the maternal mortality ratio by three-quarters between 1990 and 2015.

during the antenatal, intrapartum and postnatal periods” (p. 74). The report findings noted “the lack of professionalism shown by healthcare professionals” making the point that “This problem is often under-reported” (p. 10). The report foregrounds care with a commitment to quality as one of the five implementation strategies to save mothers.

In terms of obstetrics, poor practices are acknowledged through several publications (Farrell & Pattinson, 2004; Honikman, Fawcus & Meintjies, 2015; Jewkes, Abrahams & Mvo, 1998; Kruger & Schoombie, 2010; Rucell, 2017; Vivian et al. 2007). A number of projects are developing to improve current practices and to establish respectful maternity care (RMC), a goal for both the global community and South Africa. One of the limitations that I will expand on is that the “RMC approach is centered on the individual and based on principles of ethics and respect for human rights” (Reis, Deller, Carr & Smith, 2012, p. v). Recent publications include a comprehensive Toolkit for Respectful Maternity Care published online by the USAID) and the Maternal and Child Health Integrated Programme (MCHIP), the World Health Organisation’s *Guidelines for the Prevention and Elimination of Disrespect and Abuse during Childbirth* (2014) offer important information, as well as the *12 Steps to Safe and Respectful MotherBaby-Family Maternity Care* by the International Childbirth Initiative (2018). Nationally in South Africa, the *C²AIR² programme* aims to improve Caring, Competence, Accountability, Responsiveness and Respect. In the Cape Metro area of the Western Cape (where UCT students learn) the *Patient-Centred Maternity Care Code* (PCMC) has recently been implemented. According to Honikman, Fawcus and Meintjies (2015) these new policies and programmes have not yet shown their impact in transformed practices nor been as effective as has been hoped. Rucell (2017) refers to the “bad apples” in the system, and notes that the adoption of new policies demonstrates the Department of Health’s commitment to raise awareness about obstetrics violence, but that “they did not consider, nor develop understanding about the causes of this problem” therefore they appear to have missed key aspects (p. 230).

Honikman, Fawcus and Meintjies (2015) point to the need for midwives themselves to be supported in order for them to offer compassionate care. A local non-governmental organisation, the Perinatal Mental Health Project (PMHP), has recently developed training programmes to support midwives¹⁵. Brodie (2013) suggests that support to midwives is needed in four areas namely, in practical ways such as sufficient supply of

¹⁵ These programmes include YouTube videos and other resources (<http://pmhp.za.org/>).

necessary equipment, in organisational support to improve the present working conditions, in professional support such as preventing burnout and isolation, and peer support to strengthen their capacity to help reduce the attrition of midwives.

Apart from revised policies, other institutional responses to obstetric violence have included disciplinary procedures as well as new training opportunities such as the Secret History programme for midwives which is reaching out to both local and international audiences through their YouTube video series (2017). The Perinatal Mental Health Project (PMHP) who initiated these training modules for/with midwives recognised the beneficial impact of working with and through troubled knowledges and practice difficulties as midwives are confronting difficulties in their personal and professional experiences. This PMHP initiative is now used with students at UCT in conjunction with their compassion tutorials that are connected to my teaching and research activities. Students are facilitated in small groups to debrief and to talk about their obstetrics encounters in order to engage with any difficulties they may have experienced.

Several other initiatives are taking place to seek solutions that can address the abuse of women in labour, such as “evidence-based effective care to reduce adverse maternal and perinatal outcomes” and “patient-centred care in which women are treated with respect and dignity” (Honikman, Fawcus & Meintjies, 2015, p. 284). Other global initiatives include the *Humanising Childbirth Movement*, that began in Brazil in 1975 (Reis, 2013) the *Respectful Maternity Care Movement* in Mozambique and Ethiopia, as well as the South African *Better Births Initiative* that began in 1999 (Goer, 2004). However, poor practices continue with a sense of limited progress towards quality of care for labouring mothers. Goer (2004) admits “It is disheartening that so many have worked so hard for so long in so many places to so little effect for what should be a non controversial issue: maternal-child health” (p. 314). Beck (2004) sums up the situation below

Women who perceived that they had experienced traumatic births viewed the site of their labour and delivery as a battlefield. While engaged in battle, their protective layers were stripped away, leaving them exposed to the onslaught of birth trauma. Stripped from these women were their individuality, dignity, control, communication, caring, trust, and support and reassurance (p. 34).

When women are in labour they endure multiple forces from within. These destabilising biological forces during the bearing down process can leave some women feeling out-of-

control contributing to their intense sense of vulnerability and powerlessness. Labouring women seeking the healthcare services in the public teaching facilities in South Africa, who are generally from the poorer section of the population, are faced with few choices thus tend to endure the conditions in which they are placed. The multiple forms of disrespect received by these women, seem to devalue them, their bodies as well as their babies.

2.5 Impact on medical students' training

Alongside reports of harmful obstetrics practices is the raw reality of inequality of health services alongside the disempowerment of mostly poor women at their most vulnerable stage. Yet, disrespectful behaviours continue and in many respects have become normalised. As medical students are learning in and through these behaviours, questions about responsibility are raised. In terms of institutional responsibility, Gan and Snell (2014) note that:

medical schools should ... undertake interventions that alter perceived power dynamics, improve how medical students cope with the training experience, and focus on communication skills as supplemental strategies to improving the perception of the learning environment (p. 614).

The power to act in response to apparent wrongdoing is frequently obstructed by political, cultural, social and emotional barriers. Students in their fourth year of study at UCT are at the junior level in the medical hierarchy, a vulnerable group themselves, relying on others to introduce them to their new practical skills. In many cultures such as the Xhosa tradition, young people are taught not to question or challenge their elders or persons in authoritative positions. Silent respectfulness is a cultural and political tool to avoid trouble. Compliance with institutional structures and taking the role of a silent bystander is also a legacy from past injustices like discrimination in the apartheid era. Speaking out frequently led to, and continues to possibly lead to harmful consequences, as demonstrated in whistleblowing narratives (ODAC, 2015). Although present students can now draw on the policies and mechanisms that offer them support and explain the process to be followed for a report or complaint, very few students actually choose to react and respond to disrespectful behaviours that they observe.

As noted in the systematic review by Sando et al. (2017) disrespect and abuse is difficult to quantify. For students, the seriousness of an action or inaction is difficult to assess.

Proof of wrongdoing is often limited to anecdotal evidence which is fluid and uncertain (Freedman et al., 2014).

“It is not enough to observe situations now and to vow to act if similar situations arise after full professional status has been attained” (Dwyer, 1994, p. 15-16).

What is significant for student learning is that habits developed in medical school ought to promote ethical caring later. These habits of ethical responsiveness need to be developed and exercised during medical training (Dwyer, 1994). There is a strong need to address the prominence of silence that prevails as an ethical response to encounters of disrespect faced by students. According to Dwyer (1994) “a failure to speak up in certain situations is a failure of learning *and* caring” because students “need to act in those situations so that they will not learn to be uncaring physician” (p.16, italics in original).

The disrespect in obstetrics and the influence on students’ becoming is a deep concern for our future doctors and the practice as a whole. An “ethos of care” is needed in which “matters of care” take up a central concern (Puig de la Bellacasa, 2011). Resonating with this concept is Tronto’s (1993) “ethics of care” which appears to be backgrounded. It includes being alert to the reciprocal relationships of responsibility and responses, defined as:

a species activity that includes everything that we do to maintain, continue and repair our world so that we can live in it as well as possible. This world includes our bodies, ourselves and our environment, all of which we seek to interweave in a complex, life-sustaining web’ (Fisher & Tronto, 1990, in Tronto, 1993, p.103).

Care is more than an individual need. Already in 1960, Isabel Menzies¹⁶ identified how organisational structures in British hospitals were not caring adequately for their nurses. Menzies seminal work highlighted issues of detachment, silencing and other institutional and cultural practices that avoided addressing the widespread anxiety and fear prevailing among the nurses in healthcare settings. These psychodynamic forces severely affected nurses thereby impacting on their work. Menzies’ case study stressed the necessity of more structures to support the care-givers particularly modes of containment. David Lawlor’s (2009) response 50 years later, also working from the Tavistock Institute of Human Relations suggests that Menzies’ work did not go far

¹⁶ Thanks to Gabrielle Ivinson who referred me to the work of Isabel Menzies.

enough. Lawlor asserts that the problem of dealing with nurses' anxieties involves "more complex interactive webs of relationship", referring to related environmental forces that undermine staff morale and quality care such as the current emphasis on goal-setting tasks (p. 582).

2.6 Conclusion

In this chapter I have described how the ideals of healthcare and medical training are obstructed by the reality of practice in obstetrics. I have put forward how laws, policies and multiple mechanisms are in place to regulate health provision, to ensure quality of care for all, however the implementation of these governance mechanisms was, and continues to be problematic leading to questions arising in terms of institutional and students' responsibilities. The prevalence of disrespect and abuse in the South African health system and internationally has only recently become an urgent imperative for change. Despite publications opening up the inhumaneness of disrespectful maternity care from the mid-20th Century, there has been a tendency to keep it invisible.

The silencing of these practices has also been evident in medical undergraduate curricula driven by learning outcomes based on knowledge and skills. I have described a hidden reality of the context in which students learn together and apart. In the next chapter I suggest that other disciplines such as philosophy, feminism and childhood studies may offer an alternative pathway for engaging with these troubling matters. These transdisciplinary insights provide a radical and alternative stance that shifts beyond a human-centred, binary, critical perspective, a deviation from conventional pathways that seek blame and guilt. I engage with issues of responsiveness, responsibility and the ability to respond in order to seek out untapped potentials that can affirmatively contribute to transformative practices where students can be rendered capable to respond to practices of injustice in obstetrics.

CHAPTER 3 - THEORETICAL INSIGHTS THROUGH A MORE-THAN-HUMAN LENS

3.1 Introduction

This theoretical chapter begins with a concern about curriculum matters related to the landscape in which undergraduate medical students learn obstetrics, as outlined in the previous chapter. I refer to my research questions to frame the sections that follow, expanding on the theoretical concepts of a relational ontology to inform the reader about my thinking and doing. Firstly, I explain the theoretical underpinnings of my central research question that asks what renders students in/capable in their responses to injustices they may witness in obstetrics? I draw on feminist new materialism (FNM) to investigate how a rethinking of curricular matters might offer an alternative perspective for medical education that may be useful. This process takes a move away from a focus on individual student's engagement. It expands to consider collective arrangements known as assemblages, that include the emerging relationships between students, midwives/doctors, women in labour and other bodies that are more-than-human. I explore what matters in the curriculum, particularly in clinical rotations such as obstetrics, and how what matters might affect students' experiences and responsibilities. As students are immersed and engaged in their curricular tasks, I investigate the different forces that render them in/capable¹⁷ to varying degrees. I explore these relationships in terms of the injustices that students may witness in their learning encounters where abuse and disrespect is so abundant, a reality in South Africa and globally, as discussed in Chapter Two. The study also investigates how students' curricular activities might have an influence on their responsibilities and their ability to respond, referred to as their response-ability. The learning activities are discursive as well as material. I follow with a discussion about the material-discursive practices in which students are entangled (Barad, 2007), which leads into the third section where I explore how affect emerges in/through relationships, including the circulation of affective forces. I investigate how an attunement to affect might render students in/capable in their ability to respond to unjust practices in obstetrics. Thinking about, and with attunement to others, can open up a different and enlarged way of thinking (Haraway, 2015, referring to Despret's work).

¹⁷ Barad's (2007) use of a forward slash in much of her writing (that I take up in this text) indicates how she places two words in one to avoid traditional separations and to explain a continuity of becoming rather than a binary of one state of being versus another.

In what follows I expand on these notions and their significance for curricular design and teaching. By taking curricular matters beyond human dominance and exceptionalism, the theoretical underpinning of a relational ontology is put to work to investigate whether it can bring a helpful perspective to student learning, using obstetrics as a point of entry (Braidotti, 2013a; Lather, 2016). My point of departure for this thesis is to ask in what way FNM and posthumanism may offer different ways of thinking about medical education and training.

3.2 The curriculum

The curriculum is defined by Thomas and Kern (2016) as “a planned educational experience” (p. 1). The planning produces various disciplinary curricula for medical training that are structured and regulated according to the principles of outcomes-based education (Harden, 2015). Each structure is engineered to equip students with the relevant knowledge and skills to be competent, safe and responsible doctors who practice according to ethical principles.

Current curricular design is premised largely on the instrumentalist view of education, a hegemonic humanist discourse that works towards individual competence. The focus is on the atomic, independent individual as autonomous, rational and self-determining. Included in this conventional perspective is the centrality of the Eurocentric man as white, middle-class and resilient (Braidotti, 2013b), symbolised by Leonardo da Vinci's Vitruvian Man. Humanism has focused on the European hegemonic model of human perfection with a hierarchy of worth symbolised through whiteness, masculinity and youth. Such subjectivity is equated with “consciousness, universal rationality, and self-regulating ethical behaviour”, promoting binary conceptions of otherness where difference is reductive and inferior (Braidotti 2013a, p.15). This humanistic individualism that separates groups of people is highly problematic, compounded with dualistic thinking that denotes higher value to some groups and others lower status, through binaries such as us/them, right/wrong, innocent/guilty, etc. The legacy that such Western Civilisation models of humanism have set up, now needs shifting to promote “more ethical accountability” (Braidotti, 2013a, p. 15). Included in this shift is the posthumanist concern that the arrogance of Western Eurocentric norms has given limited or no respect for the agency of matter, or for a relational view of the world (Braidotti, 2013a).

The term *curriculum* is derived from the Latin word “*currere*” that in the active form means to run, which Wallin (2010) points out is indicative of “an active conceptual force”

(p. 2). It has power in itself as well as the power to generate new flows and offshoots through multiple movements. For instance, assessment drives learning, and this force has implications (Cilliers, Schuwirth & van der Vleuten, 2012). Power is inherent in all educational practices, including in medical education. Yet there is scarcely mention of issues around power, especially related to professional practice (Gabel, 2012; Donetto, 2012). The reactive meaning of curriculum, "*cursus*" refers to a "*chariot track*" or "*course to be run*", described as a "calcified, representational structure" by Wallin (2010, p. 3), highlighting the stasis in curricula. Furthermore, curricula themselves are deeply implicated in political and ethical connections that relate to students' becoming. These relationships tend to remain hidden.

The curriculum in medical education is designed for students to acquire relevant knowledge for their future practice in a progressive manner through what is termed a spiral curriculum. It enables certain facts to be introduced in a simplified way, and then for the topics to be revisited later for deeper engagement and a more complex level of understanding (Gibbs, Brigden & Hellenberg, 2005; Masters & Gibbs, 2007). Kern's (2016) six step framework has provided a guiding structure for medical curricular development over the past 20 years. It includes problem identification, needs assessment, goals and objectives, educational strategies, implementation, and the measuring of outcomes. Recent adaptations to this widely used framework include a renewed emphasis on competency-based training with milestones related to "entrustable professional activities" (Thomas & Kern, 2016). Graduate attributes are the overarching goals achieved through learning outcomes, which in effect, act as hoops for students to jump through in order to progress through their undergraduate curriculum (McCrea & Murdoch-Eaton, 2014). However, there is growing recognition that much learning in a clinical context such as in obstetrics, arises from the "unanticipated experiences with individual patients. In many situations, the most useful learning derives from learning needs identified and pursued by individual learners and their mentors" (Thomas, 2016, p. 60).

In this study I question established humanist understandings that assume that individuals are independent, intentional and bounded entities. In exploring the student-curriculum relationships, I seek to understand how FNM might provide an alternative lens for looking into curricular matters. In the process I wish to find out how theory might open up new possibilities that may interrupt traditional thinking and acting in obstetrics, and more broadly in medical education (MacLure, 2010; Krejsler, 2016). This study

attempts to find out how thinking about curricula might be shifted by considering how materiality in terms of a relational perspective speaks to curricular matters in medical education. Snaza, Sonu, Truman and Zaliwska, (2016) assert that ethical and political considerations of curricula need to expand to attribute agency to “*all matter*” because humans are actually “an *effect* of a broader, largely disavowed, play of nonhuman agencies, and these other agencies must be thought of as political” (p. xviii, italics in original). In other words, bringing materiality into educational research is a political matter that goes beyond considering humans as independent entities, to include materialising forces that have the potential to possibly alter conventional power dynamics that affect students’ learning. In terms of responsibility, Higgins and Tolbert (2018) illustrate how the curriculum in science education can be re/examined by recognising that responsibility is more about being able to respond rather than being or not being responsible. Although their work responds to science syllabi that produce ways of othering indigenous knowledges and ways-of-being, it has relevance here as it takes note of the material-discursive relationships that emerge in intra-actions, suggesting that “the homework of response-ability must not strictly be a knowledge project, but rather an ethical-knowing-in-doing” (Higgins & Tolbert, 2018, p. 288). Accountability needs to extend to and through different paradigms to explore the relationships that matter, as well as those that are left out (Barad, 2007).

3.3 Intra-acting relationships

The human, as a biological, multi-functioning, independent body is the central focus in medicine, hence falling under the umbrella term of a “human profession” (Toll, 2012, p. 2498). The human story is core and is foregrounded in the related field of medical humanities which brings interdisciplinary scholarship and inquiry into historical and cultural influences on medical practices (Schillace, 2017). However, arising even within the medical humanities, are moves to go further into the “critical medical humanities” to explore “how health, illness and treatment are constituted in and through tangled webs of human and non-human biosocial organisms, political-economic formations, discourses and affects” (Viney, Callard & Woods, 2015, p. 2). Such recommended shifts illustrate an acknowledgement of the complex entangled relationships threading through medical practice, whether from the point of view of autonomous individuals or collectives.

The integration of the medical humanities into curricula continues to centralise the rational human with binary conceptions such as subjects and objects. In this study I

explore further shifts that move curricula beyond centerings human exceptionalism. Current examples of such movements can be found in disability studies (Goodley, Lawthom & Runswick, 2014) and in practices associated with technology where infinite innovative possibilities are informing new ways of thinking and doing clinical medicine, including incorporating artificial intelligence into professional practices (Beam & Kohane, 2016).

Relationships are a core theme threaded through this research project and central to FNM “where things and matter, usually perceived as passive and immutable, are instead granted agency” (Hultman & Lenz Taguchi, 2010, p. 539). A Baradian (2007) relational ontology moves away from thinking about individuals and their choices, a position described as “the individualised subject-of-will” (Davies, 2010). The philosophical understanding is that all entities, whether human or more-than-human, do not pre-exist any relationship, nor are they bounded as separate entities. Rather, they come into being in and moving through relationships, which are dynamic processes of becoming, in each moment of an encounter (Despret, 2015). These relationships are not static or determinate but fluid, contesting the assumption of pre-existing independent entities or agents that have fixed identities and structures. A relational ontology asserts that individual actions are formed in relationships that become part of larger relations, a process of becoming-with the other (Haraway, 2016). It is predicated on the belief that we come into being through relationships.

Current curricula in medical training tend to assume students as independent and individualised with a need for self-determination that can be fostered with learning strategies to enhance their self-regulation in order to build their competence (Butler & Brydges, 2013). Although training takes cognisance of environmental factors to support student learning, agency is limited to human interactions which are located inside individuals. A relational ontology differs in that it assumes that agency occurs in enactments or events. Agency is distributed, emerging through the interference of forces where entities, including humans as well as matter, come into being through the multidirectional relationships affecting them (Bozalek & Zembylas, 2017). Such a posthumanist perspective offers opportunities to extend our thinking to look beyond humanist interactions and responses. It enables a reconsideration about what matters, how matter matters, what are the concerning matters and how they relate to each other, and how this matters for matters of care, by taking up “a conviction that matter matters” (Bozalek, 2018, p. 398).

A key point that will be expanded on in this study is the notion of intra-action, a foundational principle in the Baradian relational ontology in that it shifts or “queers” our thinking; it “unsettles the metaphysics of individualism (the belief that there are individually constituted agents or entities, as well as times and places)” (Barad, interview with Kleinman, 2012a, p. 7). Barad (2007) points out that “[s]ubjectivity is not a matter of individuality but a relation of responsibility to the other” (p. 391). Relationships are enacted, not only through human-to-human interactions but through on-going forces of materialisation on and with human bodies, that generate phenomena. Thinking through such expanded relational processes of becoming-with others has important implications for issues of “causality, agency, space, time, matter, meaning, knowing, being, responsibility, accountability, and justice” (Barad, interview with Kleinman, 2012a, p. 7). For the medical curriculum this means that teaching concepts around individual’s self-regulation, rule-bound ethics and binaries (such as cause/effect) can be expanded into the recognition of multiple relations and agential forces that impact on students’ knowing/acting/being/becoming during their curricula encounters, thereby bringing an alternative perspective to issues of responsibility, response-ability and accountability in an environment that bleeds injustice. FNM questions whether ethical responsibilities can be taught and shaped by defined knowledge-making practices governed and regulated by fixed programmes, policies and legal structures.

A growing body of work is emerging that illuminates the intersections of human and animal relationships, (Despret, 2004, 2008, 2010, 2013, 2015; Haraway, 2008, 2016; Pedersen, 2013; Pedersen & Pini, 2017) with other forces, that include the materiality of matter (Bolt, 2010) referred to as “thing power” by Jane Bennett (2010). The authors above, plus others both internationally (Lenz Taguchi, 2010, 2012; MacLure, 2010, 2013a, 2013b, 2013c; Tsing, 2015) and locally (Newfield & Bozalek, 2018; Motala, 2018; Murriss, 2016) have pointed to the expanded gaze and potential materialising from theoretical explorations that go beyond human-to-human interactions to the more-than-human relationships inherent in all encounters. New possibilities are opened up, fostering transformative potentials. Taking such an alternative perspective is new to medical education, particularly to exploring curricular matters. This study considers how matter matters in terms of students’ responses to unjust practices, emerging in the in-between learning spaces “where a body or an idea encounters another body or idea” (Hultman & Lenz Taguchi, 2010, p. 438). My innovative, experimental approach based on a relational ontology opposes the reductiveness of determinacy and human-centredness in current conceptions of the medical curriculum. I move through a “a

contested space of mutations” that Braidotti (2006) refers to as nomadic subjectivity (p. 4). In essence, nomadic thinking is a way of picking up the tensions that are not easily evident, often hidden in the cracks or ruptures of flows from habitual thinking (Deleuze & Guattari, 1987). These tensions emerge as forces in events or encounters, breaking through into new spaces, in the middle/in-between spaces causing a disruption to established boundaries such as binary oppositions like subject/object and body/mind. In explaining the Deleuzian nomad metaphor, Semetsky (2008) points out that it is “a dynamic and evolving character of philosophical concepts versus their having forever-fixed and eternal meanings independent of context, time, place, subject, or culture” (p. vii). What is relevant for this study are the movements and flows as opposed to static, fixed entities based on individualism and separations. In this study I take up assemblage theory, moving away from examining separate entities as it presents and contributes a relational and functional perspective.

3.3.1 Thinking with and through assemblages

An assemblage is a collective formed by different components. A clear description is elusive as it is a continually shifting enactment with iterative reworkings on it and through it. Even the translation ‘assemblage’ from the original French term put forward by Deleuze and Guattari ‘*agencement*’ appears to distort possible meanings and interpretations (Despret, 2013; Phillips, 2006; Nail, 2017). *Agencement* places emphasis on the arrangement of processes of becoming through the construction of multiple agencies that produce connections. This process of construction of different elements differs from the English word *assemblage* drawn from the French word, “*assemblage*” which refers to joining or bringing together towards a unity. Massumi’s translation of *agencement* to meaning *assemblage* in the introduction to *A Thousand Plateaus* by Deleuze and Guattari (1987) seems to undermine the force and agency of the multiple heterogenous components that are represented in the original term. The term *assemblage* denotes a fixed structure rather than one that is always emerging and dynamic. Manning (interview with Massumi & Brunner, Massumi, 2015) admits that *agencement* is “impossible to translate” as it is about an event “agency-ing” itself or understood as “a doing doing itself” (p. 157). *Assemblage* as such, appears to not adequately reflect the flexibility and the movement or nature of flux in the entanglement of the different bodies including the more-than-human, nor the active agency of each component. There are forces at play in the in-between spaces, that at each moment contribute to our sensual experiences. According to Despret (2013) we need to be attuned to the forces as they “enact and articulate agency” (p. 38).

Livesey (2010) claims that assemblages, as conceived of by Deleuze and Guattari (1987) “are complex constellations of objects, bodies, expressions, qualities, and territories that come together for varying periods of time to ideally create new ways of functioning” (p. 18). Dixon-Roman (2017), also referring to Deleuze and Guattari, further explains an assemblage as “a system of organisation, arrangement, relations, and connections of objects, actualities, or organisms that seemingly appear as a functioning whole.” (p. 41). An assemblage is made up from differing elements that work together through their relationships. There is a coming together of forces that coalesce. These are changing processes generated in individuals’ behaviour patterns, in institutional organisations, in spatial arrangements and other places and spaces where bodies meet (Livesey, 2010). Nail (2017) notes that “an arrangement or layout is not the same as a joined or unified gathering” (p. 22). He refers to Deleuze and Guattari’s analogy of concepts coming together like a dry-stone wall where the pieces are held together “only along diverging lines” (citing Deleuze & Guattari, 1994, p. 23). These in-between relations are what is important and different from multiple elements fitting together into a unified entity like in a jigsaw puzzle (Nail, 2017). All assemblages are political, according to Nail (2017) as power diffuses through all connections in our daily activities and particularly in educational environments.

Assemblage theory presents a relational and functional perspective which is different to an examination of separate entities. It appears to be a relatively untrodden path with few publications¹⁸ available on assemblage thinking in educational practices (de Freitas, 2012; Olsson, 2009), however it is being increasingly valued in educational inquiry and forms an integral component in my study. Assemblages can generate “a new means of expression, a new territorial/spatial organisation, a new institution, a new behaviour, or a new realisation”, according to Livesey (2010, p. 19). There are multiple components (human and more-than-human) all influencing each other in the relationships of the constituent parts and in their intersections with other bodies/matter (Deleuze & Guattari, 1987).

In this research, thinking with and through assemblages offers a novel and productive approach towards a possible new reality for a long-standing problem in medical education. It provides an alternative pathway for thinking about problems by working

¹⁸ In the special issue on assemblages in Project MUSE in 2017, Nail (2017) claims that his paper is “the first full-length journal article to focus exclusively on Deleuze and Guattari’s formal theory of assemblages” (p. 21).

through collective agencies and relationships which differs from the usual thinking about independent individuals with rational choices and intentions. An assemblage “allows us to think outside of dualistic modes of perception to focus on the present as emergent” (Kennedy, Zapasnik, McCann & Bruce, 2013, p. 46). This process of becoming “includes the material flows and *doing* of matter” and is taken further in the next section on relational ontology (Dixon-Roman, 2017, p. 48, italics in original).

I propose that assemblage thinking through relational ethics might provide a productive and affirmative perspective for medical training. It includes matter as an agential component of all encounters and is an integral element of a relational ontology. Braidotti (2013a) urges us to be “acknowledging the ties that bind us to the multiple ‘others’ in a vital web of complex interrelations” (p. 100). Rather than examining, unpacking and evaluating socially unjust practices in terms of ethical issues of moral judgement and conduct in the obstetrics curriculum, below I explore relationality in terms of agential forces with the intention to broaden notions of learning and response-ability for ethics in practice.

3.4 Entangled relations

In this section I acknowledge that a relational ontology can disrupt the established humanist knowledge practices and traditional meaning-making processes. I explore how a relational point of view in FNM may provide “a new rhythm, a way of putting ideas in conversation with theories” that decentres the human, the hierarchy of knowledge production and the dominance of epistemological concern (Kuby, Spector & Thiel, 2018, p. 8). I draw on critical posthumanism/FNM as an alternative thinking and navigational tool (Braidotti 2013a, 2018) for re-thinking curricular matters of responsibility in medical training. This study is situated at the intersection of research, practice and ethics.

Braidotti (2013a) claims that there is an ethical imperative to consider our interdependence with multiple other bodies.

A relational ontology is increasingly viewed as an ethical imperative (Barad, 2007; Kuby, 2017; Lenz Taguchi, 2010) as it moves beyond conventional human-centred thinking based on the centrality of a rational, reasoning independent individual. Terms such as “*humanism’s enclosure*” (St. Pierre, 2013a) and “*the cul-de-sac of humanism*” (Taylor, 2018) denote how such human exceptionalism is considered reductive and biased by offering only a partial perspective. A relational perspective goes further providing an

enlarged and inclusive perspective that respects all bodies, both human and the more-than-human.

In FNM (as in posthumanism), matter is ascribed agency, with force and vitality. There is no longer a disregard for matter or sidelining it as inert and passive, with binary assumptions such as subjects and objects as occurs in traditional human-centred approaches associated with taken-for-granted pedagogical practices (Lenz Taguchi, 2010). FNM brings a theoretical understanding that students are becoming-with others (both human and more-than-human) in on-going and multiple relationships influenced by different flows and forces (Barad, 2007). These movements and flows provide a productive way for reconceptualising and rethinking curricular matters by seeking out innovative possibilities that may enable transformative potentials. In obstetrics, and medical education more generally, a relational ontology may offer an alternative way of thinking about current practices, especially those that are problematic.

Medicine is about the human body, and obstetrics about a basic function of a woman's body to reproduce. So, why do I escalate the importance of matter and develop a deep concern for it in this study?¹⁹ There appears to be a contradiction. In terms of FNM and posthumanism, the human is not a bounded entity distanced from matter but a porous organism becoming-with other bodies and amidst a network of entangled forces. Different becomings are enacted between these multiple bodies, both human and more-than-human (Barad, 2007).

Current curricular structures represent the boundaries of positivist and hegemonic practices. Curricula are designed by task teams to be aligned to accreditation requirements for each field of study, with clearly defined and fixed pathways through which students progress and which are intended to control teaching and learning. Thinking with FNM ruptures established human boundary thinking and separateness. It opens up a porosity that allows us to think through boundaries at the intersections of relationships, in these in-between spaces. Braidotti (2018) refers to a process of mutation, an explanation of the continuums in relationships bringing a more expansive perspective than contained, fixed enclosures with boundaries and associated binaries. The term "viscous porosity", coined by Nancy Tuana (2008) is useful as it portrays the dynamic, fluidity of possible relations. Tuana described the entangled forces and

¹⁹ Stephanie Springgay raised this point during our discussion at the American Educational Research Association meeting in San Antonio, 2017.

a/effects of Hurricane Katrina that hit New Orleans in the United States in 2005. In terms of epistemic responsibility, Tuana (2008) suggests

If we are to fully understand the complex practices of knowledge production and the variety of factors that account for why something is known, we must also understand the practices that account for not knowing, that is, for our lack of knowledge about a phenomenon (p. 204).

I propose that the disrespect in obstetrics can be compared to the unexpected force of a hurricane resulting in the emergence of different powerful and unwelcome phenomena, that previously were excluded from knowledge-making practices in obstetrics. Moving from thinking about boundaries and individuals as bounded entities to issues of porosity and emergence in FNM, brings an alternative ethical stance away from self-centred individualism. self-centred obligations and responsibilities that are actually pitting 'self-versus-other'. Braidotti (2017) asserts that we need a collaborative understanding that "we-are-in-*this-together*" providing a posthumanist theoretical stance to "better understanding of the mutation we are undergoing, in all its complex and confrontational aspects" (p. 25, italics in original). This way of thinking can lead to a new kind of ethics, and consequently a different thinking about responsibility. The human ought not to be considered as a unitary, separate bounded entity but "is a relational entity that becomes in and with the world" (Braidotti, 2017, p. 28). Separations invoke opposing dualisms such as right/wrong, innocence/guilt, and benefit/harm. There is a sense of othering through the assumption of self-regulating ethical behaviours which represents a negative undermining response. In obstetrics, thinking with and through separateness may be exacerbating disrespect. The safe delivery of a neonate ought not to exclude other relationships. For instance, several studies indicate how open curtains contribute to undignified care with a lack of privacy and respect (Bohren et al., 2015; Sando et al., 2016;

Universal humanism imposes constraints that set apart the self and Others²⁰ (Braidotti 2013). In terms of student learning, their individual development of competence directed by curricular imperatives becomes the central concern, often at the expense of respect and regard for others. Below I explain the multiple relational and multidirectional forces and flows that are being and becoming enacted in student learning yet tend to remain unrevealed or ignored through such individualist, humanist conceptions of curricula.

²⁰ The capital "O" in Others places an emphasis on the other rather than a diminished regard for anything other than the human, considered as the abject other by Braidotti (2013).

3.4.1 Forces and encounters

In clinical medicine there are encounters that act as events in students' learning experiences. Each event is more than a person-to-person happening that can be described as a human-centred narrative. It is an intersection of becomings that involves the flows and interferences of forces, that Despret (with reference to Deleuze, 2013, p. 37) refers to as a "rapport of force". For student learning this is pertinent, as students are not acting alone with their patients but with multiple other bodies, both human and more-than-human.

It is helpful to understand that force does not relate to pressure or power. St. Pierre (2018) ascribes this notion of force to Deleuze's Nietzschean understanding of it as the "intuited, sensed force of the preconceptual becoming" (p.6). What is important is the relationship of forces. In the Deleuze Dictionary, Stagoll (2010) describes force as "*any capacity to produce a change or 'becoming', whether this capacity and its products are physical, psychological, mystical, artistic, philosophical, conceptual, social, economic, legal or whatever*" (p. 111, italics in original). Stagoll (2010) further notes:

All of reality is an expression and consequence of interactions between forces, with each interaction revealed as an 'event' (in Deleuze's specific sense of the term). Every event, body or other phenomenon is, then, the net result of a hierarchical pattern of interactions between forces, colliding in some particular and unpredictable way (p. 111).

These colliding forces surface in different ways and can be opened up to explore new possibilities and responses. In this study I use the theoretical philosophy of FNM to explore how a different narrative to the same encounter can provide a version that is interesting and "*one that adds to the world, opens more deliberations, and makes us think and imagine*" (Despret, 2015, p. 153, italics in original).

In moving away from conceptions of individual agency and intentional purpose, the process of becoming-with others is termed a witness by Manning (2009), who also presents a "thisness" which is described as a "quality of experience that folds the many in the one, an interfusing of agency" (Manning & Massumi, 2014, p. 29). As explained earlier, individuals come into being and doing through relationships that emerge in working and thinking together with others, other humans and other matter that matters

rather than as isolated entities. This study conceives individual students as constantly moving in and through relational processes in which each is not determinate or a determining entity. These in/determinate processes of becoming-with others encompass ongoing movements and relationships with important implications for students' curricular engagement, and more generally for their being and becoming in medicine. The self is itself a multiplicity, a superposition of beings, becomings, here and there's, now and then's" (Barad, 2014, p. 176).

3.4.2 Relational ethics

In terms of ethical concerns of responsibility, I turn to relational ethics, also called posthuman/new materialist ethics by Carol Taylor (2018). Relational ethics provides an inclusive and productive yet disruptive approach to contentious ethical pedagogical matters, acting at the interconnections between multiple bodies that are both human and more-than-human (Braidotti 2013). Taylor's (2018) five orientations of a posthumanist/new materialist ethics provide a succinct description and framework to engage with student learning in obstetrics

1. *Posthuman/new materialist ethics are affirmative in respecting and valuing all bodies* (Taylor 2018, p. 86). There is no supremacy of the human or othering through difference. This affirmative stance may facilitate a different way of engaging with the dilemmas of practice faced by students in their obstetrics learning.
2. *Posthuman/new materialist ethics propose a logic of entanglement* (Taylor 2018, p. 87). FNM recognises how students (as well as educators and women in labour) are not fixed, independent, bounded entities but rather come into being through their becoming-with multiple others. There is a power dynamic generated through the interconnecting dynamic forces that make up the different and differing assemblages. Student learning does not occur in isolated incidents with determinate boundaries but is embedded in their embodied becomings within the unpredictable entanglements of encounters. It is not separated into divisions but entwined in an ethico-onto-epistemology, a Baradian (2007, 2012) term indicating the combination of epistemologies (knowledge-making processes), ontologies (their being and becoming), and ethics. Thinking about learning through these entwining processes can be beneficial to medical education which has become very segmented with separations of disciplines, specific subject teaching and other curricular components like ethics and human rights.

3. *Posthuman/new materialist ethics are powered by an affective politics* (Taylor, 2018, p. 87). The force and vitality of affect refers to a capacity to act and be acted upon (Clough, 2007). The power of affect can provide political potential for acting differently, such as not conforming to the established norms. A concern with current medical training is that it offers limited, if any recognition of affect, consequently tending to encourage students to conform with a degree of docility (Wear, Zarconi, Garden, & Jones, 2012). When ethical dilemmas arise, there is often silence shrouded by fearfulness to respond or take up a responsibility to act (Wear, Zarconi, & Dhillon, 2011).
4. *Posthuman/new materialist ethics activate an ethic of concern* (Taylor, 2018, p. 88). What matters and what comes to matter in ongoing relationships is a central component in FNM. Concerns delve into relationships that are not closed or constrained by only human-to-human interactions but extend more widely beyond human reason and choice. There is a need to shift from matters of fact and logic that assume fixed, determinate and separated entities to matters of concern (Latour, 2004) and to care that acknowledges the interconnections and entwined inter-relationships. Measurements and facts only give a partial indication of reality (Latour, 2004). For instance, in medical faculties the student throughput rates are a measure of the movement and speed of students through the curricula -- an indicator and measure of faculty responsibility in terms of the efficiency and the effectiveness of the institutional training and curricula design. However, how students engage with their curricular activities is less clear. The undergraduate curriculum is not an inert object but has a force and vitality that strongly influences students' becoming.
5. *In posthumanist/new materialist ethics each intra-action matters* (Taylor, 2018, p. 89). As explained earlier in this chapter, intra-actions assume that entities come into being through relationships while interactions relate to entities that pre-exist relationships, acting as separated units (Barad, 2007). Students are immersed in a multitude of *intra-actions*²¹ emanating between humans as well as the more-than-human bodies.

²¹ *Intra-action* is the neologism introduced by Karen Barad (2007), explained earlier in this chapter.

Among the many intra-actions is the notion of responsibility which will be further explained below in terms of relationality.

3.4.3 Responsibility and response-ability

This study seeks to examine the relational entanglements that can and do render students in/capable in their responses to what they observe in birthing facilities. I draw on the theoretical concepts of FNM to reconfigure our thinking into students' responses to curricular matters in terms of their responsibilities and response-ability in curricular encounters. Responsibility tends to be associated with obligations and issues of accountability frequently structured into rules, policies, codes, human rights, and principle ethics. Such practice accountability gets measured in terms of governance, and whether it adheres to the requisite standard setting such as that laid out by professional bodies like the Health Professions Council of South Africa (HPCSA).

From a relational point of view, responsibility refers to the attentiveness in and through relationships that requires a pragmatic shift from a moral language that is about claiming rights and respect to responsible activities. Students immersion in obstetrics become troubling encounters where they face dilemmas in their responses and responsibilities.

Sevenhuijsen (2003) suggests that

moral dilemmas are in many cases not experienced as a collision between different ethical principles, but as conflicts of concrete responsibilities, for example when one feels opposing responsibilities, or when one doesn't have the resources to do what should be done according to one's responsibility (Sevenhuijsen, 2003, p. 393).

The challenges associated with conflicting responsibilities are limited by individualistic viewpoints, therefore the notion of collective inter-dependencies in assemblage thinking is useful (Sevenhuijsen 2003). Responsibility is one of the five essential elements²² of a political ethics of care (Tronto, 1998; 2001; 2013) also known as a relational ethics. Tronto and others (Bozalek, 2013; Sevenhuijsen, 2003) extend their perspective of responsibility beyond individuals towards notions of solidarity, such as the collective African notion of Ubuntu, suggested by Sevenhuijsen (2003). However,

²² Tronto's (2013) elements or phases of care refer to *attentiveness*, *responsibility*, *competence*, *responsiveness* and *trust*.

FNM/posthumanism takes responsibility further beyond accountability, duty-bound actions, and obligations by opening up relationships to include matter.

All relationships matter, therefore there is always an ethical component in each enactment. When ethics is separated from enactments, there is a problem.

Posthumanism considers ethics as an integral component of all events, including care. There are controversial challenges for an ethics curriculum in medical training, which tends to be introduced as a separated bounded field of study, that comprises a relatively small component of the larger medical undergraduate curriculum. Four pillars or principles of biomedical ethics are taught to students to equip them to be and become ethical in their medical practice. Firstly, the principle of autonomy refers to the right for each individual person to make their own choice in terms of medical management. Secondly, beneficence directs medical care in the best interest of the other in mind thus avoiding other vested interests. Thirdly, non-maleficence refers to the overriding principle to do no harm, and fourthly, justice indicates the need for fairness and equality among individuals (Beauchamp & Childress, 2001). These principles guide ethical training with the assumption that students' reasoning through their professional dilemmas can be directed to appropriate ethical choices. Recent efforts to measure the proficiency of these principles demonstrate how the current focus for medical education is to evaluate and measure outcomes (p. 2012). Deliberating about moral dilemmas forms part of the bioethics curriculum in the Health Sciences Faculty at UCT (Benatar & Benatar, 2012). Moreover, moral responsibility in terms of principled ethics is fraught with controversy, for instance De Vries (2017) points to the "maternal-fetal conflict" with invisibility and the multiple levels of disrespect of mothers, claiming that there is "[t]oo much autonomy and not enough respect" (p. 219). Like moral principles, rights-based approaches (despite their legal standing) also rely on idealistic entitlements of individuals and the profession's responsibility to protect, uphold and fulfill basic human rights such as respect for the dignity of all (Zembylas & Bozalek, 2014).

In the South African setting, the ideals raised by our progressive Constitution (that includes reproductive rights) have not been realised. The country continues to exhibit enormous levels of rights violations, particularly related to women's reproductive rights. Cooper et al. (2016) report on the limited progress to advance women's rights after 22 years of democratic rule, noting the "epidemic proportions of sexual violence [that] require redress at a broader societal level" (p. 85).

Lokugamage and Pathberiya (2017) assert that a human rights perspective in childbirth is not enough, recommending that a narrative approach of restorative justice ought to be implemented rather than litigation which can actually exacerbate current circumstances. Although a human rights-based approach has foregrounded “many untapped or repressed areas of rage, anger and conflict within maternity care” a different avenue for addressing these issues is needed to help “break a cycle of animosity, defensive medical practice and post-traumatic stress which litigation can amplify” (Lokugamage & Pathberiya, 2017, conclusion, para 1). These authors suggest that narratives be used towards a process of restorative justice to promote improved relationships that in turn, can strengthen communities (Lokugamage & Pathberiya, 2017). This reparative process takes the issues beyond the individual to acknowledge the institutional, cultural and political responsibilities, moving beyond established boundaries that tend to restrict reparative processes.

3.4.4 Transdisciplinary moves

In order to reconceptualise curricular matters from an alternative point of view through thinking about students’ responses, responsibilities and response-abilities in their troubling encounters in obstetrics, I have moved with and through the porosity of different disciplines in this study by including insights from Physics (Barad), Philosophy (Deleuze, Guattari, Haraway, Barad, Despret), Ethology²³ (Despret), Botany (Haraway), Anthropology (Despret), Sociology (Moore), and Psychology (Despret). These tentacular²⁴ movements have spread out theoretical connections in different directions, integrating these disciplines.

These expansive rhizomatic²⁵ moves go further than the critical/medical humanities. Braidotti (2013b) refers to the “often conflict-ridden relationship between the Humanities and the sciences” proposing that interdisciplinary work facilitates the expression of a vitality with the potential provision for innovation (p. 11). An increasing amount of crossover is happening between the sciences and the visual arts, which I have incorporated into my research process with the inclusion of drawings and images.

²³ Ethology is the science and study of animal behaviour

²⁴ Tentacular is a term used by Haraway (2016) who refers to tentacular thinking that moves away from “bounded individualism” (p. 5). She relates the term to the attachments and detachments of a Californian spider that is both open and knotted.

²⁵ The rhizome is a tuber-like metaphor and a Deleuzian figuration that describes a process not constrained through bureaucracy rather that “acts on desire by external productive outgrowths” (Deleuze & Guattari, 1987, p.14).

Braidotti (2013a) refers to Barbara Stafford, an art historian who works across disciplines with neurosciences, the arts and more recently, affect (described in the next section). On her website, Stafford (2012) notes that such intersections of work provide opportunities to think about educational programmes differently, suggesting that we ask “what does it take to persuade—to move people from one position to another, or to get them to care about an event that never before stirred their interest?” (n.p.).

Despite the lack or limited use of FNM in medical education, it is worth noting that this approach has been put to work and appreciated in other disciplines in higher education including teacher education, as well as in pedagogical practices in schools and pre-schools. Theorists such as Kuby (2017), Hultman and Lenz Taguchi (2010), Murriss (2016), Olsson (2009), Sellers (2010), and Taylor, Blaise and Giugni (2013) have adapted their teaching practices with children to recognise the centrality of the entangled arrangements between humans and other-than-human agents. Many references are made to current childhood studies (Kuby, 2017; Lenz Taguchi, 2012; Murriss, 2016) where curricula are flexible, adaptable and draw on creative ways of being and doing. I suggest that from these examples, we can gain fruitful insights into seeking alternative, responsive ways of students’ becoming that can transform present practices both in medical education and in higher education more generally. Karen Spector (2015) recommends “a pedagogy of relational being” as an ethical engagement for pedagogical encounters to meet halfway, that is, between students and educators (p. 447).

In social services, FNM has been recommended for curricula (and policies) in social work to question present practices that objectify matter, and to provide a vehicle to enhance moral judgements as well as promoting an ethics of care through recognition of the interconnections entailed in assuming caring responsibilities (Bozalek, 2016). There is a notable paucity of FNM and critical posthumanism in the health sciences educational literature, despite the integral importance of ethics and relationship-centred care (Suchman, 2005). David Nicholls (2018) aptly picks up the congruence of movement and materiality for rethinking traditional practices in physiotherapy through new materialism.

In what follows I suggest that in order to promote a response-able pedagogy, educators and students need to be aware of the wider forces impacting on students’ learning moments (Puig de la Bellacasa, 2011) like “thing power” (Bennet, 2010). I consider what matters in the obstetrics curriculum and how these priorities affect undergraduate medical students’ experiences and responsibilities. Different forces play out in the

students' intra-actions. These multiple forces are entangled with student learning and have social and ethico-political implications for concerns around responsibility. According to Barad (2007) we need "to contest and rework what matters and what is excluded from mattering" (p. 178). Embedded in the entangled forces are ethical obligations and responsibilities that emerge from the process rather than being separated concepts that can be considered or avoided.

3.5 What matters in the obstetrics curriculum

The curriculum for medical training promotes and measures students' acquisition of the relevant and necessary knowledge, skills and attitudes that will enable students to meet the contextual health needs of individuals and population groups. There is an assumption of students as rational, autonomous, self-organising individuals with the power to learn on their own and from others such as in the workplace, and to take responsibility in providing appropriate quality healthcare (Harden, 2015). These rational and humanist directives assume professional accountability as a social function that can be organised, determined and performed (Cruess, Cruess & Steinert, 2010).

Undergraduate medical curricula provide standardised and regulated pathways for facilitating student throughput, a priority in South Africa where there is a dire need to address the increasing burden of health and disease (Parliamentary Monitoring Group, 2016). Political leadership is a key driver which also places pressure on training institutions to prioritise student numbers over relationships. There is a growing movement towards socially accountable medical schools that extend their focus on the medical profession's relationship with society and individuals, as discussed in the previous chapters. Yet the increased pressure and obligations on institutions to demonstrate their social responsibility does not contribute to the hidden aspects of practice that weave through students' curricular engagement and tend to remain unrevealed, such as the injustices they may witness. Furthermore, measurements of throughput and academic success tend to keep students' learning experiences invisible, hidden and silenced, maintaining a knowledge culture that backgrounds students' voices.

3.5.1 Matters of time

From the students' point of view, graduation from the Faculty of Health Sciences does not necessarily bring closure with past learning moments. I propose that each learning

encounter matters for students, at that time and in the future for when they will become practising doctors. Time is entangled with students' becoming. The past is part of the present and the future. "There is no absolute boundary between here-now and there-then" (Barad, 2014, p. 168). What students observe in their fourth year of training can remain with them, shaping their future practice in different ways through the years. The past, future and present all exist in and with each other, impacting on students' becomings. The force of the past is explained by Massumi (2015) in the term *immediation*, which is explained as "the past bumping against the future in the present" (p. 148).

Students' histories are essential components in and with their future potentials. Whether referring to students completing their whole undergraduate degree or the small component of their obstetrics modules, students' learning moments hold a vital intensity and force that is carried through the events, contributing to a nexus of forces co-constituting students becoming-with others (Barad, 2007). These forces arise at the intersection of the different relationships in moments of time, also known as *Kairos* time, or "felt-time at the moment of birth" (Crowther, Smythe, & Spence, 2015). Obstetrics is one such vital moment of time in which students are placed and which makes a mark on students' future practice.

The iterative entanglements of forces can be compared to the folding process of a mountain range that emerges through the interference of forces (Barad, 2014). Similarly, students themselves are affected in an iterative manner through the forces to which they are exposed at different times in their lives. What has been cannot be erased but is rather a part of their becoming through the materiality of practice. Like in mountain formation, there is a type of sedimenting process within the open field of practice. Barad (2014) points out that "sedimenting does not entail closure" (p. 168). There is no erasure or closure of experiences, even those that are silenced or hidden (Barad, 2010; Newfield & Bozalek, 2018; Bozalek, Bayat, Motala et al., 2016). Barad (2010) describes the *hauntology* of time, explaining how events are "threaded through one another, knotted, spliced, fractured, each moment a hologram, but never whole ... Time is out of joint, off its hinges, spooked" (Barad, 2010, p. 243). Such a concept of time shifts our conventional thinking about time as linear, sequential and with clean-cut predefined periods as represented by training curricula. Barad (2007) asserts that

the past is never left behind, never finished once and for all, and the future is not what will come to be in an unfolding of the present moment; rather the past and

the future are enfolded participants in matter's iterative becoming. Becoming is not an unfolding in time, but the inexhaustible dynamism of the enfolding of mattering. (p. 234)

Because the past, future and present are so entangled, I will argue that there is intense importance to consider the issue of responsibility in terms of what was and is to come. Green-Thompson, McInerney and Woollard (2018) point out that “[a]ll actions impact lives”, encouraging processes of reflection, understanding the complexity of practice and acknowledging the tensions in the relationships that emerge from the asymmetrical power differentials (p. 90). Issues of responsibility are far-reaching, though the conventional forms of responsibility remain centered around safety, risk and ethical concerns.

3.5.2 Safety and risk

Safety measures are prioritised in medical curricula as they matter to all forms of medical practice and research. Student competence includes the acquisition of the necessary skills to take precautionary measures to reduce any medical complications. However, an additional force in terms of safety that is embedded and related to medical training and curricula is the large and pertinent issue of increasing levels of litigation. Managing risk and possible legal actions do matter to medical practice and to medical training and are becoming more invasive forces affecting the medical profession both locally and globally, reflected by the increasing high indemnity costs to professionals. Erasmus (2017) reported that these costs are driving doctors away from obstetrics practices in South Africa, leaving a crisis in which there are not enough professionals willing to deliver babies. Undergraduate medical students are immersed in this crisis. Defensive measures are increasingly becoming necessary considerations, especially in a discipline such as obstetrics. This culture of defence acts on health team members who develop skills to protect themselves.

In this study I suggest a shift from information that supplies matters of fact to matters of concern (Latour, 2004; Puig de la Bellacasa, 2011). Facts and measurements only offer a glimpse of the reality, a perspective that is limited. Barad (2007, 2010) refers to agentic cuts that determine what is included and what is left out in intra-actions, known as agential separability. For instance, the cut of this study prioritises concerns in terms of students’ learning experiences which, as mentioned earlier, are generally left out, hidden or unrevealed when throughputs, safety techniques, ethical principles or the

assessments for progress are what matters. There is a congealing of forces in the entanglements of students becoming-with others. In the obstetrics curriculum the safe delivery of the baby with a healthy mother is the ultimate goal. Yet within the birthing process there are relatively unexplored matters of concern in the in-between curricular spaces where hidden, unpredictable intra-actions are affecting students through their journey in becoming doctors. Below I explore the theoretical underpinning of matters of injustice then move on to discuss the materialising forces enacted in the learning practices.

3.6 Responding to injustice

In what follows I consider how engagement in curricular matters can render medical students in/capable in responding to the in/justices they witness in their obstetrics learning. This study sets out to investigate what else matters in student learning, apart from academic success represented by marks. I explore what emerges through students' learning encounters in terms of their varying levels of in/capacity to respond to what they witness in those moments. These responses can be nurtured by others who render them capable or undermined resulting in reduced capability to respond. The reference to others includes the more-than-human agential actors.

Vinciane Despret's work with animals and humans is foundational for exploring relationships that are open to other bodies and responsive to different positions. She encourages us to think with/through others by acknowledging the multiple forces acting in each intra-activity. It is a move beyond human individualism, binaries and separations. In every encounter there are multiple forces that play out between different bodies thereby rendering them in/capable (Despret, 2013). Bozalek and Zembylas (2017) explain that to be rendered capable "means that there is no pre-existing knowledgeable other but that all are affected and affect the other (both the human and the more than human), becoming-with the other through relationships" (p. 66). In terms of this study, students are immersed in multidirectional forces and relationships with/through their curricular tasks. They are becoming-with others thereby influencing their level of capability (Barad, 2007; Bozalek & Zembylas, 2017). These relationships (which include more than human interactions) and their forces will be examined in my study.

3.7 Material-discursive practices

The reference to 'discursive' in FNM moves beyond conceptions of descriptive conversations or texts. Discourse is not a representation of an action or thought but "that which constrains and enables what can be said" (Barad, cited in Kuby, Spector & Thiel, 2018, p.146). Foucault's (1980) work on power highlights how different societies exhibit different types of discourses according to what is valued, which then leads to what counts as meaningful in a culture, at a particular time or in a specific context. Thinking about the intermingling of power, politics and emotions in discursive practices is not new (Zembylas, 2007).

Discursive practices have placed dominance on language, yet they are also related to the material world (Barad, 2007). When considering the materialising forces of matter, these different relationships that are enacted generate an alternative focus that is encapsulated by a relational ontology. For example, the role of a student or doctor's white coat is similar to that of a suit worn by a professional. There is an intra-active force of "a mutual production of agency", as [s]uits are constructed to render an image on the part of wearer as conferring status, conformity, and confidence" (Jackson & Mazzei, 2012, p. 780). The importance of looking beyond the discursive is highlighted by Ehret and Leander (2019) who contend that "[d]iscursive-material concepts *matter*. They are not ways of knowing, they are knowing in the making; they are a part of matter, bodies, becoming" (p. 10, italics in original).

In medicine, there are many competing discourses, adding to the complexity of practice. For instance, in the field of obstetrics, birthing gives rise to debates about the natural process versus a medicalised one (Chadwick, 2007). However, medical students become embedded in evidence-based practices and their associated discourses. I will propose that by using the lens of a relational ontology, new insights can be gained by examining the material and the discursive practices. Both are threaded through each other as material-discursive enactments which are co-composed in/through students' curricular tasks, as iterative intra-activities (Barad, 2007). Educational institutions, birthing facilities, classrooms, and online spaces can be considered as "material-discursive apparatuses of bodily production" in which agency is enacted (Barad, 2003, p. 827), or more simply, as intra-active learning apparatuses. They are not separated spaces for teaching, learning and practical engagement for knowledge making processes but entanglements of spaces, with time and matter that Barad (2007) refers to as spacetime-matterings. The Baradian concept of spacetime-mattering foregrounds the

importance of understanding the emergence of events through the different relationalities, rather than events being predetermined through determinate entities. Spacetime mattering may be a contributing element to developing a socially just pedagogy that can address responsibility in student learning. Students' learning in obstetrics is not merely a coming together of their knowledge, their being and their actions but an enactment of the multiple forces intra-acting in each moment of an encounter as students are becoming-with others. Barad (2007) contends that:

Particular possibilities for (intra-) acting exist at every moment, and these changing possibilities entail an ethical obligation to intra-act responsibly in the world's becoming, to contest and rework what matters and what is excluded from mattering (p. 235).

The material-discursive practices of curricular activities enact different relationships that intersect with each other to produce the effects of difference. Discourse, matter and events are ontologically inseparable as they co-exist in a relational ontology. Barad's (2007) broader concept of agential realism is premised on the multifaceted intra-actions between the multiple agential forces. A material-discursive perspective examines the phenomena²⁶ that materialise in multiple and dynamic relationships. Thinking through material entanglements and phenomena is different to an understanding that entails separations based on individual choices and intentions with assumptions of individuals as fixed entities that pre-exist events and encounters (Barad, 2007; Mazzei, 2013).

Along with a concern around matter and how matter matters, the next section turns to affect. I explain how sensitivity to an affective attunement can influence students' ability to respond to unjust practices. Affective attunement is a term used to denote a sensitivity to the complex differences flowing in an assemblage. It is "a crucial piece in the affective puzzle" (Massumi, 2015, p. 56). Obstetrics is an in/tensive space where affect circulates, impacting on all relationships.

²⁶ Phenomena are "specific material configurations of the world's becoming" (Barad 2007, p. 91), described further by Barad (2010) as "*material entanglements enfolded and threaded through the spacetime mattering of the universe*" (p. 261, italics in original).

3.8 Tuning in to affect

Affect is pertinent to my study as it can mediate change in issues related to responsibility. Affect marks a transition.

When you affect something, you are at the same time opening yourself up to being affected in turn, and in a slightly different way than you might have been the moment before”; there is a “passing of a threshold, seen from the point of view of the change in capacity (Massumi, 2015, p. 4).

Below, I refer to my question on how an affective attunement can work towards rendering students capable in their response-ability to unjust practices in obstetrics. The importance of affect is acknowledged by a growing number of scholars despite there being “no consensus on the meaning of affect” (Houser, 2018, p. 15). The multiple perspectives of affect can, according to Ott (2017), be placed in two main categories; namely affect in terms of an “elemental state” which is associated with psychology and the neurosciences and includes individual’s feelings and emotions, and affect as an “intensive force” that is the thread picked up in my research findings and described below. My focus is on the latter, a particular view of affect, drawn from a Spinozist or monist philosophical view rather than a psychological perspective. The Dutch philosopher, Baruch Spinoza first introduced the concept of affect which is not just about ourselves but about our multiple connections with others (Massumi, 2015).

Affect is defined by Massumi (1987) as “a prepersonal intensity corresponding to the passage from one experiential state of the body to another and implying an augmentation or diminution in that body's capacity to act’ (p. xvii). This Deleuzian interpretation of affect focuses on the intensities and capacities that power the body to move or be moved (Colebrook, 2002). Affect is the “*perception of one’s own vitality, one’s sense of aliveness, of changeability*” (Massumi, 1995, p. 97, italics in original).

There is an increasing body of work proposing that theorising with and through affect as an affirmative approach, can be an enabler for change, providing a valued contribution to higher education and different areas of pedagogy (Bozalek & Zembylas, 2016; Farrugia, 2016; Hickey-Moody & Page, 2015; Leander & Ehret, 2019; Postma, 2016; Zembylas & Schutz, 2016). The “affective turn”, coined by Clough (2007), has been used extensively in different academic fields (Seigworth, 2011; Athanasiou, Hantzaroula & Yannakopoulos, 2008; Zembylas, 2016). The *Capacious Journal for Emerging Affect*

Inquiry (<http://wtf.affect.com/capacious/>) showcases new perspectives and propositions. Working with/in affect is not about working with concrete facts (Read, 2016). It is not measurable as it is a force in becoming,

In a scientific evidence-based discipline like medicine, there is therefore limited exposure and expression of affect in the curriculum. In this study, I examine the rupture or crack in curricular matters in obstetrics that emerged and became a potent force in my engagement with students. Leander and Ehret (2019) contend that “attuning to affect might help educators and researchers engage in thinking-feeling around issues of inequality as a base for amplifying processes and possibilities for social justice” (p. 17). I propose that affective sensibility and attunement may provide a channel for engaging with students’ response-ability to issues of social in/justice that would not otherwise be foregrounded. It can be considered as an ethical act because it affects where individuals might go or what they may do. Massumi (2015) encourages us to think with affect as it “is to think through our implication in relational fields, and the potential we might find there” (p. 151).

Many theorists are advancing the notion that affect is more than emotion (Anderson, 2014; Brennan, 2004; Clough, 2007; Danvers, 2015; Gregg & Seigworth, 2010; Leander & Ehret, 2019; Massumi, 2015; Thrift, 2008; Zembylas, 2009; Zembylas & Schutz, 2016). A turn to affect in obstetrics offers the possibility for new insights into student learning in terms of their capability to respond to events they witness. In obstetrics there are curricular matters that enhance students’ affective flows such as their excitement at reaching the momentous initiation into real medicine, and the idea of being part of birthing, yet the tensions and fears inherent in the discipline, such as the challenging relationships that students have heard about from others, become limiting elements in students’ learning. Massumi (2015) explains that affect is “not something that can be reduced to one thing. Mainly because it’s not a thing. It’s an event, or a dimension of every event” (p. 47). In each event, the power to affect and be affected is key.

Affect is more than emotion. Yet even emotion has had a difficult relationship with/in the humanities and arts, and teaching and learning in the sciences, according to Zembylas (2016). Zembylas (2016, also referring to 2002, 2013) points out that “at the heart of pedagogy is the provocation of emotion and affect” (p. 540). However, even in a highly

charged emotional space with intense affective forces, there appears to be little attention given to emotion and affect.

Affect moves, and moves students and others, enabling them to pass through thresholds that offer opportunities for changing their capacities (Massumi, 2015). Affective change involves an opening up to be affected, a transition from what was before. This openness to affect is determined by the body's potential (Massumi, 2015). Affect acts as a charge with potential which is enhanced by an affective attunement. Springgay and Zaliwska (2017) refer to a politics of attunement, an opening up to new thinking that "invites us to learn to be affected" (p. 274).

Zembylas (2016) points out that affect "enhances our vocabulary to theorise the psychosocial complexities that difficult knowledge raises for teachers and learners" (p. 549). But Massumi (1995) claims that one of the difficulties in exploring affect is the problem that "there is no cultural-theoretical vocabulary specific to affect" (p. 88). Affect acknowledges the challenges and complexities of learning with/in discomfort amplified by the inequalities of the present and past social, affective, historical, and political connections. However, it is also problematic through the lens of FNM. There is an implication of a human-centred choice in which "affect is a thing" that can be taken up or left behind or placed in a certain position like a fork and spoon in relation to a plate, as explained by Massumi (2015, p. 150). Affect is in us and circulating with us. It is "the felt quality of a relational field" that is not fixed but open to possibilities of more to come (Massumi, 2015, p. 124). It can effectuate change.

Thinking with and through affect illuminates how responsibility in terms of obligations and regulations avoids the reality of precarity and uncertainty that results from the multiple, emerging and intersecting relations and forces enacted in learning processes and their dynamic vitality. When we conceptualise matter as implicated and entangled in and with students' curricular engagement, the landscape changes. Different forces are generated that create and change the circulation of affect.

In summary, FNM moves issues of accountability and responsibility from un/acceptable behaviours to the wider issues around relationality and responsibility; from rule-bound

perspectives to a fluid dynamic and open affective field among humans and more-than-humans.

3.8.1 The micropolitics of student learning

“Everything is political, but every politics is simultaneously a macropolitics and a micropolitics” (Deleuze & Guattari, 1987, p. 21).

In this study I take up a concern for the micropolitics of student learning to gain insight into students’ affective encounters. Micropolitics, introduced by Deleuze and Guattari (1987), is a concept related to the multiplicity of connections. It is “what makes the unimaginable practicable. It’s the potential that makes possible” (Massumi, 2015, p. 82). This potential can bring change through processes that can “destabilise existing power relationships” (Blaise, 2013, p. 189).

I examine response-ability through what is usually hidden within and across student relationships. There is a strong connection between assemblage thinking, affect and power as power is inherent “in the affective flows between relations in assemblages” (Fox & Alldred, 2015, p. 402). Fox and Alldred (2015) suggest that by revealing the micropolitics in a research-assemblage, new methodological strategies can help us to better “to understand the world, and to change it” (p. 411).

Micropolitics is not about the dimensions of the learning event but about the “event-propagation” (Massumi, 2015 in interview with McKim, p. 79) in terms of the significance to other processes and changes. Micropolitical positioning is about being in the “thick of things” rather than at a distance (Massumi, 2015). It is an “immanent critique that actively alters conditions of emergence. It engages becoming, rather than judging what is” (p. 71). Immanent refers to the “not yet, the yet to come” (St. Pierre, 2018, p. 2). Issues of power manifested in both micropolitics and macropolitics challenge all organisations including health sciences faculties and health facilities. What is valued, and what power is able to be exercised and constrained falls under the micropolitics of educational organisations (Malen, 1995).

3.9 Conclusion

In this chapter I put forward a different way of viewing medical education, one which foregrounds multiple and collective relationships, shifting away from humanist,

individualist thinking. I explain theoretical moves that draw on a relational ontology, such as FNM and posthumanism, which I argue, provide an expanded perspective for engaging with curricular matters in the obstetrics curriculum. The chapter explains relevant concepts in FNM such as intra-action and assemblages. I show how current views of medical training might be seen as reductive in that they omit appreciation of the agency of more-than-human bodies and the relationship of matter to students' learning experiences and their responsibilities. FNM is premised on a relational ontology which focuses on processes of becoming-with others through intra-actions. The chapter elaborates on the expansive views of my inquiry using FNM, in which matter matters.

The ethical responsibilities of teaching, learning and research become more complex when considered through intersecting movements and interrelating forces that are indeterminate and precarious. When the material becomes as important as the discursive, new insights are opened up through recognising learning moments as material-discursive practices. Possibilities arise for the emergence of newness through different relationships, which are not fixed, nor contained in bounded entities. Barad's notion of agential realism has guided my explorations into possible interconnections and interdependencies that may be enacted through the material-discursive practices in students' clinical encounters. The term "more-than-human ethico-onto-epistemologies" coined by Kuby, Spector and Thiel (2018) seems to appropriately summarise this conceptual framework (p. 2). FNM is a useful theoretical framework to examine relationships and responses in terms of ethical practices emerging in student learning from which there are material and political consequences.

The chapter provides the ground for reconceptualising curricular matters by taking "a leap forward into the complexities and paradoxes of our times" (Braidotti, 2013, p. 54). The intensity of injustices and disrespect in obstetrics feels like a hurricane blowing through the curriculum, breaking through boundaries and determining what matters in students-becoming. A focus on learning outcomes allows us to stand on the edge with indifference and silence. A shift from this stance provides the driving force of exploring what renders students in/capable to responding to in/justices they may witness. This study is driven and moved by a curiosity and experimentation to explore the multiple and 'tentacular' (Haraway, 2016) connections to student learning in obstetrics. Within learning contexts there are affective flows that circulate and mediate relationships. Despite the scarce mention of affect in medical training, affect theory provides a new way of addressing student learning and contributes a vital role in developing a socially

just pedagogy, amidst the injustices played out in obstetrics. In the next chapter I describe the constitution of the apparatus of my research, how the process began, moved and emerged, and how non-representational methods in post-qualitative research were implemented.



CHAPTER 4 - PROCESS OF EMERGENCE: MAPPING MY RESEARCH ASSEMBLAGE

4.1 Introduction

Looking for trouble, looking to be troubled by being on the lookout for unexpected encounters and even producing startling encounters has become, for many of us, a kind of method (McCoy, 2012, p. 763).

In this chapter I discuss the processes that were enacted in my research as I worked in and through the troubles emerging from student learning in obstetrics. In recognising students' challenges, I explored how feminist new materialism (FNM) might provide an avenue for innovative thinking as an alternative perspective towards issues of responsibility and promote socially responsible curricular engagements. The research project set out to examine the relational entanglements and resultant forces that can and do render students in/capable in their responses to what they observe in birthing facilities.

This study evolved in an indeterminate and unpredictable manner. Ideas germinated through my teaching at the University of Cape Town (UCT) in the Health Sciences Faculty (HSF) and in particular in the Department of Obstetrics and Gynaecology (Dept O&G). Other spaces influenced my insights such as informal conversations, conferences where I presented and networked with people, social media, weekly reading groups, regular meetings with my research supervisors, and my involvement in broader National Research Foundation funded projects related to social justice in higher education. Mixing theory with data and data with theory became an experimental collaborative process in which a relational ontology, affect theory and visual resources added value to my research and the related educational practice (Jackson & Mazzei, 2013).

Donna Haraway's (2016) concept of becoming-with others is a key component of my study and its methodology. I attempted not to examine isolated, separated entities, nor create separation or disaggregation through my analysis. I explored how relationships were enacted in order to discern differences and how they come to matter, rather than finding commonalities through themes and classifications. The effect of these differences was what was important, as it influenced what students experienced in their entanglements with their clinical encounters. Inspired by Haraway and Despret, I have found it productive to think with matter (and with animals) as a form of working

with/through different relationships. The theoretical frame of a relational ontology, explained in the previous chapter, has provided way for me to experimentally explore connections and becomings in the in-between spaces of the multiple relationships between human and more-than-human bodies (Manning, 2010; Pedersen & Pini, 2017). In these interstices, multiple forces are unfolding and relating with each other determining the perceived enactment. Each encounter in my research process, in student learning and my own teaching is an event in which many different forces interact to make up the assemblages that transpire. In their introductory chapter explaining a move from concepts to processes, Jackson and Mazzei (2012) claim that an assemblage “isn’t a thing— it is the process of making and unmaking the thing” (p. 1). Exploring assemblages and the “happenings in the unfoldings, and the in between” is argued to be more challenging than traditional research methods that focus on identities and interpretations (Guillon, 2018, p. 108).

My methodological considerations are not directed to solve the problems that are evident in student learning, as outlined in Chapter Two (which provides the context of this research). Furthermore, I do not seek to evaluate, assess or make judgements about these actions nor to examine the determinants of abusive practices. There are currently many experts working on this global problem, such as is evident in the recently published International Childbirth Initiative (2018). My inquiry rather opens up an exploration of a different pattern of relationality to illuminate what renders students in/capable in their responses to injustices in obstetrics. This study moves beyond definitions and measurements in an attempt to reconfigure and to re/conceptualise responsibility in terms of the curricular tasks in obstetrics. In my considerations, I explore the entanglements in/through relational fields that are enacted in students becoming-with others in their learning encounters, through the theoretical lens of a relational ontology. Rather than separating or disaggregating aspects of practice, I draw on FNM to seek out a novel approach that may energise pedagogical input to re/look at responsibility and response-ability in the context of student learning in obstetrics, and to possibly re(con)figure responsibility in pedagogical and curricular matters (Higgins & Tolbert, 2018).

This alternative process-driven approach captures the dynamic movements and unfoldings that are activated in/through the study. It is an expanded rather than contained research process, seeking out more than what can be represented or is directly visible. The emphasis is placed on the additive component, on the AND, that St.

Pierre (2013a) drawing on Deleuzian theory refers to as “a logic of connection ... “a logic of the *and* (this *and* this *and* this *and* . . .)” (p. 252, italics in original). I moved away from containing data into classifications or trying to find binary logics such as either/or, or making judgements that can be oppositional. I have avoided criticisms that make one perspective appear superior to another, rather taking a methodological approach that moves outwards enabling different connections to become possible, a “tentacular” movement. . To move forward expansively, researchers are encouraged to move through an innovative process of “becoming attuned to the lively excess that always exceeds capture by structure and representation, leaving openings where something new, or something else, might issue; that MacLure (2013b) refers to as the “wonder” of research and the “cabinets of curiosities” (p. 229)

Finding meaning by interpreting students’ lived experiences regarding their curricular tasks was not my objective, nor was it to interrogate the intentionality or logic of the events that unfolded during students’ learning. The many personal narratives in this study happened in in-between spaces revealing the multiple and different forces that play out and shape different relationships (Jorgensen & Strand, 2014; Snaza, Sonu, Truman & Zaliwska, 2016).

What ... most ... [research] perspectives have in common is that they take humans or human meaning-making as the sole constitutive force. From a relational material perspective this anthropocentric position is of course problematic. It reduces our world to a social world and neglects all other non-human forces that are at play. A turn to relational materialism, where things and matter, usually perceived of as passive and immutable, are instead granted agency in their intra-activities, can be understood as promoting a more ethical research practice. (Hultman & Lenz Taguchi, 2010, p. 539–540).

A response to the concerns noted above is that there is a wide interest and movement away from traditional humanist qualitative methodologies opening up fields of experimentation for new thoughts and insights that take cognisance of the multiple relationships emerging through/with intersecting forces acting with/in our practices at each moment. As noted in the previous chapter, Barad (2007) points out that intra-activities take into account more than human-to-human interactions. There are many strands of agency and relationality that are constantly on the move, interfering with each other, producing multiple forces.

This chapter is set out in two parts. In the first part I put forward reasons for using post-qualitative research and what work it did for my study, and its significance, as well as its differences to conventional qualitative inquiries. In the second part I describe the practical components of the research and the administrative processes that were undertaken. Human dominance is decentred as I examine the “more-than of human life where the body is but one verging surface on the field of experience, where the body is always more than One” (Manning, 2010, p. 118). This expansive perspective provides no procedural certainty as the relationships emerging in and through the project directed the flow rather than a predetermined structure.

4.2 Part 1: Moving with a relational ontology into a post-qualitative inquiry

In my effort to re/look at responsibility in terms of curriculum-student relationships and pedagogical practices, I turn to my research questions then move on to explain my post-qualitative approach and the processes involved.

4.2.1 Research questions

Below is the main question framing this study followed by three sub-questions:

What renders students in/capable in their responses to injustices they may witness in obstetrics?

1. What matters in the obstetrics curriculum in terms of undergraduate medical students' experiences and responsibilities?
2. How does the curriculum as a material-discursive practice render students' in/capable²⁷ in their response-abilities?
3. How can an affective attunement work towards rendering students capable in their response-ability to unjust practices in obstetrics?

4.2.2 The flow of the research process

it is surely the case that as the world is forced to face up to the damage done, so we can no longer move along the same cul-de-sacs of practical cum-conceptual possibilities. Other possibilities need to be alighted upon for thinking about the world (Thrift, 2008, p. vii).

²⁷ in/capable is a Baradian (2007) way of using a forward slash to avoid binaries. It implies here that there is a continuum of capability, not either capable or incapable or both capable and incapable, but an indeterminacy regarding capability.

In seeking out new possibilities for researching issues of responsibility in this study, I took up an experimental approach that was non-representative in order to open up (rather than represent) the harmful reality of disrespect in obstetrics. It involved a sensitivity to the movements and flows of forces emanating through different encounters. Braidotti (in Dolphijn & van der Tuin, 2012) points to Deleuze's "philosophical pragmatism" and encourages researchers to "experiment with thinking", to be "inventive and creative ... with thinking beyond criticality" (p. 29). St. Pierre (2017) also encourages researchers to be experimental:

Inquiry should *begin* with the too strange and the too much. The rest is what everyone knows, what everyone does, the ordinary, repetition. Post qualitative inquiry asks that we push toward the intensive, barely intelligible variation in living that shocks us and asks us to be worthy of it. It asks us to trust that something unimaginable might come out that might change the world bit by bit, word by word, sentence by sentence (p. 5, italics in original).

This emergent process can be considered different to traditional qualitative research practices that are clearly structured and representational of the object of research. Springgay and Truman (2018) note that if we want to make inquiries that can change the world we need to work in different ways to the usual, to "attend to the immersion, tension, friction, anxiety, strain, and quivering unease of doing research differently" (p. 2). They refer to "thinking-in-movement", a generative process that enables research to begin in the middle as a speculative event and then move outwards (p. 6). The movement entails more than data collection as it is an experimentation with tangled relations emerging in and through each event, also termed "speculative eventing" by Springgay and Truman (2018, p. 84) who explain further:

In the middle, immanent modes of thinking-making-doing come from within the processes themselves, not from outside them. In the middle the speculative "what if" emerges as a catalyst for the event. The middle is a difficult place to be ... The middle can't be known in advance of research. You have to be "in it," situated and responsive. You are not there to report on what you find or what you seek, but to activate thought. To agitate it (Springgay & Truman, 2018, p. 206).

To make a difference in the world or different worlds, we need to think differently, away from human individualism and separation (Barad, 2007; Haraway, 2016; Springgay & Truman, 2018). The dominant human-centric lens, known as an anthropocentric viewpoint, offers a particular perspective based on the rational individual, as explained in

the previous chapter. In this study I go beyond a focus on the human to explore the multiple forces that influence students' becoming in their obstetrics learning. This ethical move takes into account all actants²⁸ responsible for the behaviours exhibited in birthing units and witnessed by students. It moves away from judgement and blame to acknowledge that students' knowledge-making processes are entangled enactments constituted by more-than-human forces. There is a mutual becoming. This ethico-onto-epistemic positioning is inclusive as it engages with all relationships rather than prioritising one (such as the human) and excluding others as separated entities (Barad, 2007). I attempt to be non-judgemental as judgements and critique are considered to be formulaic, predictable and reductionist, reinforced by holding issues at a distance (Latour, 2004; Edwards & Fenwick, 2014). Rather, I made efforts to become attuned to the students' learning experiences. Attunement signifies "the direct capture of attention and energies by the event" (Massumi, 2015, p. 115) with a heightened sense of seeing and feeling as Lorimer (2015) explains:

the researcher is ready to stare with the ear, as much as the eye, to notice differently, by listening out for the ways that smell, color, or taste is given voice. It is an attentiveness to the small dramas formed by fragments of speech, or the expressive force of sounds and vocalizations that aren't words, but that make up so much of our regularised communication and everyday associations, and on which we are dependent for non-verbal forms of togetherness, sympathy, or frustration (p. 186)

Post-qualitative inquiry is considered to be provocative and challenging in shifting away from considering only human interactions. It aims "to create different worlds for living" (St. Pierre, 2017, p. 604), by offering a productive and experimental option for research that moves beyond conventional, normalised and self-evident options (St. Pierre, 2011; Lather & St. Pierre, 2013). It avoids the repetition and representation of what is present and recognisable thereby generating novel thoughts rather than repeating known facts through seeking out common themes, as occurs in "methods-driven research" (St. Pierre, 2015).

It cannot be measured, predicted, controlled, systematised, formalised, described in a textbook, or called forth by pre-existing, approved methodological processes, methods, and practices ... Its focus is not on things already made but on things

²⁸ Bennett (2010) refers to Bruno Latour to describe an actant as an entity which "has efficacy has efficacy, can do things, has sufficient coherence to make a difference, produce effects, alter the course of events" therefore it can modify another entity (p. viii).

in the making. . [it is] always becoming ... always incomplete ... There is no recipe, no process (St. Pierre, 2017, p. 604).

In this study, conventional qualitative methods were used to collect data, however the relational processes became more important than the representations of what was happening in students' learning. Data then moved from collection to creation. This movement is more risky as it takes the research from a determined structure to indeterminacy -- a characteristic of post-qualitative processes. Strom (2015) points out that these moves are not common as academic researchers have a tendency to stay with traditional approaches. Strom (2015) suggests that a reason for such conformity is that academic output needs to appeal to the readers of potential publications, therefore "when attempting to push transformative ideas into mainstream outlets, departing too sharply from accepted norms could result in the exclusion of readers" (p. 324). I recognise that as a mature, part-time academic, my position gives me freedom to break through such barriers and concerns. In what follows, I explain how the post-qualitative approach to research worked in and for this study as a process encompassing the philosophical elements of FNM. I first describe general concepts of a post-qualitative approach and non-representational theory then lead on to key components to explain the connection with a relational ontology.

4.2.3 How a post-qualitative approach worked for/in this study

In this section I present arguments that relate to the limitations of conventional humanist qualitative methodologies then draw on Thrift's (2008) notions of movements, openness and connections to describe the potential offered by non-representational theory (NRT) using a post-qualitative process of inquiry.

Traditional qualitative research methods represent a reality, reporting on it through various forms of interpretations and meaning-making, to represent and repeat what is present. Such representation, according to Doel (2010) "has an obligation to give back a true semblance of that which it re-presents" (p. 119). Doel (2010) points out that representation is developed to ensure that it "should resemble rather than dissemble" and this can lead to confusion (p. 117). He uses the example of a photograph of a sunset. The image is different to the sun itself setting. In reality, Doel highlights how the camera is actually taking charge; the camera's material vitality is understood to be interfering with traditional forms of re-presenting.

Traditional coded research tends to privilege a normative voice based on the logic of representation, thereby having a contracting influence on the data, as it brings stasis and repetition. It adheres to hierarchical structures that appear to reduce difference to sameness, not encapsulating the expansive dynamics of thinking with becoming (St. Pierre, 1997; Sellers, 2013; Davies et al., 2013; Koro-Ljungberg & MacLure, 2013a). Furthermore, the reductiveness of conventional qualitative research methodologies is noted as being anthropocentric, adhering to the dominance and centrality of the human.

MacLure (2013c) points out that traditional coding “does not recognise changing speeds and intensity of relation, or multiple and mobile liaisons amongst entities” (p. 169). Conventional categories and classifications can be seen to represent static and treelike methods²⁹ implying fixed, limited and defined outcomes. An argument that MacLure (2013c) puts forward is that coding “renders everything that falls within its embrace explicable” (p. 169). Such qualitative research processes are perceived to produce “brute, sense data”, in which “researchers strip the words from context, manipulate them, order them in binaries and hierarchies and categories, label some words with other words (code data), and even count words” (St. Pierre, 2013b, p. 224). These actions are based on interpretations and meaning-making of the data from a conventional humanist position and can be misleading as they reduce interpretation to humanist interactions. Furthermore, coding can wash out the richness of the data through prioritising some aspects at the expense of others and seeking commonalities rather than differences. Jackson (2013) notes that:

The codes, the themes, and the meanings become stabilised structures on which to ground an unchanging truth about the real – a knowledge claim. Thus, the practice of coding data that essentialises people and their experiences – and that leads to representations of the real and true knowledge – is an epistemological project flavored with humanism (p. 742).

In terms of relooking at research methodology through a flattened, relational perspective, Barad (2007) asserts that:

practices of knowing cannot fully be claimed as human practices, not simply

²⁹ Deleuze and Guattari (1987) describe traditional education as arborescent or treelike in its structures as it is linear. They compare it to their concept of a rhizome with starts in the middle and spreads out through unpredictable connections.

because we use nonhuman elements in our practices but because knowing is a matter of part of the world making itself intelligible to another part. Practices of knowing and being are not isolatable; they are mutually implicated (p. 185).

Separation is a core component of conventional research methods in terms of data, methods and analysis. According to Mauthner and Doucet (2003)

there is an assumption built into many data analysis methods that the researcher, the method and the data are separate entities rather than reflexively interdependent and interconnected. Most methods continue to be presented as a series of neutral, mechanical and decontextualised procedures that are applied to the data and that take place in a social vacuum (p. 417).

I take up a process-driven ontological approach that St. Pierre (2013b) explains does not:

assume there is a given, a real world (data) that can be gathered together (collected) and described (analyzed and known) as in logical positivism/empiricism nor do they assume, as in interpretive theories like phenomenology, that there is an underlying meaning in an already existing lifeworld that interpretation can bring to light and describe (p. 225)

Post-qualitative research decentres the human, enabling knowledge-making to be viewed through an alternative relational lens. Below I list Nigel Thrift's (2008) seven tenets or principles that guide NRT then describe how NRT contributes a helpful theoretical tool for my post-qualitative study in terms of what was valued in my research (such as multiple and different voices), the research process and my findings.

Thrift's (2008) first tenet is try to "capture the onflow" of everyday experiences rather than static ways of being. Thrift points to the significance of performance and play which is privileged in NRT. Secondly, NRT "is resolutely anti-biographical and pre-individual" because relationships entail all and different things coming into relationships with each other in "various spaces through a continuous and largely involuntary process of encounter". Assemblage thinking is foregrounded as opposed to conceptions of determinate entities with certain specified characteristics. Thirdly, NRT includes a focus on practices and how they come to be enacted in different encounters. In the fourth principle, NRT gives equal weighting to objects. Things are given agency as indicated by

the example above with the camera. Thrift notes in the fifth tenet that experimenting is key to the NRT process. His seventh point is that affect and sensation are integral components, and that they are “important as signs and significations but that only recently have begun to receive their due”. The seventh tenet points to NRT providing an opening up of an “ethic of novelty” towards a more enlivened life of possibilities that moves towards joy (p. 5- 14).

Ralph Pred (2005) refers to the “onflow of experiences” with a continuity of relationships, in which each moment of an experience flows into the next like a stream of consciousness that opens up for more (p. 2). Although consciousness brings a humanistic interpretation, this term is useful as it does not presume a “specific spatial location (such as the biological body) or any necessary sensory modalities” (Thrift, 2008, p. 227).

Non-representative methods involve a becoming-with different flows and intensities of forces. My study adopted an open and expansive approach that involved experimentation with NRT and its methods to find opportunities for newness to emerge with movements of shifting thoughts, to understand the world from within, as part of it rather than at a distance from it (Barad, 2007). A non-representational methodology moves away from linearity, prediction and control as it aims to “enliven rather than report, to render rather than represent, to resonate rather than validate, to rupture and reimagine rather than to faithfully describe, to generate possibilities of encounter rather than construct representative ideal types” (Thrift & Dewsbury, cited by Vannini, 2015, p. 15). Vannini (2015) contends that it is “no longer what happened that matters so much but rather what is happening now and what can happen next” (p. 12).

I included different voices and senses as a move to find “the voice that escapes and that does not make easy sense”, described as “a more fertile practice” by Jackson and Mazzei, 2012, p. 263) than easier classifications of naming and categorising the humanist voice. Matter was acknowledged with agency. Therefore, my research-creation allowed for data to emerge through the mutual agency of humans and more-than-humans. This mode of thinking away from meaning-making and interpretations avoided any sense of othering, a “colonial relation of researcher to subject” (MacLure, 2013c, p. 168). The vitality of matter intra-acting in material-discursive processes provided a potential for gaining new insights into curricular matters.

In the process of my research, thinking with assemblages became a crucial component. I considered the curriculum as not a separated entity from students' experiences, but rather as intimately entangled in students becoming-with it. The dynamic nature of the multiple entanglements provided connections with new possibilities.

Included in the connections and assemblages was myself as the researcher. I was part of the data-making-process. The analysis emerged from the assemblages within which I was/am immersed which is very different from the neutral distancing approach characteristic of qualitative research where researchers make efforts to "pull back from the data" (Mazzei, 2014, p. 743). In my study, the research components were not separated out as is the case in conventional research. Research, practice, data and theory are not separated linear components of either research or practice but produced through their relationships that are dynamic and flexible (Jackson & Mazzei, 2013). As the researcher, I am not on the outside but also "part of the world in its ongoing intra-activity", immersed in it (Barad, 2007, p. 146).

In order to avoid separations and divisions, the relational connections in my research drew on the Baradian (2007) stance of the ethico-onto-epistemological perspective, as outlined in the previous chapter. All actions result from the entangled intra-actions that are constituted in and through relationships. In this study, ethics is a key component acting with and threaded through the whole process. When data are dissected, sliced and cut into groups or chunks determined by choice and interpretative intentions of human-centred thinking and acting by the researcher, questions of ethics and responsibility may arise and be relevant.

In my post-qualitative approach opportunities became available to be sensitive to affect circulating in through the research intra-actions. Drawings were used as the prime vehicle for generating affective flows. The vitality of the drawing assemblages offered an opening for affective expressions which is an alternative to the more usual dialogue, that can limit affect (Massumi, 2015). Knudson and Stage (2015) point out that developing methodologies for affect research is interesting and inventive, opening up a zone that can "collect material that has previously been perceived as banal or unsophisticated" (p. 3). I suggest that such a viewpoint is relevant for this study as students' experiences of pedagogical practices have tended to be backgrounded and not examined care-fully or closely

In terms of my study findings, I avoided alignment to fixed classifications and structures that suggest determinacy. What emerged from the research intra-actions was what mattered. Indeterminacy is a key element in post-qualitative processes. Moreover, my findings have the potential to be connected in and through other relations to produce new creations.

The text of this dissertation is not closed but continues as an open apparatus moving through iterative changes in relational movements that are continually emerging (see Annexures 8 and 9). The dynamic “research-assemblage” remains open-ended as it “shapes the knowledge it produces according to the particular flows of affect produced by its methodology and methods” thus influencing the outcome (Fox & Alldred, 2015, p. 403). The work of this thesis may continue after moments such as printouts, researcher graduation and other events that could assume closure. The apparatus of this thesis is not closed but rather moves on as dynamic and continually emerging (Adema, 2014). The text reveals a hidden space for more-to-come. According to Barad “the world is materialised differently through different practices” (p. 89).

4.2.4 Research creation

Data collection is perceived very differently in qualitative and post-qualitative research. Traditional data collection (Denzin, 1989; Lincoln & Guba, 1985) follows an anticipated structure which St. Pierre (2013b) contests is problematic as it is in effect textualising a certain interpretation. Koro-Ljungberg and MacLure (2013) asked “If we choose not simply to “interpret,” what else can we do with data; and what does it do to us” (p. 220)? From a relational ontological perspective, data collection is viewed as a process in which agential cuts (Barad, 2007) are enacted. At each point and turn certain viewpoints are captured and others left out as cuts are made, creating boundaries. These enactments result from the entangled intra-actions. In the research process, I needed to “sieve the data, focusing on the flighty, and grasping sometimes miniscule comments, moments and asides that have impact and traction” (Cole, 2013, p. 235).

The emergence of knowledge always separates out or excludes other knowledges (Barad, 2007; Despret, 2015). It is a boundary-making process. For instance, asking students to perform one story as they reflect on their obstetrics experiences or write about one event, means that other encounters remain unrevealed. Rather than understanding this process as an individual choice to act in a certain way, FNM refers to the intensities that emerge to make matters glow (MacLure, 2010, 2013a, 2013b). It is

more than a choice of representing an experience, as the researcher is pulled in by the data too.

In terms of new materialism, even the concept of data is questionable, as noted by Koro-Ljungberg, MacLure and Ulmer (2018) who critically review how the status of 'data' has changed, noting how data "have acquired a kind of agency and dynamism" with moves away from control and containment (p. 463). Through the theoretical framework of FNM, conceptions of data as inert and passive components of research methodologies are inappropriate.

There are suggestions that interviews ought to be considered as intra-views as the relationships include "a set of material-discursive intra-actions" (Peterson, 2014, p. 41). According to Peterson (2014) data could be replaced by the term "creata" as they are not fixed; or even termed "relata" as they are enacted through relationships. Relata emerge through the intra-actions that form part of phenomena within the apparatus of the interview situation. While I respect these terms, I have stayed with conventional naming of data and interviews.

In this study I have not focused on the known, finding common threads to create clear-cut categories with disaggregated data. I have purposefully chosen an alternative pathway to seek out new potentials in/through the dynamic relationships and assemblages that constitute this study. Haraway (2000) claims "[t]here's you, there's me, there's a tape machine, and there's the interaction that is producing the world in this form at this moment rather than some other" (p.25). The in-between space between machines and people has become as important to me as what is said between research participants and myself. FNM provides a means to explore the intra-actions that constitute student learning and the patterns of interference that are constructed in the multiple relationships in student encounters. An analysis through a relational ontology can involve a to-and-fro or zigzagging movement, the "plugging in" of theory with data and data with theory (Jackson & Mazzei, 2013). Through this process I was drawn into the in-between spaces which tend to be the intersecting and disruptive points of difference where certain data "glow" (MacLure, 2010, 2013a, 2013b, 2018). These hotspots emerged as moments that ruptured the research/practice assemblages, aptly explained by Ringrose and Renold (2014) as a "flash [that] resonated with the slow burn of our interest" (p. 776).

4.2.5 Ethical matters matter

Ethics approval for this research project followed the channels linked to traditional humanist practices. The process began with registration and approval by the Department of Physiotherapy at the University of the Western Cape (UWC), followed by ethics approval by the UWC Senate Research Committee and the Human Research Ethics Committee, University of Cape Town (UCT).

All study participants who were interviewed or involved in the FGs in this study provided or gave written informed consent prior to our interactions. This consent was for our conversation to be recorded and possibly quoted, as well as for their drawings to be used as research data. Confidentiality was ensured through using pseudonyms in my writing up of the study. Participants were also assured that in all forms of dissemination, they would not be identified by name, facility or any other identifier. All data was closely controlled and stored in password protected computer files. Digital recordings were removed from the recorder after data transcription.

The UWC Senate Research Committee approved my study (Registration no 14/5/16), followed by approval from the UCT's HSF Human Ethics Research Committee (Reference 280/20140). Further approval and permissions were gained from UCT's Executive Director of the Department of Student Affairs, UCT's Human Resource department to access staff members, and later the Chief Operations Officer of Groote Schuur Hospital. By working through the National Health Research Database, an online portal that provides a repository for health-related research, I received permission (reference no. RP28_931) to gain access to the Midwife Obstetrics Units (MOUs).

Ethical considerations were always prominent in/through this study as ethics became truly embedded in the process. Rather than trying to interpret my data, I allowed new insights to emerge with transformative possibilities. In asking interviewees to draw a summary of our discussion, an opening was created for more insights to emerge. This enmeshed process is valued as ethically and politically powerful and significant. Barad's (2007) concept of ethico-onto-epistemology captures these connections for all knowledge building processes and the importance of this move from separation of issues about behaviours to becoming-with others is identified by Kathrin Thiele (2016) who explains that it:

moves the ethical discourse from one focused on the right conduct (assumed as given), towards one that exposes itself to the real precariousness and ambiguity of each and every of our practice (Exploring Ethico-Onto(epistemo)logy, para 2). Ethics continued to be a vital force in my study. It was threaded through each intra-action. I strived to produce a response-able research project entangled with my teaching. In terms of FNM, this study was not driven by choices that I made and controlled, rather it was through my relationships that new insights emerged. For example, the value and force of using visual methods such as drawings, emerged as an important process in the inquiry. What appeared on papers in drawings in the classroom, acted as a trigger for more drawings to be used and to illustrate how such assemblages can offer new possibilities for examining affective forces influencing students' responses. The agential cuts (Barad, 2007) made in my teaching and research process, (and with the write-up in this text) emerged with/through my intra-actions with others in multiple connections and relations that could not be predetermined. The cuts were determined not by my intentions or choice but emerged through the patterns of interference of forces which then led to further cuts reflected as decisions, such as what was placed in this text and what was left out.

Barad (interview with Kleinman, 2012a) explains that individuals are not determinate or independent, rather that an individual's existence, like my own, is "within phenomena (particular materialised/materialising relations) in their ongoing iteratively intra-active reconfiguring" (p. 34). This notion of indeterminacy places an emphasis on the emergence of relationships rather than stable and foundational stances from which institutional ethical regulations are based. This in/determinacy differs from thinking about static, bounded fixed entities engaging with each other. St. Pierre (1997) points out that "we must learn to live in the middle of things, in the tension of conflict and confusion and possibility; and we must become adept at making do with the messiness of that condition and at finding agency within" (p. 176).

A relational ontology assumes that there are no fixed boundaries, and that certainties can be misleading. There is a reality of the unexpected, and the "always already more than" that St. Pierre (2017) claims is not fulfilled by traditional humanist inquiries (p. 5). A relational ontological approach to ethics concerns the whole entangled research process rather than a separate/d contained aspect of it. The assumption that research ethics can be contained in a prescribed manner is problematic in terms of FNM. Ethics, according

to Massumi (2015) is “about how we inhabit uncertainty, together” (p. 11). It is pragmatic and situational and not about judgements.

Ethical concerns ought to seep into all aspects of the research process through the entwined material-discursive relationships. In this study it became necessary for me to pull together what is generally regarded as separate.

In exploring how students can be rendered capable in their responses to injustices I have taken up a collaborative and generative approach where difference is not viewed as something negative to be judged but can rather offer new possibilities for ethical responses. Drawing on the Deleuzian concept of positive difference, Lenz Taguchi (2012) explains that “difference as positive emerges as an effect of connections and relations within and between different bodies, affecting and being affected by each other” (p. 272).

In terms of thinking around issues of responsibility and justice, accountability for myself and others is enmeshed in the intra-acting entanglements.

what materialises and of what is excluded from materialising – cannot be a straightforward calculation, since it cannot be based on the assumed existence of individual entities that can be added to, subtracted from, or equated with one another. Accountability cannot be reduced to identifying individual causal factors and assigning blame to this or that cause. Indeed, causality is an altogether queer matter. Rather, accountability is an ethico-onto-epistemological commitment to understand how different cuts matter (Barad, 2012c, p. 46).

Barad (2012b) asserts “that our responsibility to questions of social justice have to be thought about in terms of a different kind of causality” (p. 68).

quantum accountability shifts the ethical terrain from the supposedly known responsibilities that ‘we’ have to take up in ‘our’ lives – an ethics of the right conduct and fully based on the (human) subject – to on-going precariously located practices, in which ‘we’ are never categorically separate entities, but differentially implicated in the matters ‘we’ engage with (we are) (Thiele, 2014, p. 207).

Through the relational ontological research process, spaces have opened up revealing new possibilities, moving away from accepted habits of practice. Davies et al. (2013)

suggest that this opening up is “a moment by-moment ethical questioning that asks how things come to matter in the ways they do” (p. 680). In Part 2, I discuss what matters in the students’ curricular engagement in obstetrics.

I propose that this study has rigour because it engages with the dynamic forces of theory and data, allowing each to engage with the other in terms of the complex dynamic forces embedded in the entanglements of theory/data relationships. This process of ruminating on the details, that is emphasised in Barad’s (2014) metaphor of earthworm activity, illustrates the progressive reshaping that occurs through the research process. A strong component of accountability emerges through these iterative, care-ful materialisations of the constitutive elements.

Below I explain the ordered process of my study method. In each section, intra-actions are enacted, However, as Barad (2007, 2012a, 2012b, 2012c, 2014) frequently points out, each of the “[d]ifferent intra-actions iteratively constitute different phenomena, and exclude others” (Barad, interview with Kleinman, 2012a, p. 80). I have been continually conscious of how the methods and analysis used in this study have enacted agential cuts that result in different exclusions of aspects in the apparatuses of student learning. The cuts constitute agential separabilities within phenomena in the study, thus realising certain boundaries and properties. For instance, by foregrounding materiality in the intra-activities of students’ learning experiences, certain human-to-human interactions have been set aside. Barad (2007) claims that:

Accountability to marks on bodies requires an accounting of the apparatuses that enact determinate causal structures, boundaries, properties, and meanings ... Objectivity, then, is about being accountable and responsible to what is real (p.340).

4.3 Part 2: Administrative processes

4.3.1 The research setting and learning context

Students’ clinical encounters are events which are more than happenings or states of being. Drawing on Deleuze’s work, Stagoll (2010) explains an event as “the potential immanent within a particular confluence of forces” (p. 89). Students are learning amidst material-discursive relationships that are multiple and multi-directional. There is “always a swarm of vitalities at play” that are intra-acting when agency is attributed to “things” (Bennett, 2010, p. 32).

Student learning is divided into distinct time slots. For instance, in the clinical years at UCT the curriculum is organised through eight week rotation periods. In 2015 and 2016, Year 4 students in their obstetrics rotation were required to spend five 12 hour night sessions (arranged by the Department of Obstetrics and Gynaecology) in specified birthing units in the Western Cape metropolitan area. These facets of organisation result from long-established relationships and negotiations between all clinical departments and the health system through annual negotiations and policies, such as the multilateral agreement between the Western Cape Government and the University of the Western Cape, UCT, Stellenbosch University, and Cape Peninsula University of Technology. Although my study does not include these systemic structures, they do influence what emerges in practices in the birthing facilities as described by Rucell (2017) in her doctoral thesis describing structural obstetric violence.

The methods section below explains the processes taken to foreground students' experiences in order to explore the forces that render them in/capable of responding to the injustices they witness in obstetrics learning. Anecdotal reports have shown a tendency for students' voices to be hidden, silenced or pathologised which is consistent with the individualistic and deficit model of education that is so prominent, as reflected by the growing emphasis on the need for students to develop resilience and other coping skills to manage the stresses and workload of the profession.

To gain multiple perspectives for this study I included engagement with people connected to UCT student learning such as the educators in the Health Sciences Faculty at UCT and in the health facilities where student placements are arranged. Each person's insight contributed to my understanding of the potential forces that shaped students' engagement with the curricular tasks in obstetrics, and which connected to the wider implications for shifting student learning towards a socially just pedagogy that can respond to the prevailing practices.

Images and image-making became a vital component of this study producing new and unexpected insights. Below are the details of the recruitment of research participants, the sample population of research participants and the data collection process. I describe the setting of the different engagements before moving on to the research findings in the next chapter.

4.3.2 Recruitment of research participants

As described in Chapter Two, there is a growing concern and interest globally in developing respectful maternal care (RMC) with more and more stakeholders becoming involved. While publications, public and social media have reported on the narratives from patients and midwives, little has been heard from students. In order to understand the context of student learning in obstetrics and to problematise the issues that undergraduate medical students face, I initially involved myself in informal conversations with a wide range of people to hear their different perspectives, which included experienced and junior doctors, nurses, individuals working in related non-governmental organisations such as the Perinatal Mental Health Project (PMHP) and the Zoe Project, and students in their senior years of study. These discussions provided a departure point for this study. I later followed up with formal engagements with educators, administrators, midwives and students. Initially, purposive sampling was stated as the intended method for finding study participants, to “achieve representativeness” of the settings and learning activities, and to capture and represent the “range in variation” of different insights and experiences (Maxwell, 2008, p. 232). However, the method of recruitment changed as I recognised the sensitivity of speaking about disrespect in obstetrics and how it places some individuals in a vulnerable position which they may choose to avoid. Therefore, study participants were largely recruited through open invitations and networking, usually through snowball sampling methods. The recruitment thus happened in an unpredictable yet dynamic way, yielding sufficient participants to provide fruitful findings.

The study respondents were largely self-selected. The students who agreed to participate in the focus groups and interviews may have had their own agendas from their personal learning experiences in obstetrics. For instance, they may have been primed to think more deeply than others about abusive practices from our classroom engagement.

Student participants

At the beginning of the project, an invitation to participate in an online survey was sent to senior students. A further invitation was extended to students in classroom interactions, through WhatsApp messaging and through email communication. A class representative in Year 6 (2015) offered to post an invitation on their group Facebook page. However, few students responded.

Educators and administrators

Educators connected with Year 4 teaching at UCT and administrators were sent email invitations. All those who were approached, agreed to take part in the study.

Midwives

Once clearance was obtained to interview midwives in the birthing facilities, communication progressed through email and through the facility networks. For instance, when I visited the two Midwife Obstetric Units (MOUs), I interviewed midwives on duty on that day who were willing to participate in the study. They decided between themselves who would come forward.

Each study participant, whether a student or professor received a shopping gift voucher for R150 as a token of appreciation for their time spent with me. In most instances it was a surprise gift. I was struck by the impact this made on each person. It was generally most welcomed with one group of students even screaming with delight. On one occasion the thank you token was refused as the educator did not feel comfortable accepting it. My explanation was that I chose to share some of my grant money with informants as I did not need to incur costs to reach them. My study was located close to my home and in my own work setting.

Below, Table 4.1 details the dates and details of interviewees and focus group participants, with pseudonyms used in this text. My intention with the table or grid below is to offer the reader clear details regarding my interviews and FG interactions.

Timing	Participants	Detail
Educators 2014, 2015 and 2016	13 Doctors + 2 administrative assistants 4 Midwives connected with the Dept O&G	Connected to UCT Dept O&G These connections involve teaching, supervising and organising where the individuals take on a varying degree of levels of responsibility in student learning
Students 2015 14th August 4th September 11th September	22 UCT medical students in FGs Year 6: 7 students - FG 1 Year 4: 9 students - FG 2 Year 4: 6 students - FG 3	
Students 2015 x 2 Student 2016		2 individual interviews 1 individual interview
Midwives in birthing facilities 2016	9 midwives Facility 1 Facility 2 Facility 3 Perinatal Mental Health Project	MOU 1: 3 midwives Secondary hospital: 3 midwives MOU 3: 3 midwives Midwife educator
Volunteers	3 2 qualified nurses 1 retired midwife	volunteering for the Zoe Project, a non-governmental organisation that assists MOU 1. volunteering as a Doula and invited guest at my workshops
Clinical Psychologist	1 Arranged meeting	

Table 4.1: Process details

Pseudonyms are used for the interviewees who came forward to engage with this study. Interviews and focus groups took place between 15th January 2015 and 20th May 2016.

4.3.2 Unfolding of the research process

Information sheets and a list of guiding questions (Annexure 2 and 5) were given to each study participant either during initial discussions before the day we met or at the start of our engagement. Ethics consent forms (Annexure 3) were read and signed by each participant before beginning and recording the conversations.

Interviews and FG were recorded and then later transcribed. For every engagement with participants the Information sheets, list of guide questions, ethics consent forms were made available if they wished to refer back to them. An A0 sheet of blank paper, a box of pastels, marker pens in blue, black, red and green and a shopping voucher were also provided.

Interviews were conducted in private spaces, usually in a student workroom or an office. Privacy is important for eliciting beliefs and feelings and for addressing sensitive topics, where contradictions are likely to shape individual's experiences (Mack, Woodsong, MacQueen, Guest & Namey, 2005). Focus groups were held in the departmental museum on September 4th and then on September 11, 2015 and in a student tutorial room on August 14, 2015. Time taken for the interviews and FGs varied. The interviews ranged from 20-80 mins, with FGs taking 40-80 mins. The time spent by participants to draw an image also varied widely ranging from one minute by an educator to approximately 15 minutes by a student.

4.3.2.1 Drawings

Alternative research modalities and pedagogical practices that include physical movements, like drawing, are on the increase, and emerge in different ways. For instance, drawings were used in the digital story workshop led by Brushwood Rose and Low (2014) who noted how their research participant, Amria, "made the unusual choice to hand draw" her images for her story, and through these drawings was able to express herself and reach an emotional depth about her postpartum depression which would have otherwise been obscured through her more controlled spoken narrative (p. 35). There is an implication of logical reasoning by Amrita, which through the lens of FNM, can be explained by the agential force of the drawing apparatus.

Drawings are increasingly valued in qualitative research as an alternative communication medium that enables participants to explore their own experiences beyond the confines of text and language (Rohleder & Thesen, 2012; Reavey & Johnson, 2008; McLean, Henson & Hiles, 2003). Drawings open up a different way of thinking, resulting in stories emerging with an unexpected intensity. Cousins (2009) suggests that "picture elicitation" can introduce information on students' perceived relationships, symbolising patterns of meaning-making (p. 222). The "living stories" can "cast a light" on the micropolitics of organisational problems "thus revealing new

possibilities” for teaching and research, according to Jorgensen and Strand (2014, p. 63).

Although unusual in the health sciences, as a form of communication, the use of images and visual communication is growing, with research around data-in-the-making becoming widely appreciated (Holbrook & Porchier, 2014; Clark, 2012; Springgay & Zaliwska, 2015). In a publication of the *Journal of American Medical Association*, a seven-year old’s drawing (Figure 4.1) provided a feedback tool to highlight the distracting impact of electronic medical records (Toll, 2012, p. 2497). The image highlights the force of technology in pulling in the doctor’s attention to comply with data capturing requirements, limiting his attentiveness and care to the patient and her family which resonates with the circumstances in some birthing units where students learn. It is described as “a stunning piece of feedback—not surprisingly out of the crayon of a babe” (p. 2498).

The Cost of Technology



Figure 4.1: The force of electronic record keeping reducing the doctor’s capacity

In my study, the timing of drawings was different for individual interviews and FGs. At the start of each interview I explained the process mentioning the possibility of a drawing at the end of our discussion. I explained that the drawing could be a way of summarising our conversation or pointing out something special that the interviewee would like to emphasise. In the student FGs the drawings were used at the start of the sessions, acting as an icebreaker. Although the students knew each other, being in the same class or friends in the faculty, the drawings acted to energise the groups as well as providing a creative space for each student in the group to have a voice from the start. Students

were given the option of using their drawings previously created in our classroom workshop and adding new elements to them, or to create fresh drawings about their experience in obstetrics on the A0 sheets of paper available at the time of the FG. Because drawing can be quite intimidating for some, I stressed that the process was more important than the product and explained that the drawings were being used as a different mode of communication to our conversations.

After we had completed our conversations, a photograph was taken of the images created by the research participants. After the FGs I created a collage of the collection of drawings from that group. These collective collages overlaid with a thank-you text were sent to the FG participants with the intention for them to have an artefact as a memory of the shared experiences. My intention was to share my appreciation openly, enabling the visual data to be put to work in multiple ways that could affirm students' experiences in their obstetrics learning events.

4.3.2.1.1 Why include drawings?

There were three factors that motivated this mode of inquiry. Firstly, my personal preference for using visual tools in teaching and learning, encouraged by the positive feedback received from students over the past ten years. Secondly, the success and impact of the use of drawings as Participatory Learning and Action (PLA) techniques in an interdisciplinary, inter-institutional study among Psychology and Social work students at two differently positioned local universities, in which drawings became tools for data-in-the-making (Bozalek, Carolissen, Leibowitz, Nicholls, Rohleder & Swartz, 2010). The descriptions of the drawings illuminated hidden insights and moved me, inspiring me to experiment with arts-based research. Rohleder and Thesen (2012) pointed out how visual communication in this project provided "a medium of communication in which most students could participate as equals" (p. 87) -- a motivating factor for my study too. Research participants are positioned with the possibility of becoming-with the paper and drawing tools. Drawings can "act as a catalyst for different ways of thinking and knowing" (Bozalek & Biersteker, 2010, p. 553).

Thirdly, I was moved by a creative need to try a different mode of communication that could bring imagination into my teaching and research, and could extend the potential of drawings beyond a representational perspective as was the usual practice in my institutional environment. I felt a sense of frustration and agitation with representative modes of interpretation. When drawings as products are interpreted as representing

meanings, this meaning-making can distort reality. For instance, in Kress and Van Leeuwen's (1996) "grammar of images", based on Halliday's (1985) systemic functional grammar, elements of a conceptual composition are examined in terms of their spacing and symbolic meanings. These interpreting tools are integral components of social semiotics, a social process of meaning-making through detailed examination and interpretation and analysis of images in terms of what they represent. The specific categories in these analytical frameworks draw meaning from the signs represented in the visual communications. While apparently useful and productive in the field of multimodality³⁰, I felt constrained by the human-centred interpretative perspective. Bennett's (2010) concept of "thing power" offered an alternative by considering the agency of the drawings and the emerging assemblages.

Although not often used in pedagogical approaches in medical education, the value of understanding visual communication is gaining interest. For instance, Rachel Weiss (2017) in her doctoral study entitled, *Patient-centred communication and patient education: a multimodal social semiotic approach* analysed the representational messaging of the Pharmacology (also now known as Therapeutics) textbooks used as knowledge resources for students at the University of Cape Town. Weiss and Archer (2014) noted how the visual representations of different messages and meaning-making contribute, contest or undermine students' developing knowledges and notions of truth, citing Luke (1996, p. 308) who claims that medical education is "a battleground for a politics of representation" (p. 129).

4.3.2.2 Student focus groups and interviews

Student FGs were used for eliciting opinions and norms where the group dynamics could facilitate the conversations and the sharing of information (Mack et al., 2005). The recruitment of senior students began in 2015 when students in their 5th and 6th year were invited to an interview or a FG in the online survey. Despite there being 10 students who responded in the survey indicating their willingness to volunteer for an interview or FG, when contacted only two responded affirmatively. However, through a snowballing process one student introduced four peers. This led to a FG with seven Year 6 students in August 2014.

³⁰ Multimodality is an "eclectic approach" that is "primarily informed by linguistic theories"; It assumes that "meanings are made (as well as distributed, interpreted and remade) through many representations and communicational resources (Jewitt, 2008a, p. 246)

In September 2015 there were FGs for year 4 students on two separate dates initiated from requests in the classroom and through WhatsApp. Again, snowballing by an enthusiastic student brought in the bulk of participants. Participation was voluntary, with each participant signing a confidentiality binding form and informed consent (Annexure 3) after reading the information sheets (Annexure 2) and viewing the questions (Annexure 5) that would guide the group discussions. Ground rules that included a trusting relationship of confidentiality were acknowledged.

There were three students who participated in one-on-one interviews. One final year student connected with me over email and agreed to an interview rather than FG. This student had been in my small group in her first year course, *Becoming a Professional*, where we had established a comfortable relationship with each other. Her insightful thinking had been striking, as was her special interest in art which she had willingly shared with her group members. The second student had hoped to join his colleagues at the fourth-year FG but was unable to make it on the day. The third student was in his fifth-year and volunteered to be my tutor assistant in several of the introductory sessions with later fourth-year students. He continued to assist me in the computer lab where he willingly shared his experiences with the students new to obstetrics. He agreed and was keen to be interviewed for this study.

Students as participants

Classroom and online engagement with Year 4 students' personal anecdotes was the initial trigger that activated this research project and continued to inform it. My own relationships with students' experiences and their personal narratives in the birthing facilities developed through classroom roleplays, storytelling, poetry, video recordings of their own discussions and PowerPoint presentations as well as through the reflective commentaries based on the Six Step Spiral for Critical Reflection (Mitchell, 2017). More student narratives were elicited in the student FGs and individual interviews. These were recorded and transcribed providing additional evidence for a small sample of student experiences.

4.3.2.3 Setting

The student FGs were held in the Dept O&G's museum room (Figure 4.2) on the H Floor of the Groote Schuur Old Main Building (a familiar room for the students where they often receive lectures and have workshops) and in a room in the New Learning Centre at

UCT Health Sciences' campus where small group learning happens in the pre-clinical years.



Figure 4.2: Table with forms for each FG participant in departmental museum room

Ongoing engagement with Year 4 students online and in the classroom

Students' personal stories developed agency, becoming entangled in student learning. Stories were shared in online reflective commentaries, classroom presentations/performances and workshop feedback notes. Events described in the stories became amplified with the sharing, contrasting with a closed process as represented when student reflections stay between student and educator, whether that occurs through hard copy hand-ins or uploading on a one-way delivery system on the institutional Learning Management System. Open sharing contributed a force that influenced this inquiry into developing a socially just pedagogy for obstetrics learning.

4.3.2.4 Educators: clinicians, administrators and midwives

Below in Tables 4.2 and 4.3, I note the number of research participants and gender binaries because behaviours related to gender preferences did become part of the research discussions.

Position Dept O&G, UCT	No of participants	Gender
Professors, retired clinicians, clinicians and medical officer	13	5M + 8F
Lecturers - Midwives	4	1M + 3F

Administrators	2	2F
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Table 4.2: Research participants working in Dept O&G at UCT

Positioning in curricular level	No of participants	Gender
FG 1 Year 6	7	7F
FG 2 Year 4	9	1M + 8F
FG 3 Year 4	6	6F
Individual interviews Year 4: 2 students Year 6: 1 student	3	2M + 1F

Table 4.3: Student research participants

Clinician educators

My initial intention was to engage with clinician educators in FGs. However, this was not a feasible option due to their workload and commitments that were spread out in various locations. Therefore, all educators were interviewed in one-on-one interactions.

I began my data collection with educators in the Dept O&G where my own teaching took place. Invitations were extended to staff who in 2015 and 2016 worked with Year 4 students or had experience in the past. The breakdown is indicated in Table 3 above. From January - May in 2015 the majority of the educators were interviewed. However, in March and April 2016, two more were included in the study. The decision to include more educators was made after I overheard one of the study participants explaining that the students' experiences were all fine, just after I had facilitated an unnerving workshop with this same student group. The other educator became a colleague on the Faculty Professional Standards Committee. She engages with students on perinatal mental health issues and the well-being of students themselves and midwives in particular MOUs.

Administrators

One of the educators who was interviewed alerted me to the important role that administrators play in student learning. Through the years I developed a close relationship with these administrators who were keen to add their contribution to my

study. In the privacy of their own offices, I interviewed the two individuals who worked full time in the Dept O&G engaging with the students either in their fourth-year or beyond.

Midwives

In my proposal I planned to facilitate FGs with the midwives. However, as my study progressed I realised that this would be difficult to arrange in under-resourced facilities and, like the doctors, I did not wish to add to the burden of their demanding work. Furthermore, the format of a focus group could have hindered what was said by midwives who may have feared exposing themselves to an outsider or possibly putting themselves into a situation that could lead to victimisation by colleagues for exposing unprofessional practices.

My negotiations to connect with midwives working in the birthing facilities was not straightforward. The regulatory framework and hierarchical culture of the health system and fragile relationships made it difficult to get access. I first approached the MOU that displayed an openness to engage. The midwife team leader agreed to meet with me. After my interview with her in her office, another midwife came through and then another - an unexpected snowballing in recruitment following the pattern of the student recruitment. This MOU is located in an impoverished area on the southern part of the Cape Flats. In the second facility the Head of the Obstetrics unit gave me permission to visit and to interview midwives there. This doctor in charge facilitated the process by introducing me to the matron who then led me to colleagues, including those on night call, recognising the value of meeting the midwives who interact with the medical students who are scheduled to do their deliveries in the night to allow midwifery students to take deliveries during the day time. Again, this snowballing recruitment was helpful although I wondered who was being left out. Perhaps I was not connecting with midwives who have been problematic? At the third birthing facility, meeting with midwives was more problematic as the operational manager would not allow me access to the staff without reference to a Research Database number. Once access was gained, I interviewed the operations manager, who is a midwife herself. She then invited others on duty that day. Again, recruitment through snowballing proved effective.

4.3.3 Limitations and contestations

In the initial online survey, I clumped together abuse, neglect and disrespect into a single category represented by the acronym ANAD, despite each reflecting very different

behaviours. Such a grouping could have been misleading for some students who then had to draw on their own interpretations. Despite "abuse" having a legal definition, I called on students to consider abuse as a more general term for disrespectful behaviours. Similar difficulties with definitions of abuse in childbirth for research studies were noted by Sando et al. (2017).

This research could be considered risky. It was experimental and creative, aiming to unearth previously invisible aspects of student learning through innovative processes that gave recognition to the movements and connections of different bodies. It led to the emergence of new insights in terms of students' response-abilities. Haraway's (2016) concept of composting (described in Chapter One) seems to aptly portray the production and generative intra-activities.

How can I use posthumanism for a research topic that is so human? This was a question posed to me by a colleague probing the relevance of post-qualitative research in this study. I myself felt conflicted. However, it also gave me impetus to search how FNM could possibly make a difference in a field that was wrought with conflict. Could a relational ontology offer new insights into students' responsibilities by de-centring the human and acknowledging the agency of the material components in the assemblages of student learning?

4.4 Conclusion

In this chapter I have described how post-qualitative inquiry provided an appropriate avenue for my research into students' learning in obstetrics amidst a context struggling with disrespect. I wished to use an alternative approach to illuminate curricular matters in terms of what matters to students in their obstetrics rotation and how they respond to in/justices they witness. This study is unlike the usual scientific discourse in medicine and traditional qualitative research that traverses conventional boundaries and binaries. It was set up to elicit novel insights that could provide an alternative and productive contribution to student learning. I have taken an affirmative, non-judgemental stance avoiding the possibility that criticality can be reductive and unhelpful.

In the first section I explained a post-qualitative approach in terms of its non-representative and experimental attributions. It avoids judgements and moves away from hierarchical categorisation such as coding. In the second section I described the

processes undertaken in this study that began with an online survey, leading into interviews with educators, administrators, students and midwives, and FGs with three sets of students. Drawings that developed in and through these interventions were carried over into my teaching practice with the fourth-year medical student classes, as a pedagogical tool. The power and value of the art-in-the-making emerged more and more through the research process, leading me into new openings and potentials for developing socially just pedagogies that can focus on student response-abilities. Before concluding I noted challenges and limitations to this study's methodological approach. In the following two chapters, different aspects of my findings will be illuminated.



CHAPTER 5 - FINDINGS: WHAT MATTERS IN CURRICULAR ARRANGEMENTS

5.1 Introduction

Ontological indeterminacy, a radical openness, an infinity of possibilities, is at the core of mattering ... Matter in its iterative materialization is a dynamic play of in/determinacy. Matter is never a settled matter. It is always already radically open (Barad, 2012d, p. 214).

Chapter Four explained how post-qualitative research seeks to explore the enactments that emerge from my research project's intra-actions. Agential cuts are created that highlight certain moments and relationships and exclude others. In this and the following two chapters I report on my findings through the lens of theory to understand them as I explore my main research question, which asks, what forces render students in/capable in their responses to injustices they may witness in obstetrics? Each of these chapters focuses on a sub-question related to students' response-abilities. Inherent to this study is the complexity of pedagogical practices in clinical settings which are amplified in the overburdened and struggling South African health system. Medical training, especially in obstetrics (where the lives of both mother and baby are at risk), is immersed in the tensions and forces that play out in each clinical encounter.

In this chapter I refer to the context of learning in obstetrics and related challenges as described by several research participants. I put forward the range of emotions expressed by students as they enter their obstetrics curricular rotation then follow up by asking what the force of the obstetrics curriculum is doing with/to students. My study explores the troubling events witnessed by students. I then move on to examine what matters for students as they traverse the obstetrics curriculum and how different forces act on/with students that appear to undermine their ability to respond to the unjust practices they observe. These forces include the human and more-than-human relationships generated in/through the students' learning encounters. By drawing on the theoretical insights in a relational ontology, I acknowledge that students' learning experiences are co-constituted through multiple forces that determine what matters in/through their engagement and entanglement with their curricular tasks.

The medical curriculum immerses students in divisions and separations with consequent distancing. I refer to the separation of different disciplinary needs, such as between

nurses and doctors), general boundary-making processes and binaries, and then describe how time matters beyond the divisions in time. These are a few of the many enactments in student learning in obstetrics where traditional positivist practices prevail. In this chapter I expand on these notions with examples in order to propose that a relational ontology may offer new and different insights. My research survey, conversations in interviews and FGs, as well as the drawings conducted in this project, and classroom and online communications have contributed insights that generated data that glowed (MacLure, 2010, 2013a, 2013b). These encounters are described in this chapter and those that follow.

5.2 Students' becoming-with curriculum

When students enter into their obstetrics rotation they have a compulsory introductory week. Included in this period is a class session in the computer lab where I facilitate discussion about health and human rights in obstetrics. Over three years I created word clouds³¹ comprised of three words put forward by students to describe how they feel about going into obstetrics. Figure 5.1 shows a sum of the word clouds made up from 575 student entries in 2015, 2016 and 2017.



³¹ A word cloud is a collection of words where the font size represents the frequency of responses.

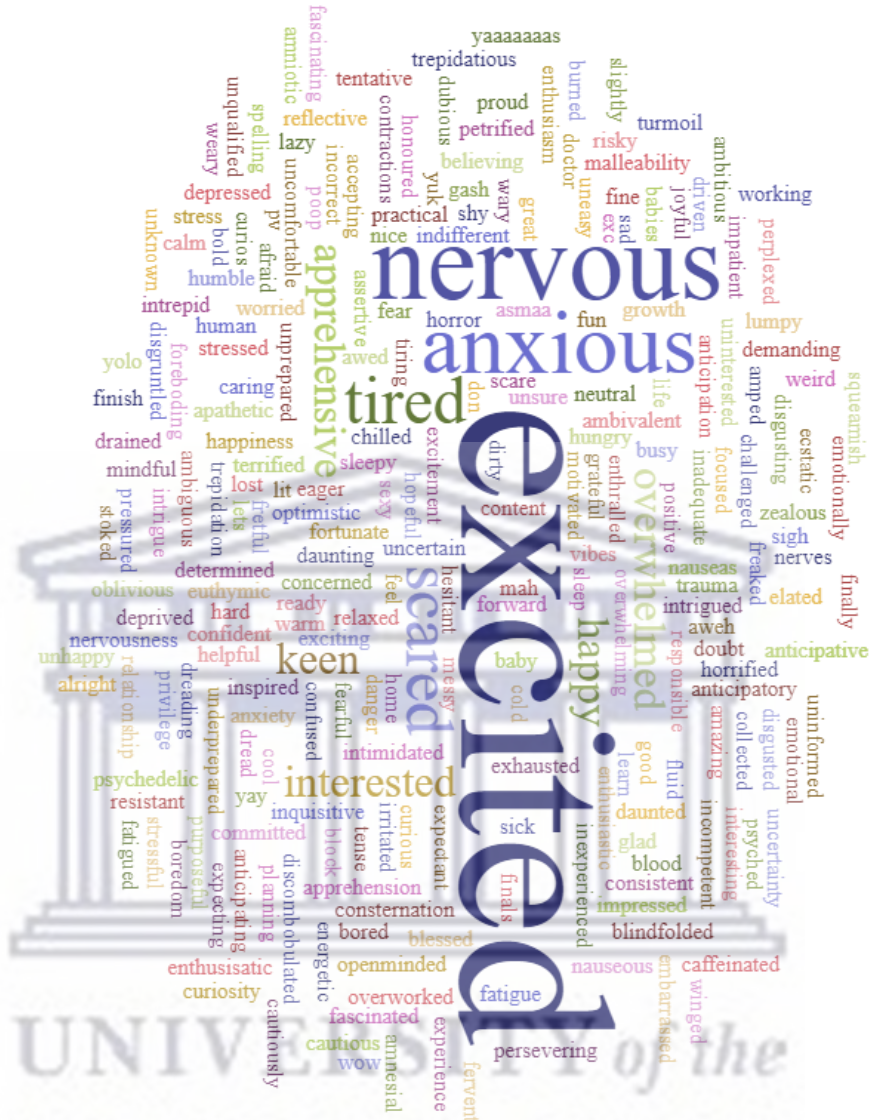


Figure 5.1: Students' feelings about entering into clinical obstetrics

Excitement is always prioritised, with nervousness as the second most common response. Obstetrics is known to be one of the most exciting parts of the medical undergraduate curriculum when students begin to feel like real doctors and take part in the responsibility for two lives moving into a different state of being and becoming. The positive emotions are entwined with intense nervousness, fear and trepidation, with some students even admitting to being terrified and overwhelmed at the prospect of the collective responsibility to safely bring a new life into the world.

Once moving into the birthing units during the obstetrics rotation, there follows a rollercoaster of emotional experiences as students become immersed in their curricular needs and the reality of practice. Understandably, each student's journey varies according to the different forces that play out in their birthing events and curricular tasks. Their reflective commentaries at the end of the rotation provide a unique glimpse of their experiences and responses to practices they witness. By far the majority of these reflections (which fall under the topic of health and human rights) report on disrespectful practices that have moved students yet also left many of them numb, helpless, and unable to respond. Few students report on their joyful moments.

5.3 Immersion into practical obstetrics

Obstetrics is a particularly challenging discipline in medical training, as outlined in Chapter Two because, as clinician Tim explained, the tensions and stresses are amplified:

We're in a very difficult speciality, I think our work environment is a very stressed environment, and I think people deal with stress differently in our country, in our situation – unfortunately I think people deal with a stressful situation in an aggressive way and respond aggressively. Not everyone but I think a huge proportion of our population do when stressed. And I think that that doesn't excuse it but I think it does explain to some extent how people respond. And it's unfortunate – the solution to it is not an easy task (interview, 2016)

Tim suggests that aggressive ways of responding to the stresses in obstetrics are part of the pattern of behaviour reflected in South African society that is dealing with the legacy of an oppressive regime. When students enter into their obstetrics training, they experience a shock of reality as midwife Gabriel shared:

you can see that the shock on their faces that this is not what they expected, they didn't know the violence in it, the screaming, the fear, the drama. It's just you can sometimes see that they're shell-shocked that they didn't expect that this is how birth, what birth is about (interview, Facility 3, 2016).

However, contributing to these practices is “a full and writhing can of ethical worms beneath clinical decision-making in maternity care” influenced a great deal by the power relationships (Newnham & Kirkham, 2019, p. 7).

5.3.1 What students find

Students walk into the birthing units to face the unexpected. Although stress is an integral component of medicine, students do not anticipate being confronted with aggressive behaviours, neglect and abuse to women in labour despite the topic discussions and cautions offered to them in their introductory sessions. In this study I suggest that students' exposure and entrapment to the prevailing poor behaviours that they witness has vast consequences.

In my initial online survey, an anonymous student noted with disappointment that obstetrics was not as expected:

Very disappointed that it had to be that way. Of the 18 deliveries I did, only one was happy where both the parents thanked all the staff and looked like they really wanted the baby and were excited for it. The rest were all just going through the motions without being happy. It was very weird. No one wanted to be there, not the students, nor the nurses, nor the parents.

Below is an excerpt from a student's reflective commentary written at the end of her obstetrics rotation and accompanied by a series of drawings (Figure 5.2). The text was written in the third person and epitomises the birthing facility setting and the impact it had on the student:

Our student is shocked to the core. The patient's screams prove to be too much to handle, and she can't help but look away for a few seconds. She feels useless as she is frozen in place and can't even move to the patient's side to offer her any form of support. She is angry at the events that are unfolding before her, angry that the nurses have shown such little empathy and remorse for the pain that they caused the patient, and angry at herself for doing nothing (Year 4 student, Block 5, 2016).



Figure 5.2: Illustrations drawn by Year 4 student (2016: Block 5)

Reflecting on “doing nothing” was a frequent response by students. This particular student was keen to share her insights, even willing to be named to bring awareness to this situation (Mitchell, 2016). Both her text and her sketches reflect her own shock and disbelief which is shared by other students as they find themselves in the troubled and troubling context. Students are immersed in a complex set of relationships that appear to disempower them, as indicated by this student’s helplessness, and further elaborated on by others.

Student Lesego³² (2015) captured her dilemmas in her reflective commentary noting:

I felt like I was in a butchery. I remember the look in that girl's face. Her eyes full of so much fear and tears. I felt helpless I wanted to say STOP. But who am I and who was I? I'm just a student and I'm at the bottom of the chain. I was so angry, so bitter and emotional at the same time. I felt that I failed myself and the patient. I should have done something. I believe in standing up for those who are weak, but that day I failed. I didn't stand up for that little girl. I felt the need to sit down with her family explain to them what had happened, I wanted to inform them about their rights. I wanted to see that doctor pay. If it meant being sued then so be it. I guess that was just because of the anger and frustration. It has been 3 weeks and I'm still angry and hurt but I'm healing. Healing takes time, but the scar always remains. At times I wish I had not witnessed everything that happened that day. I wish I was on the other side of the curtain. I think about that girl and what she went through every day (student, Block 3, 2015).

³² Pseudonym given to individual student in FG (2015). She was particularly vocal and had an intensive shift in reflecting on her shocking experience.

The “scar” of such events stays with students leading to many questions and ethical considerations. Such learning encounters do not fit into the neat compartmentalising that the curriculum is intended to provide for students’ learning. There is no clear line to assist students to evaluate what is acceptable in terms of professional practice or not. In an evidence-based culture it is often difficult to put forward an immoral claim despite a felt sense of wrongness. For instance, when students witnessed behaviour that was clearly unfair they were horrified yet did not respond.

Descriptions of the midwives in just one FG (Year 6 students, 2015) included comments such as “honestly just horrible to the patient”, “a very mean sister”, “absolutely horrendous”. In FG 3, one of the Year 4 students said, “I’m just trying to imagine what a third year would say [laughter] if they ... just realise you’re going to be treated like utterly dog food”. Laughter was noted in this conversation, perhaps a light-hearted expression and way of dealing with the students’ earlier difficulties. Abusive actions are not limited to midwives as doctors at all levels have also been reported for their disrespectful behaviours, even leading to disciplinary responses through active engagement by the departmental head and others in positions of authority.

Students’ experiences were shared through the research process as well as through ongoing classroom presentations and reflective commentaries. Below, I describe the specific case of the pervasive action of disrespectful vaginal examinations³³ (PVs) then report on a further five examples (Table 5.1) of poor practices that were frequently presented by students as scenarios that they roleplayed for their peers and opened for class and research discussions. These events illustrate moments that mattered to students.

Vaginal examinations were frequently observed to be performed with force, without information or consent, care, concern or respect. A student spoke about the action of a midwife saying, “she was throwing PVs, just shooting in” (student, FG 2). Another student recalled:

I even remember this one incident; I wrote about it in my reflection task where this doctor was coming to do a PV on a patient. She just came in and she didn’t greet the patient, didn’t greet me ... and she looked at the patient’s folder, she

³³ A PV is a routine procedure in the birthing process where the midwife would have inserted her gloved finger into the woman’s vagina to measure the dilation of the cervix that gives an indication of the progress of labour.

opened it and then she put on sterile gloves and she was just like, 'Open your legs.' And then the patient was like, 'What?' She said [matter of fact and irritated] 'Open your legs.' So the patient opens her legs and then she goes on to perform the most like violent PV I've ever seen ever (student, FG 3).

From their study in Brazil, Jardim and Modena (2018) point out how repetitive and aggressive acts of vaginal examinations are pervasive. Their findings indicate that 10% of women in their study "suffered painful vaginal examinations" (p. 8). Perhaps these acts of physical violence reflect the "invisibility of birthing mothers" who are marginalised with the higher needs of the healthcare team and neonate (de Vries, 2017, p. 216)

Even the teaching and learning about PVs appeared to raise students' concern for respectful patient care. For instance, in one of my early student workshops in 2010, students reported and roleplayed their experience of a clinician's effort to teach at the expense of respecting the dignity of the woman in labour. A student recorded his colleagues' roleplay and another (Chapman, 2010) uploaded it on YouTube under the classification of Comedy, titled "Sisi...you've killed your baby!". This student roleplay demonstrates the relationships of disrespect provoked by the stream of students repeating the same examination on the woman in labour, indicating their collective sense of helplessness. While the students observe these kinds of shocking practices, even the necessity to perform a PV is questionable. Newnham and Kirkham (2019) suggest that midwives tend to go with "the flow" of the institutional needs and policy practices that have a bias towards medical safety.

In Table 5.1, below I point out particular disrespectful practices and include a column that refers to the recent publication by the International Childbirth Initiative (ICI) (2018) which provides steps as guidelines for routine practices that ought to be avoided or that contradict universal intentions to promote respectful, quality care to all women in labour.

Scenarios roleplayed by students in class workshops, acting out and enacting their own clinical encounters for their class peers	Quotes from research study	ICI Steps ³⁴ that relate to these events
Fundal pressure, also known as Kristeller maneuver is a harmful procedure (Malvasi et al. (2018) yet the practice continues to be used	<i>The sisters were shouting at her and then one of the sisters ended up ... putting fundal pressure using her elbow ... And she kept doing it ... I could see that it wasn't helping <u>at all</u> (student Bongani 2016)</i>	Step 7: Harmful practices to avoid
Analgesics are withheld	<i>At X MOU no one got any form of pain management in labour, there wasn't even entonox; they didn't give morphine to anybody, or pethadine. ... we asked them if we can please give the patient morphine because she was already screaming and in agony and she was only 4 cm dilated which means she's going to be screaming for a long time still and the nurses were just like, no, we don't give morphine here... she said, we do have it but we only give it to very special patients, like those particular patients (student, FG 3).</i>	Step 5: Provide pain relief measures
Students observe the horror of inappropriate blaming and shaming, watch and endure power struggles between health team members, women in labour and themselves	<i>The baby fell in her pants and she's like looking at the baby in pants ... at least she was fine and the baby was fine so it's okay at the end. What was not fine is that they blamed the woman for giving birth in the bathroom; she didn't do it on purpose (student, FG 3).</i>	Step 1: Provide respect, dignity and informed choice

³⁴ ICI have published 12 Steps to guide Safe and Respectful MotherBaby-Family Maternity Care

Scenarios roleplayed by students in class workshops, acting out and enacting their own clinical encounters for their class peers	Quotes from research study	ICI Steps ³⁵ that relate to these events
Observe the impact of multiple forces undermining women in labour such as a lack of information which negates opportunities for informed consent	<i>An 18 year old girl came in late. She had no transport. She hadn't booked. She had nothing explained to her at all. It was the first admission. You don't listen. Open your legs. This sister comes and does a PV. She says you opened your legs before (student, FG 2).</i>	Step 1: Provide respect, dignity and informed choice Step 7 Harmful practices to avoid: Frequent or repetitive vaginal examinations
Discrimination and harmful treatment against certain groups of women such as adolescents, foreigners and unbooked mothers	<i>Sometimes when a woman comes in, like for example if she's unbooked or if she hasn't attended an antenatal visit in a while, or, ja, there's some other situations I can't think about now, where the sisters, some just say, oh no, I'm not going to help you – which is an obvious violation of that right to healthcare and access to healthcare and things like that (student FG 2).</i>	Step 1: Provide respect, dignity and informed choice

Table 5.1: Typical students' experiences with related quotes

Students have referred to moments such as those described above as encounters that shocked them and left them powerless in their incapacity to respond to injustices they witnessed. Many students expressed a sense of shame at what appears to be their innocent complicity. Students were astute to notice how poor practices continue, a status quo that has become acceptable and that exacerbates their sense of helplessness and frustration. In FG 2, a 4th year student said “I get really frustrated because nothing is ever done really; the same behaviour, the same thing”, and reinforced by a final year student (FG 1) sharing her concern that “this kind of behaviour in our labour wards just becomes repeated and repeated and repeated to the point where it becomes the norm”.

³⁵ ICI have published 12 Steps to guide Safe and Respectful MotherBaby-Family Maternity Care

The establishment of such norms as acceptable behaviours appear to be partly attributable to the health facility arrangements where institutional needs override those of women in labour. The ongoing difficulties faced by students mirror those of other health team members enabling disrespect to continue despite numerous attempts to halt it through local codes of practice, institutional policies and international guidelines as outlined in Chapter Two. In the Western Cape, the good intentions by people in leadership positions to develop “zero tolerance” of unprofessional practices have reportedly not had much impact (Clinician Doreen, interview 2015). The students’ pervasive experiences witnessing multiple instances of disrespect demonstrate how poor practices continue and are actually exacerbated by structural systems and the medical culture (Rucell, 2017). For instance, the hierarchical medical culture and the prioritising value given to competence and measurable outcomes undermines efforts to promote social justice and quality of care. Doreen admitted, “these midwives who are some of the cruel ones, are often very good (in terms of their skills) ... They know how to bring out a live baby, but in a dreadful way”.

Doreen further explained

I think also we as managers and leaders have to understand the multiple levels of complexity of the health system and of humanity and human beings and how we treat each other and in a country like ours with our racial history, our gender history, the fact that we’re a violent society, in fact a lot of nurses live in [suburbX] in fear of their lives every day. So we live in that; but even so I think if one is consistent in saying zero tolerance, this is not okay.

Like the nurses, many students also live and commute through unsafe areas. The level of violence in South Africa is extreme and has become an endemic problem with widespread implications. While such local issues exacerbate the disrespect in obstetrics, it must be noted that obstetric violence has reached the level of becoming a global epidemic (Miller & Lalonde, 2015) that has been allowed to be legitimised and trivialised in daily routines in many countries (Jardim & Modena, 2018). What is significant to this study are the emerging relationships between human and the more-than-human forces and how these intersecting relationships constrain and enable students’ responses, and those around them.

5.3.2 Limited responses with the “untouchables”

The unwillingness and incapacity to respond to unjust practices is experienced by women in labour, midwives, doctors and students. For many, giving birth is a mechanical and technical process, aligned to the biomedical approach in medicine, which has little regard for relationships. Obstetrics outcomes focus on the safety of mothers and newborns reflected in the facilities’ maternal and neonatal mortality and morbidity figures. Such measurements seem to reduce the subjective and personal experience of birth to a quantitative measure of death. The process of labour evokes fears that seem sidelined against the mechanics of a successful delivery. The fears and tensions seem to actually provoke the multiplicity of poor practices, as well as incapacitating affirmative responses by women in labour, healthcare colleagues and students. Midwife Gabriel explained how the tensions build up:

I think it’s the midwife’s fear that’s showing, her panic comes out in that way. It shouldn’t be but thinking of how this baby is going to come out – we learn the theory, it’s now an hour, she shouldn’t push past an hour, so now you start panicking, it’s now an hour and things are not going well, baby’s going to turn out with HIE³⁶, – so I think all of that goes through your brain and it spills out like that. And I think that moment when the midwife sort of loses control over the situation – like I said, it’s not going as planned, should be; the time is now moving into a dangerous area where you’ve been taught, okay, it shouldn’t go past this or you’ll hear the foetal heart is decelerating. Your heartbeat goes up as that heartbeat goes down – so that is what spills out and you lose sort of control of the situation; now you and the mother is not understanding each other now, she is also panicking, you’re panicking – and when you lose control then all that [indistinct]. The thing is it all starts with fear (interview, Facility 3, 2016).

The quote above emphasises how fear leads to a level of incapacity. The force and intensity, expressed as panic, negatively affects both the woman in labour and the midwife. In some facilities, the inclusion of doulas³⁷ is encouraged to help avert such fear. In my interview with Joan (2015), who practised as a doula and midwife, she expressed the need for supportive care in the birthing process, adding “what we want is calm and peace”, explaining that a woman in labour “needs to be loved, not hated, not

³⁶ HIE is the acronym for Hypoxic Ischemic Encephalopathy.

³⁷ A doula is a “trained professional who provides continuous physical, emotional and informational support to a mother before, during and shortly after childbirth to help her achieve the healthiest, most satisfying experience possible” (Independent Midwife Professionals Association of Cape Town, 2015).

hit, not bitten, not have her legs apart and all these terrible things we hear about”. Only a few medical students get opportunities to learn from doula-assisted practices because not all the public health birthing facilities provide such a service due to “infrastructural problems such as poor security, lack of privacy and a lack of enabling policies” (Honikman, Fawcus & Meintjies, 2015, p. 285). Furthermore, anecdotal stories of doulas overstepping their role by intruding on medical decision-making alerted me to the current fragile relationships between doulas and the healthcare providers.

Women in labour are generally referred to as *patients* which indicates how the medicalisation of birth also tends to pathologise the process. Among the women in the birthing facilities, there is an apparent docility, with a culture of acceptance of the disrespectful behaviours in the birthing units. Such compliance and unresponsiveness is understandable as a woman in labour is in an extremely vulnerable position. She is dependent on those around her to protect her own life and that of her baby. Yet this incapacity to respond also seems to contribute to the normalisation of the disrespectful behaviours. The labouring woman finds herself amidst the collision of forces that include her own biological natural forces as she bears down in labour and the multitude of other forces acting on her from both a human and more-than-human perspective.

One of my most striking interviews in this project was with clinician Julian. He highlighted how traditional Cartesian thinking separates body and mind and how labour can be explained through such rational interpretations, saying “I think there’s something in second stage³⁸ which completely cuts off the brain from the rest of the body... there’s dissociation between the brain and the rest of the body”. He admired the way the birthing event enabled the memory of the painful experience of birth to “disappear”, comparing this erasure perspective to using Midazolam, a sleep-inducing drug. From his experience as a clinician, he claimed that “birth is like that; it just completely wipes out all the memory of pain”. Through this rationalising, binary thinking he then took up the commonly held belief aligned to a biomedical authoritarian and possibly patriarchal perspective to explain nurses’ disrespectful behaviours, saying:

I think that what happens is because mothers do not respond to instruction again and again and again, because the only thing that matters to them is the pain and

³⁸ In the medicalised perspective of birthing there are three distinct clinical stages of labour. The first is marked by the onset of uterine contractions. The second, known as the active stage takes place when the woman is deemed ready to push. The third, indicates the time for expulsion of the placenta.

they're tired and they want the whole thing over. They're actually not listening. And so to overcome this not listening barrier I think some nurses do become a little bit excited about their management (interview, Julian).

I would suggest that this form of excitedness is perhaps a euphemism for the intensity of tensions around the assurance of safe practices during the delivery process. It appears to give an unfair and inaccurate account of birthing events where there is intense fear and anxiety leading to different defence mechanisms (Menzies 1960) and a prevalence of abuse. Julian assumes power and control for the birthing process to be solely in the hands of the doctor or midwife. He seems to connect excitement to authoritative power. His viewpoint appears to justify nurse's actions as a professional response to the apparent unresponsiveness of women in labour who are expected to be submissive. Julian's drawing (Figure 5.3) below is indicative of such beliefs. He placed the student as a passive observer at a distance with the face unrevealed. He drew the woman in labour in a fixed lithotomy position³⁹. In the drawing process I noticed how the bed was the first item he drew, making it prominent as he placed it centrally.



Figure 5.3: Woman on bed (drawn by clinician Julian)

In terms of responses to the practices of disrespect, and particularly passive acceptance, midwife Sibela (Facility 2, 2016) confirmed that most women “take everything that you're giving to them, whether it's appropriate or whether they're not

³⁹ The International Childbirth Initiative notes in their Step 7 that the “supine or lithotomy position” should be avoided (p. 14). In a lithotomy position (which provides an advantageous positioning for the doctor) the woman is recumbent with her legs held up in metal stirrups.

appropriate”, adding that it is only the “odd one out” who will complain. Such in/actions are mirrored by the students.

Midwives, themselves feel unable to respond to the in/actions of their colleagues as explained in the quote below:

Maybe that sister that’s rude and impatient, she is scared off anyway by the colleagues, by the staff. The staff will be scared and will treat her like an untouchable. Now what do you do? (midwife Gaye, Facility 3, 2016)

Gaye justified her lack of responsiveness by referring to her colleague saying, “she’s my buddy, she’s my colleague, you know I loved her – she was a nice lady. I think something [clicked fingers] – you know just slipped you know, she just lost it”. She described two incidents that stayed with her that related to the harshness and discrimination to youth and to foreigners. Amidst the shouting in the passages she heard:

Why are you young, and all that – you know, you shouldn’t be here, you should be at school. ... in another hospital I was working in, this foreign woman came – shame and she was really like freaking out, she was in labour and all that ... Why are you here? We are the ones who are paying taxes here, you come all over from whatever you are in Africa and you come here to our country and we’re using our tax money over you; you must go back. [laughter in voice]. Gaye added her thoughts saying, “a pregnant woman in labour go back to where she came from. You see what I mean? Okay, I’m laughing here ... And the bad part of it is what I feel bad about is that I do anything (interview Gaye, 2016)

Doing nothing was also noted as a concern for students as they too felt a need to accept established practices and to develop coping skills with emotional resilience to work through their troubles. In my interview with clinician Gretel (2015) she referred to the evidence related to the importance of resilience⁴⁰ for students to cope with unsettling events:

I think it’s almost all emotion, because you are teaching people how to be more emotionally competent – maybe that’s the way to put it ... to develop that resilience in order to cope with the degree and all these traumas that happen ...

⁴⁰ In their paper on the value of guided feedback in reflective practices in medical curricula, Wald et al. (2009) refer to “building emotional muscle or resilience” (p. 831).

so resilience and a capacity to cope is all about your inner experience and how you can modify that – so it's core emotion.

Gretel expanded her explanation saying:

we're stealing opportunities of growth from our students by not actually asking them what they need and responding to that ... [there is a] lack of context for teaching ... We spoke about student resilience and helping them cope – and I think that starts right from the beginning, in fact even before... [the problem is that] we are still focused on percentages and we need to stop that – because that sets the tone for the whole experience.



Figure 5.4: Conception of how the curriculum is working with students (drawn by clinician Gretel)

Resilience involves an individual's negotiation and navigation in adverse situations (Ungar, 2008) and reflects a humanist perspective with a focus on individuals as intentional entities. In a similar vein, Dyrbye and Shanafelt (2012) note that medical educators "must help students to recognise that caring for oneself is an essential part of being a doctor" (p. 344). In terms of a relational ontology, this viewpoint is problematic as it assumes individuals as independent entities with rational intentionality and self-regulation rather than becoming with emerging relationships and multiple forces.

In Gretel's drawing (Figure 5.4) she continued to explain "the bandit culture" in medical training, describing how students are being led along a structured path by the curriculum but they are blindfolded, thereby purposefully separated away from seeing the wider context that ought to be strongly connected to their learning. The curriculum is keeping students at a distance from relationships that matter. The current isolation and separation of students appears to be disabling them by reducing their capacity to cope and to respond to injustices that they may witness.

The curriculum-student relationship is a vital component and dynamic assemblage to consider in students' learning experiences. Such assemblage thinking can open up a different perspective for medical curricula and education more generally, to bring attention to the unpredictable and entangled arrangements that emerge in curricular relationships.

5.4 What's the matter? What matters to students

Students' learning events do not happen in isolation but are connected to past, present and future relations. In what follows, I expand on how the curriculum-student-facility assemblages connect with students' responsibilities/response-abilities. I examine curricular arrangements in terms of what matters to students and how students' engagement in curricular matters renders them in/capable in their responses to the injustices they witness. I include the problematic aspects of separation, isolations, divisions and binaries which characterise traditional curricula focused on individual competence and which emerged in this study as prominent forces that limited students' responses. I investigate how a relational ontology may offer new insights about what matters as students are becoming-with others. In my study I move away from exploring determinate and measurable health and learning outcomes to examine what the current curriculum is doing, what it is leaving out, and how this impacts on students' responsiveness to injustices they observe.

5.4.1 Curriculum working for institutional standard setting

The obstetrics syllabus and list of curricular requirements at UCT as set out in student booklets (Annexure 7) indicate a linear trajectory along which students are expected to learn. The timetable represents a series of time-driven student activities that begin with an academic week involving introductory teaching activities and end eight weeks later with written and oral exams. At the introductory sessions each student receives their

logbook to record and to ensure they get sign-offs for their achievements as per the identified skills and knowledge that are required. The book provides a regulatory medium for logging students' activities which are checked and monitored. The completion of the rotation realises an end-point, a closure marked by students' successful acquisition of their Due Performance (DP) certificate⁴¹ and assessment results.

Beyond the time slots and the listed curricular tasks for knowledge production, my research findings indicate that students feel a sense of distancing and isolation. A final year student expressed his wish for more involvement of educators as he recalled his own perception and classroom experiences from 2013:

Okay, guys, welcome to obstetrics, you're going to deliver babies – okay. So they showed us a video on the first day, this is how a baby comes out. So, ja, guys, good luck – go fetch your babies – and that was it. And no one ever asked us or maybe they would once in a while how are your experiences – but it was in a group, it was in a class, and you thought I want to say something but I'm scared, like what do I say? And even if I say something, how's the lecturer going to think of me, how they're going to look at me after I say this. So I just felt like there was a separation between the lecturers themselves and the students; we were just there when you had lectures – our job was just to get in there, sit down, listen to the academic content that they delivered to us, go home, study, and move on with life, and not actually getting involved; I don't think they were involved in our learning at all (student, FG 1)

This student's feelings provide a perspective of curricular engagement that tends to be hidden. This student perspective is reinforced by traditional approaches to lectures that maintain a sense of distancing and encourage individual competitiveness. Furthermore, the outcomes-based linear arrangement of the curriculum generates enactments with students that can be unproductive. In this example the student highlighted the powerful force of fear and how it impacted on his responses. He explained his conformity with the pedagogical practices as involving a static transmission of knowledge. His awareness and sensitivity to his apparent isolation and misrecognition⁴² appears to have been exacerbated by the curricular needs. Later this student expressed his joy at helping

⁴¹ A DP certificate indicates that the student has completed the requirements for the course which involves attendance and curricular tasks.

⁴² *Misrecognition* is a dimension of discrimination when an individual's attributable characteristics are devalued (Fraser, 2009).

mothers connect with their babies through kangaroo mothercare⁴³ and breastfeeding. Both these practices involve closeness and touching which contrast with his earlier sense of isolation. In these moments that he referred to, he said “I actually found happiness” which led to him considering taking up the speciality of obstetrics as an option for his later career (student, FG 1).

5.4.2 Emergence of un/responsiveness

From a relational point of view, students find themselves in the in-between space of different curricular assemblages as they move into and through their clinical encounters. Their doing and becoming is not a separated independent choice but entwined in the multiple relational forces that include ongoing struggles. Students are caught in the messy middle of unexpected relationships and forces through their entanglement with the curriculum, finding themselves in the interstices of sites of dissonance; or what Cole and Masny (2012) call “points of non-equilibrium” (p. 2).

As noted by my findings, there is a wide range of student responses emerging in/through the relationships between the obstetrics curricular tasks and the students. What is apparent is that many students feel undermined, disempowered and incapacitated in terms of responding to poor practices they face in their clinical encounters. Their lack of responsiveness to troubling matters can be summed up by the term, “I’m just a student” which was repeatedly used in student conversations, in classroom workshops and in reflective commentaries.

Although lack of responses was most prominent in all areas of my research study, it must be noted that there were competing forces where just being a student acted as a catalyst to a response, as indicated in the comment below:

that statement in itself, ‘just a student’ has made me realise that no, you’re not just a student; you’re a student, yes, but you’re also a voice and you can also be, like to be clichéd, the change that you want to see in the world (student, FG 3).

The hidden voices and experiences of students became evident in my initial anonymous online research survey where the prevalence of student expressions of helplessness, shock, anger, fear and confusion at witnessing unjust practices to women in labour

⁴³ *Kangaroo mothercare* is a technique used to provide skin-to-skin contact between mother and baby.

reflected how students view their position in a submissive way, as indicated by the student responses below:

I felt helpless, though I knew better.

Felt angry, but helpless. If that senior health professional has been working this way for years who am I as a student to tell them that they are wrong. Telling the patient is the best I can do.

Students appear to rarely respond to discomfoting events that they witness. Such unwillingness to respond was noted in two survey responses:

[I] felt angry, but helpless. If that senior health professional has been working this way for years who am I as a student to tell them that they are wrong. Telling the patient is the best I can do.

I also felt ashamed of the medical profession and I felt powerless to stop it in my role as a 4th year student.

When asked in a survey question about their feelings in observing abuse, a student anonymously noted the shame:

Shame that someone in health "care" could treat another person like that. Also dread that someone might do that to me one day. Powerlessness and helplessness for not being able to change the situation. Shame for being there and spending time in that environment, benefiting from someone else's pain. Shame for being held helpless by social norms, for not being more outspoken and free (anonymous, online survey 2014).

This quote illustrates the multidirectional forces acting on the student leading to an incapacity to respond, despite a sense of responsibility. The student senses the discomfort of being in a space where witnessing unacceptable behaviour has become normalised, and which is amplified as it contrasts with the student's expectations. This student notes the potential of the force of such practices whether on the profession, or the student's own personal body. The shame appears to stretch further than the event impacting on societal norms that allow such poor practices to continue.

Students feel conflicted in terms of their responsibility and connection with the women in labour. At UCT, students learn about empathy, kindness and care and are generally

keen to engage with the women's needs and support members of the healthcare team. However, in troubling learning encounters they appear to frequently find themselves disempowered. A survey response noted, "I felt sorry for woman being neglected, pitied her and was at the same time frustrated by the healthcare providers attitude and actions, or lack there of [sic]". Another student claimed, "I felt sad that this was the normal behaviour of everyone, to everyone".

Further student survey comments highlighted these dilemmas as students found themselves squeezed in the in-between space between their curricular needs and labouring woman's needs, an entanglement that was reflected by the following anonymous survey comments:

Shock and humiliation for our profession. Could not understand how someone in our profession could treat someone so poorly at such a fragile time in their life.

Powerlessness and helplessness for not being able to change the situation.

5.4.3 The reality: "I felt shocked that it was so prevalent in this day and age"

Before moving to the next section, I refer in more detail to the data drawn from my online survey in order to clarify and discern the level of disrespect witnessed by students. In the design of my Google form I clustered abuse, neglect and disrespect (ANAD) together in order to cover a wide range of practices that were discomfiting for students. From the sample of 25 students who responded to the survey, Figure 5.5 illustrates that the largest group of students observed ANAD once or twice a week during their 8 week block with only two students claiming that they had not observed ANAD during this period. Observing abuse once a day was noted by 20% of the respondents. While this survey covers a small student sample, it does resonate with the feedback I have received in my engagement with students over 7 years, and with local publications related to women's experiences in labour and students' experiences at UCT (Chadwick, Cooper & Harries, 2014; Rucell, 2017; Vivian et al. 2011). As per the earlier quotes, fear was a driving force influencing students' responses to disrespectful practices which were largely limited by their fear of punitive consequences and victimisation. Students named the rigid medical hierarchy, their need for logbook signatures, and their fear of repercussions in future assessments and professional relationships as the dominant forces influencing their sense of powerlessness and unwillingness or inability to respond.

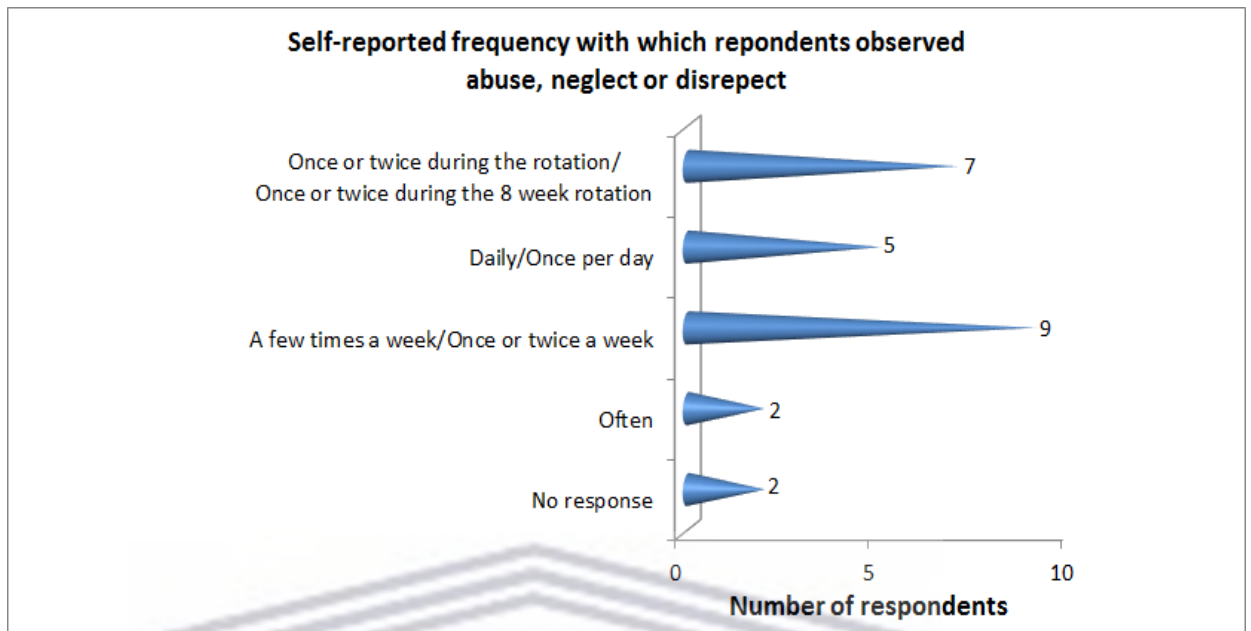


Figure 5.5: The frequency that UCT Year 4 students observe ANAD in obstetrics

Despite their limited responses, students noted in the survey that they were affected by the behaviours that they witnessed, adding unexpected tensions to the academic block. The strong forces affecting students before/through/after the obstetrics learning rotation were revealed at every stage of this research study and in my teaching interventions. Yet students consistently felt constrained in their responses, as if they were caught in a type of knot between their individual learning needs (as directed by their logbook requirements) and the needs of women in labour (Annexure 7). For instance, what mattered to students, was their logbook sign-offs, a curricular priority. The ticks and signatures in the book were needed to demonstrate students' acquired skills, thereby also acting as gatekeepers for students to pass through the block. To speak out about injustices was perceived to be detrimental to their sign-offs as reflected by the statements from different students in the survey "it's difficult to advocate when you need the doctors and nurses to sign for you later". There was a real fear of victimisation as expressed by the following responses, "these people will mark us at the end of the block. I don't trust them to be objective if a 4th year student is correcting their behaviour. An anonymous tip off would have been swept under rug" and "fear of the repercussions I may face in terms of having the midwives on my side for future work at X". Another student shared "I was scared of being ill-treated after I tried to correct the health professional".

Students fear of repercussions is real and partly explained by their entanglement in the many relationships related to their academic progress, particularly the marking of their assessments. Knowledge production in students' learning processes is not an isolated separated process but entangled with other intra-actions such as assessments, which play a key role and provide a strong force in the enactment of students' in/actions. Assessments are connected to those in positions of responsibility for student learning and who become the decision makers determining whether students pass on to the next stage towards graduation or not. Marks matter to students and to faculty. The relationship of marks with students contributes towards their dilemmas of responses. Fear in terms of assessment marking constrain students in their responses and in exercising their responsibilities to be accountable to patients by protecting them and helping to promote quality of care. Bongani, a fifth-year student explained in our interview:

I'm not going to lie to you, many of the students in med school develop a caution that unfortunately with any wrong-doing that you see, if it is someone who has potentially the ability to have influence over your marks or anything, you choose to keep quiet because you're afraid; you don't want them having a bad reflection on you just because you reported them – so you just keep quiet. ... at the time I didn't have the courage to say something then but to just do something means something (Bongani, interview 2016).

While an indication of willingness to respond to poor practices is illustrated in Bongani's comments, the force of fear of any form of repercussion that may be detrimental to the student's progress appears to override any desires to possibly take on extra responsibility to promote quality care and to be an advocate for patients' well-being. Another student shared, "I wish I could advocate without any blowback :(“

Students' fear of victimisation is consistent with research by Wear, Zarconi and Dhillon (2011) who call for more promotion of fearlessness in medical training. Students at UCT have reported repercussions on themselves, and on fellow students such as those who follow in future rotations. A student survey comment illustrated the chain of events that was triggered by a response, "I experienced being treated with disrespect from nurses because other students previously complained about them". Such experiences undermine students' ability to respond to any injustices they may witness. Similarly, there is a tendency for women in labour to not respond to any mistreatments due to their fear of being punished for challenging instructions or not complying (Chadwick, 2017).

Students seemed to justify their unresponsiveness to ANAD in various ways. Some students' responses were constrained by cultural beliefs to respect their seniors and to acknowledge their subservience through silence as indicated by the comment "No. Not my place to question the actions of a senior staff member or to call them out". This silent respect for elders was also mentioned in Chapter Two. There was an indication that some students believed that the perceived degree of severity did not warrant a response, or that there is no clear marker for an abusive situation. A student explained, "I was not sure whether it was abuse or not". It appears that a measurement of certainty and determinacy is needed by students as a guide for them to respond to the poor practices they observe. Yet, disrespect cannot be measured unless severely intruding into legal limits of tolerance.

The indeterminacy of the severity of wrongdoing as well as the possible unintended outcomes of responses creates and promotes spaces of vulnerability and uncertainty. There is a level of courage and confidence needed by students to speak out or to take action. Self-confidence also plays a part in enabling students to take a stand. One student in the survey noted "I did not confront staff about abuse or disrespect, because I did not feel confident enough at the time to do so". Another student expressed regret saying, "I felt very small that I didn't have the guts to stand up to them without fear of the ramifications I may face for choosing to make a stand".

Among the different defences used to explain their non-responsiveness, was time. Students' compliance with curricular needs in obstetrics invokes heavy time commitments where night-time calls are added to their usual full learning programme. Time becomes a precious commodity that appears to act as a limitation to students' ability to respond to injustices they may witness. A student in the survey commented "I did not have time to report incidents as it was the last block of the year, and I had a very heavy burden of both studying work as well as problems at home to deal with at that time with which I was trying to cope". This defence captures the broader influences and personal responsibilities that play out in the lives of students and drive their responses in these situations.

From a more positive perspective, there were instances discussed with research participants where groups of students (and occasionally an individual student) took action. In my interview with Clinician Doreen, she admiringly spoke about students who

walked out of a teaching session because they were “appalled” by the clinician’s behaviour. She explained that the group of eight students were told to line up to examine a labouring woman’s vulva. Doreen respected how these students took a stand by walking out of the room, removing themselves from their contact with the clinician.

Apart from rare examples like the one above, the majority of students remained unresponsive, thus becoming silent bystanders despite encouragement to take action with the support and protection offered to them by departmental and faculty mechanisms such as the Professional Standards Committee. Students appeared to conform to the hierarchical authority prevalent in birthing facilities, and more generally in the health system that seems to legitimise the poor treatment of women in labour by those in control (Bohren et al., 2015).

5.4.4 Rendering in/capable⁴⁴

Students’ responses to witnessing obstetric violence vary. Beyond the shock and disgust, there is an indeterminacy in their level of capability to take any action to respond. What is apparent is that different forces render students in/capable in their responses. An enactment of incapacity is not in opposition to capacity. It rather offers a focus on the inter-relationships. These relationships with others are multi-directional (Braidotti, 2018a). There is a becoming-with others that leads to the interlinking of incapacity and capacity through the ongoing dynamic processes in the prevailing material-discursive practices. Different forces render students in/capable in their responses. For instance, even though there are available reporting processes, students feel diminished power. Students say that not enough is being done in terms of institutional responses. A student reflecting on the learning block and classroom workshop complained “we always talk with no action” (2017: Block 2). Perhaps this student was unaware of numerous actions taken following students’ reports through the Dept O&G. Such a perception reduces students’ willingness to respond and capacity to take action. This comment highlights the importance of making the troubles visible and providing feedback that can be amplified rather than contained. Clinician Gretel referred to the pattern of limited feedback to students saying:

⁴⁴ The slash indicates a move away from a binary of either or but that the two positions are related aspects that are both different and part of the same. Barad (2014) refers to cutting together-apart as one move.

So if you evaluate something as needing change or evaluate a situation as being problematic and that it should change, then that needs to be managed and that information needs to come back to you, otherwise you kind of think that its fallen off a cliff into the big blue sea. And that's your voice that falls into oblivion if you're not told what has happened to what you said (Interview, 2015).

Feedback is important and can strengthen students' willingness to follow avenues of action available to them. There appears to be an issue of separation from institutional processes and trust that reduce students' willingness to respond as well as their capacity to act. After witnessing a vaginal examination on an 18 year old when "the doctor just put her hands in the patient and the patient obviously started screaming", a student said

I honestly feel that sometimes even when we do report these incidences, what actually happens: we never hear about follow up, we never hear about if the doctor was reprimanded or not. So sometimes you feel as if I can report it, but what's going to happen? (FG 3)

Some students have expressed a need to hold on to their personal narratives as a private matter. Even just opening up their troubled knowledges and personal experiences to others is difficult (Zembylas, 2013b). A student wrote "I don't feel too comfortable for other people to see that vulnerable place in my heart" (student workshop feedback 2014; Block 3). However, the pedagogical interventions of reflective commentaries and workshop performances have provided a facilitated channel for most students to share their personal anecdotes and insights with a reciprocal capacity for reading and hearing about the experiences of others, which has been productive. A student noted, "One doesn't really appreciate the effect that this block has had on [us] until [we] actually sit down and think about it which the reflective process and the workshop helps with" (student workshop feedback 2015: Block 1). Clinical partners becoming "critical friends" has also been encouraged as a facilitating tool to provoke discussion and mutual questioning (Costa & Kallick, 1993).

5.4.5 Events as marking moments in time

What this study points to, is that many of the students' responses before, during and after their obstetrics rotation make a mark on them, staying with them, both the good and the not so good. Their feelings and the forces felt in/with their clinical encounters are not forgotten. This means that there is no erasure of students' sensed connections nor their more specific observations of unprofessional practices connected to their associated

reactions/in/actions/responses. Such moments and memories are likely to impact on their future practice. As explained in Chapter Three, the past, the present and the future are threaded through each other (Barad, 2010). A linear chronological concept of time can be deceptive in educational practices as it carries an assumption that time past can be closed off. In order to acknowledge the entangled and dynamic interrelationships that co-create students' becoming, I propose that it may be productive to also take up time as *aion*, a Greek concept of time that refers to the cyclical time of becoming with inherent forces acting in each encounter (Braidotti, 2006, 2018a; Braidotti & Dolphijn, 2015). *Aion* time offers a different understanding of time to *chronos* (or clocktime) as it moves beyond structured and sequential issues of linear time. "Aeon"⁴⁵ is synonymous with post-qualitative inquiry according to St. Pierre (2018) who refers to Deleuze and Guattari to explain it as "impersonal, nonindividual, nonsubjective, nonlinear, never present. Aeon never is" as it is "the not-yet, the yet-to-come ... always becoming" (p. 7).

In *aion* time, each moment, each encounter matters, and continues to matter. Kohan (2015) puts forward that *aion* time is about a different quality of time that "designates the intensity of time in human life – a destiny, a duration, an un-numbered movement, not successive, but intensive" – a particularly forceful and intense experience of being in time" (p. 57). While Kohan refers to childhood education, obstetrics is certainly an intense experience for students, a slice of time in students' six year curricular engagement, and a period for responsiveness. Despite curricular efforts to provide structures that separate students' activities, the students are entangled in the onto-epistemological curricular arrangements of spacetime that do affect them.

In the section that follows I examine how current curricular practices are enacting separations and distancing that appear to be exacerbating students' inability to respond to unjust practices, rather than promoting students' response-ability. I explore the curricular structures in terms of humanist thinking then consider how a relational ontology may reconceptualise these curricular matters.

5.5 Finding the divisions and separations

Divisions happen in many curricular areas. What is particularly relevant to this study are the disciplinary divisions and those through different time frames that are a core feature

⁴⁵ The spelling of *aion* time varies with different authors. I use *aion* but when quoting use the alternative *aeon* time.

of curricular design. Divisions in medicine are clearly demarcated by the medical hierarchical system with clinicians and consultants at the top of the hierarchical structure in health delivery. Medical students find themselves at the bottom of the chain, at times feeling “othered” with a distinct sense of their own position of vulnerability. The nurses fit in between, at times reflecting behaviours they have experienced by those above, or those below them. The hierarchy can be considered as a type of binary between each level as ‘us’ and ‘others’ who are situated at a lower level. Student Muhle explained in our interview:

So there’s nurses, then there’s cosmos⁴⁶ then there’s registrars, and then there’s consultants. And everyone treats people according to what they are. I don’t know if it’s subconscious or people actually think about it; people will treat people differently compared as to what they are. So my assumption is that nurses have the same idea of medical students – it’s like they’re just doctors, they’re going to be like every other doctor because that’s just how it is in the hospital. And I found it was very difficult for us to deal with because we were not looked at the same with nursing students – like they were given preferential treatment.

Although some midwives appreciated the students’ presence (Facility 1), students perceived a resentment by some where they felt as if they were intruding into the nurses’ space, not welcomed and appeared to add to nurses’ already burdensome workload. Students in FG 3 made efforts to justify the nurses’ unfriendliness towards them. One student suggested that “it might have something to do with maybe how they’ve been treated by doctors and now they’ve got the baby doctors” and another student explained how each level in the “hierarchy pyramid” has “their own little kingdoms” and “because people are crushing you from the top, then you just think, oh well, I gave you too, and then you crush the people below you and they do the same, and they do the same” (FG 3). This “unforgiving hierarchy” (student comment in online survey) brings further divisions between the different disciplines which is manifested in various ways and contributes to the students’ unwillingness and limited capacity to respond to challenging experiences. The FG 3 discussion continued with a third student reflecting:

the nurse will be like: hmph, this doctor doesn’t know what he’s talking about because obviously sometimes that doctor is younger and the nurse has been around in the profession for close to 20, 30 years.

⁴⁶ *Cosmos* is a colloquial term for community service doctors.

This rivalry acts as a force of separation and distancing that undermines the other healthcare professions. It contributes to students' discomforts and the prevailing tensions that affect students and limits their capacity to respond to others.

A disorientating event was recalled by a student who remembered the force and unhelpful repercussion she received from a nurse:

And then when we do something not right according to the nurse, then they start getting personal, like, 'How long have you been in this block?' or like, 'Don't you know how to deliver a baby?' or, have you never ever seen this? or 'Where were you trained?' And then there they start getting like really personal.

Such undermining comments contribute to students being silenced and limits their ability to respond to the actions of others. They are entangled in the assemblages enacted in the birthing process and do get affected.

As students recalled their discomforts, they also reported feeling perplexed about how some mothers in labour were separated from their companions, at times purposefully as a mechanism of control. Students felt their limited capacity to respond. In FG 3 a student noted how this action had been used as a weapon to counteract "performing" women, described as those who were crying out with pain:

Sometimes the sisters tell them their partners can't come inside because they are performing – performing according to the sisters in labour ward and if they don't behave then the partners can't come in to see the labour (student, FG 3).

While the time in labour is a crucial period for companionship and support (Chadwick, Cooper & Harries, 2014), students feel helpless as they witness women left alone without a birthing companion present. There are many reasons for such isolation, one of which is the institutional gatekeeping when a companion is purposefully not allowed to be present as the birth. As indicated by the quote above, students witness such acts of abuse and rarely respond.

In obstetrics learning, the limited time allotted to students in the birthing facilities, places increased pressure on them to perform the required curricular tasks. Time is a crucial factor in student progress. Yet, curricular time is entangled with birthing time which is uncertain and unpredictable. Time is crucial for determining the progression and speed of labour which impacts on students in their fourth year. Conflicts arise for students when labour is perceived to be progressing too slowly or other risks are identified. For

instance, when the wait for a normal vertex delivery (NVD) shifts to the need for an urgent medical intervention such as a Caesarian section, students get sidelined. From that moment onwards, these students are excluded from the process and distanced from the birth. They have reported feeling redundant as their time and relationship with the woman in labour then becomes unproductive because no ticks can be placed against the number of deliveries needed for their logbooks, as noted in the earlier quote when the student complained about such an occasion. The Caesar seems to obliterate the students' time and effort with that woman. Their efforts at building a relationship appear to become irrelevant for their curricular needs; the delivery which is no longer a NVD is excluded from the student's logbook sign-offs. The logbook shows a blank space rather than a tick, adding to the students' tensions and frustrations. In terms of representing students' clinical learning, the logbook indicates that a delivery is either done or not done by the student, a binary representation of student learning.

In their sixth year, students take responsibility for performing Caesars. Like other procedures, the Caesar becomes a marker between becoming-doctor as opposed to becoming-nurse. A student explained "I think with medical students in our fourth-year we are kind of under their [the midwives'] guidance but still under the guidance of the doctors, and then by the time you get to sixth year we're no longer part of the nursing staff" (student, FG 1). Students have moved from a responsibility of monitoring and doing other tasks usually associated with nursing to performing complicated procedures restricted to doctors' expertise. "We do Caesars and we hardly monitor in sixth year, so there's that whole difference" (student, FG 1).

5.5.1 The force of time in spacetime matters

A student in the online survey admitted "I may observe an incident that concerns me but I may not take the initiative to report it or may forget to do so". The needs of the curriculum take priority over what matters in student learning. The sense of helplessness by students and lack of responding to different messaging is compounded by time pressures. A student in FG 2 admitted, "I was so tired I think in most of my nights that I'm starting to say, but this, but I'm just like I'm too tired to even say 'but' – I just follow her, then the next one I have to guess again ... so you're guessing there.

5.5.1.1 Thinking and acting with/in time

Curricular arrangements indicate segmented time with divisions and boundaries in which disciplinary importance is represented by the length of time taken up by the students' in

that curriculum slot. As noted earlier, UCT students pass through two “blocks” of obstetrics learning, one in their fourth year (the focus of this study) and another in their sixth year programme. Apart from whether students can perform Caesars or not, and other skills, the linear progression entails curriculum-with-student relationships that change, notably becoming more distant and detached. Clinician Derek explained:

in fourth year, the students learnt to become a birth attendant, like a midwife, because they spent long periods of time with the person – so they got insight into the person’s experience, could identify with that person and could then be upset about what happened to that person. Whereas in sixth year they became a doctor; so the contact was episodic and detached and emotional bonding with the person was more likely to be absent by that time.

Derek illustrated the force of the curriculum in actually removing students from positions of empathy and responsiveness. Such observations are in line with the notions that associate the clinical years with an erosion of empathy and trust, as described in Chapter One. Furthermore, perhaps the students, with time, become habituated and desensitised to the anxieties and fears that circulate in the clinical spaces.

Time of day is also a relevant force that is entwined in the ethical issues of students’ responsibilities in curricular matters and their response-abilities. “The nights are the worst” was a comment I frequently heard from interviewees. The hours of darkness seem to act as a cover for the silenced practices of disrespect. Yet medical students at UCT are allocated the nighttime shifts for their delivery opportunities as nursing students take up the day-time shifts. Understandably, with the competing needs from an ever-increasing student population, there is tension with these defined slots, especially at times of overlapping student groups. Clinician Doreen (2015) expressed her concerns around the enormous challenges of ever-increasing numbers of students, in both midwifery and medicine, and how their learning needs place extra demands on the nurses, adding to their already heavy workload. These challenges are exacerbated by the fact that neither qualified doctors nor midwives are trained to be teachers. The problems arising from inadequate training was raised as a concern by several research participants (clinicians Doreen and Frank; midwife Mervin) who felt that these limitations actually fuelled the current disrespectful practices witnessed by students. Further tensions arise within and between the different disciplines and their training. Frank blamed the present challenges in obstetrics on midwifery training:

So the people doing the teaching of the midwives is where the failure is because they're not being given that passion, that empathy, that caring ethos that needs to be carried out day to day next to those patients. So in your frustration you lash out at the patients. So you've got to go back to where and what is happening in the training of those midwives and that's where the identity is. To point to the maternity centre and say you're setting the standards – they're sitting in an ivory tower; unless they get off their arses and go out to these midwifery units on a day by day basis, they have no clue (interview, 2016).

He felt that leadership by those sitting in “ivory towers” keeping a distance from the reality of practice was a large part of the problem, suggesting that “unless they get off their arses and go out to these midwifery units on a day by day basis, they have no clue”. In terms of accountability, Frank stressed the important role that students have played and can contribute towards opening up spaces that reveal the prevailing poor practices, saying:

Because what the students are saying to us, and it's not coming to us any other way but through the student case reports and the reports on their experiences, they are seeing this across the board; just about every single unit there have been complaints about it.

Frank expressed the need to engage more deeply with issues of responsibility and response-ability at the training level rather than when the problems arise in the workplace. The past in terms of training and opportunities is highly relevant and significant for understanding present and future practices which are entangled rather than unfolding (Barad, 2007). Frank illustrated the power of reports in giving force to students' voices which were then being heard, a consequence of this research project. Rutberg and Gaufberg (2014) note the important role that medical students play as respondents to professional practices, as well as the influence such a position has on them. Students are:

ideal participant-observer anthropologists, bringing fresh eyes and unacculturated minds into medicine. Once immersed in the culture and subcultures of the medical world that they have long desired and worked hard to join, students tend to absorb the assumptions, behaviors, and values that surround them. They absorb and are absorbed, (p. 107).

Frank referred to concerns related to responsibility and accountability in nursing training that impact on medical students interacting with them, such as the prevailing divisions and separations of time, spaces and matter. For example, when those in leadership positions stay at a distance from obstetrics practice, it is unhelpful and contributes to the status quo and continuation of disrespect. These observations link to Menzies (1960) study in which she noted the numerous social defence mechanisms set up among health organisations and nurses to counteract their anxieties which include professional detachment, different forms of depersonalisation and fragmented responsibility. Taking up these concerns through an FNM approach would offer a broader perspective as it goes beyond humanism to engage with the intra-actions enacted as spacetime matter is materialised through each encounter.

One moment that “glowed” (MacLure, 2010, 2013a, 2013b) in a troubling and burning manner in my research findings was the time of loss and grief associated with a deceased mother or neonate. For many students, such moments mark the first time when they are confronted with death, which is particularly difficult, and where they understandably may feel and face a sense of detached professionalism (Kelly & Nisker, 2010). Although prepared through lectures and workshops, these events affect students. For many, there is a force of incapacitating them in their responses. Below I elaborate on these troubling moments.

5.5.1.2 A poignant moment: life/death in obstetrics

The medicalisation of birthing aims to reduce maternal mortality and neonatal deaths, yet deaths do happen and appear to raise more separation issues than anticipated. At times, women are left isolated, grieving alone. Students report feeling distanced, despite their own sense of shock. Loneliness prevails amidst the sadness. Death appears to bring on intense forces that propel distancing.

Furthermore, death promotes objectification of the neonate and/or the woman postpartum. Student Alice described her shock and dismay when her clinical partner was teased by the midwives who instructed her to connect to macerated baby/object discarded in the sluice room. She recalled how nurses jokingly called her partner (who had been off sick) to the sluice room, to face the unexpected. Alice recounted how they laughed “sort of ha-ha, ja, you should get used to that ... they hadn’t warned her. They

knew it was a macerated⁴⁷ – very strongly they knew it was a macerated foetus and they kind of - She hadn't done anything wrong – like it was in a punishment, it was just sort of, ja, get used to it. Ja, so that was also really terrible". Such uncomfortable incidents stay with students.

Within the health team, the marker of death appears to become a separating and distancing force with health team members. Below I draw on two examples. Firstly, I refer to an instance of maternal death, secondly to the isolation of a woman following her loss and thirdly to a students' experience of feeling unrecognised, distanced and isolated in a situation of neonatal death.

In the first example clinician Doreen related her experience of working as a gynaecological surgeon dealing with complications after the birth of a baby, where "amazing teamwork" was evident as they struggled with an emergency. However, when the patient succumbed, the convivial relationships disappeared, with only Doreen left alone to respond as she described:

We eventually terminated the resuscitation – and there was this family of about 15 people and I looked around and I just had no one standing behind me. So at that point the compassion, it was too much... there's this disjunct, there's this profound disjunct between this group of professional individuals using their expertise in the most profound way with genuine concern, with genuine heartfelt compassion, and then there's facing death and loss and dealing with that.....that disjunct where all my colleagues who've been so completely involved – they went home. It was a weekend you don't hang around if you don't have to.

Doreen recalled how she stayed behind to explain to the family but how difficult and painful it was for her "it was hard, it was very hard and I felt quite tearful myself, but I knew that I had to give them the story. And they were very grateful". In explaining why her colleagues moved away she suggested:

They weren't into that wishy-washy you know arty-farty stuff. So if I hadn't been there, one of them might have gone up and said, look, she was very sick, there was nothing we could do, we're very sorry, goodbye.....giving information. And what this family needed, I felt, was not information – they did want information

⁴⁷ A macerated foetus is the medical term given to a foetus that has died in the uterus and remains there undergoing specific changes (Strachan, 1922).

but what they wanted was acknowledgement of their pain....And recognition of their enormous loss and their terrible pain. And that's what I tried to show them.

Maternal mortality is a feared reality in obstetrics. The fear influences healthcare team members, as well as students' power to act, often encouraging a practice of distancing and separation. At times students are protected by counter actions. Clinician Sarah recalled how the challenges in facing grief are exacerbated when that death is unknown or unexpected in neonates, and how in some cases students were protected from being alone with a loss saying:

the worst thing of all is if they hadn't realised the baby was dead – I mean, the mom hadn't – that they found very traumatic. So we actually had at one stage an attempt to not let them deliver dead babies unless they had somebody senior with them. And I used to give them a tut on the loss of a baby.

However, from students' reflections and performances in class, such caring collegiality appears to be uncommon as reflected in my second example (referred to earlier in terms of the force of curtains and relationality with/on the students). In the Year 6 FG a student shared how she recalled feeling marginalised, excluded and unable to respond to the events surrounding the unexpected neonatal death. When the cubicle curtains were closed by the nurses, they became part of the grieving process inside that space, leaving the student and her clinical partner outside, and separated from it. The curtains constituted an assemblage with the students making the cut that determined the boundary-making process that enacted a separation from the activities within the enclosed space where the stillbirth was being managed. The isolation of the students emerged as they were becoming with the curtains and other objects associated with the dying process. This assemblage included the wheels and motions of matter that silently moved in and out of the cubicle. The students felt unnoticed and uninvolved caught in an in-between space of misrecognition and disempowerment despite their wish to engage in a meaningful and empathetic manner. The student in the FG shared, "we just stood there as students, like what's going on, we don't understand ... I was like nobody's explaining this – what do I do in this situation, who do I speak to? Like this is really traumatic and what-not". These students confronted this incident during their first shift into practical obstetrics. When the students asked to be involved, the nurse's response was, "no, don't worry about it, you don't need to worry about that delivery. We don't want to explain, we don't want to talk about this". The student explained that "throughout the whole night no one ever spoke to us about stillbirth or how to speak to a mother, or how

we should be to a mother in that situation, especially as students. Such acts of distancing were not unusual in students' narratives around death. In essence, the curtain-midwife-neonatal death assemblage disconnected the students from relationships that could possibly promote care and social justice. In a relational ontology, assemblage thinking could contribute a different way of engaging with these issues by questioning the interference of forces that co-constitute each event.

5.5.2 Pulling apart and together

The findings and narratives reported above indicate the many perspectives where current curricular arrangements and engagements for knowledge producing practices actually generate separations and distancing. Students observe, become part of, and experience how their capacities to respond in ways they may feel appropriate are limited.

These separations are also reinforced by much of the curriculum's theoretical content delivery that happens in different spaces away from the labour wards. Midwife educator Helen explained that in her current role as educator, she only deals with students, not with the women in labour. She engages with students in rooms that are set up specifically for teaching and avoids going into the wards where the actual birthing takes place. In other words, the power and force of the labour ward is keeping her at a distance despite the students' needs to be better supported in their encounters with women in labour and with the midwives. Perhaps Helen is also distancing herself as a defence strategy which Menzies (1960) noted was a frequent occurrence among nurses to avoid anxiety. Helen said:

I don't go with them when they do their deliveries because they rely on the midwives in the facilities....So I teach them all about obstetric emergencies and what can happen in labour and what you need to do, but I'm never there to teach them because I'm just not there with them. So they rely on what they get taught here by various people; they rely on the midwives to go and supervise them in the wards.

Interestingly, in line with Menzies's (1960) findings, Helen shared how she has developed a defence and coping mechanism by distancing herself from discomfort and the emotional burdens associated with obstetrics:

I get very upset about things that are happening out there but I've also learnt not to draw it too much to myself because that's not going to work for me anymore,

so I need to just keep a little bit of distance when I'm not there. So I'm obviously not keeping my distance when I'm there because I can be there for that person or if it's a patient or if it's a student. But when I'm sitting here and I hear the story, in the beginning it really did a lot to me and it's like whoa, it's just all too much. And I thought, okay, I need to keep a little bit of a distance and try and go through all the correct channels and do whatever I can do.

Helen illustrates how distancing protects her from forces that can increase her vulnerability. It appears that the physical distance of staying away from the ward provides a mechanism of protection that students are not able to follow. The curriculum compels students to be in the spaces of tensions thus becoming-with multiple spaces where they are immersed in the contesting forces acting on them through their pedagogical intra-actions.

In contrast to such Helen's separation and distancing, there were instances of pulling together the different elements involved in student learning that could promote their responsiveness. Such efforts in facilities appeared to render students and others more capable. In my interviews with midwives, educators and students there were indications of efforts to collaboratively work towards improving practices together, giving value to material-discursive practices. For example, at Facility 1, Kessie explained how midwives had the unusual opportunity for weekly debriefing sessions in a clinic room with a psychologist, a response and acknowledgement of the troubling moments they may be experiencing in the workplace and at home. Kessie said that she regularly tries to:

get somebody in, a psychologist to debrief the staff where we can sit and just rant or talk in an open dingus⁴⁸ ... it's good just to connect where people talk. We are all women, we all have issues: we have family, home lives – so it's not just here at work – people sit with problems at home.

There was an invitation for medical students to be part of these interactive sessions, an inclusive move that was appreciated by students, and noted in their feedback. The debriefing room was shared by all, developing a relationship that enacted a potential for affirmative actions rather than acting and producing a divisive boundary-making process. Such intra-actions that open up the troubles in an affirmative manner contribute to supportive and caring relationships. In addition, this facility welcomed the involvement of

⁴⁸ *Dingus* is a colloquial term that refers to something that does not have a specific term or name (a thing)

several non-governmental organisations such as the Zoe Project where volunteers provide “goodie boxes” (Figure 5.6) for new mothers with clothes for the new baby and toiletries for the woman; an example of a more-than-human touch of care.



Figure 5.6: Zoe Project's gift packs for mothers and newborns alongside the facility's accountability book

Students observe how these material gifts have agency in promoting care, as well as contributing towards rendering new mothers more capable. A student (2015: Block 3) reflected how his week at this facility was “like a cool breeze” on a hot day, leaving him inspired. He felt the nurse’s “keenness to teach was effervescent!” Catching this enthusiasm for learning is an example of his affective sensibility that I take up further in Chapter Seven.

5.6 Responsibility

[R]esponsibility is about putting in the work to trace worldly entanglements, including all due attention to our debts and obligations. In other words, each meeting matters, not just for what comes to matter but what is constitutively excluded from mattering in order for particular materializations to occur (Barad, interview with Juelskjaer & Schwennesen, 2012, p. 21).

A student (FG 3) expressed her concern that midwives assumed that the curricular task to accomplish the set number of deliveries was the prime need for students’ learning in the birthing facility. Once the deliveries were completed with the arrival of the neonate, and ticked off in the logbook, there appeared to be an assumption that students did not have a further responsibility:

When I got there the first time I delivered a baby and then the sister was like: you can go now. And the baby's just been delivered – and she's like, I know that's just what you want. So I said, 'No, I'm happy to wash the trolley and measure the placenta and weigh the baby.' I mean, you do everything, you don't just deliver then leave, because you still have to do post obs⁴⁹ and then you have to help the patient go up to postnatal... Ja, and I got that from most of the sisters (student FG 3).

It seemed that the midwife understood that the students' curricular task for deliveries was contained and limited to the mechanical process of birthing the neonate. Such a belief in terms of students' responsibilities creates an unhelpful boundary that can actually deny students an opportunity to engage with relationship-centred care, which they ought to aspire towards in their clinical practice, according to Suchman (2005). Instead, what is evident is that the curricular needs are equated with the safe delivery of the neonate and a tick in the logbook. Midwife Mervin explained such actions in terms of what matters in midwifery training and how those perceptions are transferred to the medical students' responsibilities:

I think it has to do with how people are trained – because current midwifery and obstetrics training focuses on the mechanics of it, the disease model.... I think care providers lack the psychosocial insights to provide this care – because in modern midwifery in South Africa, in the public sector particularly, it is all mechanised, it's a conveyor belt system, one size fits all, individuality doesn't exist.... Because it stems from this whole biomedical model.

It appears that midwifery training has lagged behind developments in healthcare that now focus on biopsychosocial well-being rather than the old biomedical model. Mervin recognised that equipping nurses and students with knowledge and skills to safely deliver babies in a mechanical way tends to undermine women in labour. When the focus is on the safe extraction of the baby, the mother's role is made invisible, trivialised and considered as a separate entity; backgrounded. Bioethicist, Raymond de Vries (2017), draws on mothers' narratives to illustrate how their "needs, physical well-being, emotional health, relationships, and [the] anxieties of mothers are ignored by their caregivers" (p. 216). What is missing is the conception of an entangled responsibility and the value given to all relationships.

⁴⁹ *Post obs* is the colloquial term for observations after the event.

Responsibility entails more than separate actions. The perspectives of midwives on medical student training cannot be separated out as it is intimately entwined in student learning. In each clinical encounter there are multidirectional relational forces acting and interfering with each other to generate and constitute what emerges and gets excluded from that moment. Students are becoming-with these forces in each obstetrics learning event which happens with/through spacetime-mattering (Barad 2007). As earlier examples indicate, the forces acting on midwives entail more than human interactions. Material vitality is an inherent component of the prevailing and pervasive disrespectful practices that are characterised by divisions, separations and distancing. The earlier examples of the impact of coffee mugs, television sets, monitors, and sterile gloves demonstrate this position.

Students learn that responsibility entails an accountability for using the right methods with dire consequences for wrong-doing. However, such humanist perspectives with binaries of right and wrong methods avoid the multiple ambiguities in ways of doing and becoming. A relational ontology takes into account the material world through decentring the human. Mauthner (2018b) claims that responsibility (and ethical agency) are “not understood as located with/in an already constituted moral agent but rather as materializing with/through specific world-making practices, along with human subjects and objects of inquiry” (p. 684). In one facility, certain methods of practice are acceptable, yet in another facility they are unacceptable resulting in an emerging confusion. Students find themselves caught in-between the ambiguities of multiple responses contributing to their sense of helplessness when abusive actions occur.

The intersection of forces in which students find themselves in terms of power differentials and curricular needs contribute to their inability to respond and disempowerment. Thus, as well as social consequences, there is a political concern. Responsibility has important political and ethical ramifications (Mauthner, 2018a; Zembylas, Bozalek & Shefer, 2014). For instance, Joan Tronto (2013) introduced responsibility as a political act of care indicating that to be responsible “we are somehow implicated in something and that we are able to act on it” (Bozalek, 2014, p. 55).

Tronto’s (2013) notion of *privileged irresponsibility* is relevant to the complex relationships enacted in birthing units. It is concerning that those in positions of privilege do not take up a responsibility in building a more just society (Bozalek, 2014). Medical

training institutions, doctors and medical students tend to be in privileged positions (due to the hierarchical culture in the health sciences) and may try to justify their in/actions and lack of responsiveness to patient needs. Tronto (2013) calls such evasive actions “passes” to indicate the moves taken to avoid or ignore the needs of others who are doing care work for them. In this thesis, I question whether medical training based on evidence-based practices with standardised linear procedures actually encourages educational institutions to obfuscate their positions of care and responsibility. In the video recording quoted below (Figure 5.7, QR code) Professor Denny⁵⁰ comments on how she feels that the universities have relied too much on state resources, and how this has added an additional workload to those working in the birthing facilities.



Figure 5.7: Explanation about the role of the university in obstetrics learning (QR code to be scanned for video clip)

5.7 Conclusion

The obstetrics' curriculum provides a highly charged and stressful context for student learning. In this chapter, I propose that the medical curriculum is designed for standard setting and to produce a certain type of doctor who is trained to be competent and able to work in the challenging environment of obstetrics. However, the curriculum that aims to develop highly skilled professionals tends to promote distancing and separations as its focus is on individual competence. A relational approach suggests that the multifaceted nature of medical training could benefit from assemblage thinking as the curriculum and students are not given entities but rather becoming-with their relationships to each other and other bodies through the different curricular tasks. The regulatory, formulaic force of the curriculum with assessment practices has an intensity and force that affects students in what they do and how they do it.

⁵⁰ During the duration of this research project, Professor Lynette Denny was the Head of the Department of Obstetrics and Gynaecology at the University of Cape Town

Students at UCT are learning essential skills and knowledge during their obstetrics clinical encounters but also being faced with unexpected and conflicting forces in a troublesome environment that is acting on students. My findings point to a need for these challenges to be more deeply acknowledged and made visible. Students find themselves in powerless positions, feeling helpless, undermined by the hierarchy in medicine, their own vulnerability and fears, and the established norms of practice. There were requests for more reciprocal relationships through feedback mechanisms in order to empower students to take action.

What matters to students is their progress through the different curricular slots in order to reach the point of graduation to become doctors. These prioritised facets of training that are determinate and measurable are leading to a backgrounding of issues of relationships. I put forward that the curriculum-with-students is actually enabling students' incapacity to respond to the many injustices they observe, thereby exacerbating the problem of abuse to women in labour.

Among the factors and forces that appear to limit students' capacity to respond is the assumption that the end of the obstetrics rotation brings a sense of closure as students move on through the spiral curriculum. I suggest that aion time could be a useful concept to further understand students becoming-with curriculum and to shift the emphasis on what matters in obstetrics. Time was highlighted as an important component to students' learning assemblages where linear, sequential time is a key component of curricula. For human flourishing to take place Haraway (2016) claims that we need to invoke our mutual becomings that include other-than-human connections. I propose that giving attention to the materiality of objects in birthing events can be helpful. This relational approach offers innovative insights that may be missed through humanist, binary interpretations that can be reductive or self-limiting processes. By considering material agency in the intra-active relationships of those involved in birthing, we can move beyond exploring human interactions that seek out cause and effect to take up the wider perspective of the co-constitution of intra-activities that open up new possibilities for thinking and becoming.

The issue of responsibility is a key element in medical training and doubly important in obstetrics where two lives matter. I refer to the notion of privileged irresponsibility as a political act that has implications for the relationship between training institutions, the students and those in birthing facilities where students learn.

In the following two chapters I continue to describe my findings in terms of how matter matters in material-discursive assemblages, then turn to the potential of acknowledging affective assemblages that may open up spaces for affect to become a productive force towards developing students' response-abilities.



CHAPTER 6 - FINDINGS: STUDENTS' RESPONSES WITH CURRICULAR MATERIAL-DISCURSIVE PRACTICES

6.1 Introduction

Matter is neither fixed and given nor the mere end result of different processes. Matter is produced and productive, generated and generative. Matter is agential, not a fixed essence or property of things. Mattering is differentiating, and which differences come to matter, matter in the iterative production of different differences (Barad, 2007, p. 137).

In this chapter I illustrate how an investigation into material-discursive practices can add deeper insights into students' experiences, to explore how matter matters and how all relationships matter in terms of students' response-abilities. Students' relationships with midwives and women in labour have intra-acted with other, more-than-human bodies such as the beds, curtains, instruments, curricular material, etc. These objects, and more, produce material-discursive forces that influence students' learning encounters. In terms of Barad's agential realism, students are becoming-with the discursive as well as material practices in their curricular tasks. Different materialising forces are acting at each moment, generating different enactments.

In what follows I take particular note of the material forces shaping what matters in student learning, much of which has been sidelined as passive and inert in traditional humanistic perspectives. I explain what is meant by the more-than-human forces and how these interfere with other forces to contribute to students in/capacity to respond to what they witness and perceive as wrong-doings. I draw on Barad's (2007) ethico-onto-epistemology to examine what new insights can emerge through the entangled relationships of students' becoming-with multiple differently constituted elements in the learning assemblages. This relational ontology provides an alternative perspective for unpacking students response/abilities as it situates the behaviours of students (and other health team members) as emergent through multiple relational forces rather than apart as individuals' intentional actions.

Niels Bohr (whose philosophy-physics research deeply influenced Karen Barad's ideas) proposed a radical rethinking of epistemological frameworks, taking into account that "things do not have inherently determinate boundaries or properties, and words do not have inherently determinate meanings" (Barad 2007, p. 138). Such indeterminacy

necessitates a different way of examining our use of language and what is measured. Barad (2007) asserts that “[l]anguage does not represent states of affairs, and measurements do not represent independent states of being” (p. 138). Thinking with and through a relational ontology brings to light the mutual connections and dynamic forces of multiple agents and the processes of “agency-ing” (Manning, in Massumi, 2015, p. 157).

Material-discursive practices are not fixed and cannot be fully anticipated. What is apparent is that the obstetrics curriculum is a material-discursive learning apparatus that sets out specific requirements for medical students to acquire the skills necessary for birthing babies. Apart from the mechanics of the birthing process, student learning involves elements in the intra-actions of human-to-human relationships such as communication skills, empathy, and reflective practices. In terms of Barad’s (2007) relational ontology, student learning in the birthing facility is immersed in the open apparatus of material-discursive intra-actions happening with each encounter.

6.2 How matter matters: the more-than-human forces

As my research process unfolded, materialising forces surfaced as prominent active agents in terms of what mattered to students in their curricular intra-actions. While students seemed to normalise the poor practices and injustices they observed, they were affected by the realities that they faced. What was striking were the different versions that emerged from similar narratives such as incidents when babies were born with the floor being their first point of contact. A student expressed his horror saying:

And the blood on the floor ... happened often in that facility where women will just give birth on the floor. And it wasn’t an unknown story; everybody knew that at some stage sometime this week some woman is going to give birth on the floor. And you’re like, - umm, how is that a normal thing? How is that something that happens? (student FG, Year 6)

The intensity of the materialising force of the mother-floor-baby assemblage in this narrative illustrates how materiality was entangled in the students’ intra-active learning encounters. To give birth on the floor indicates hardship, neglect and disrespect. The floor is a surface we walk on, not a surface anticipated for birthing. Such intra-actions evoke assumptions of harm and unlawful practices. Yet the student’s narrative contrasts with midwife Gabriel (interview, Facility 3) who claimed that birthing on the floor does not happen often. She explained that “people are not understanding; it’s not that the midwife

is cruel” but that sometimes, especially with foreigners, the floor becomes the appropriate place for the urgency of birth:

it's not that you are pulling and fighting but you ask for one of the students, whoever is around, to bring a blanket or whatever and deliver the baby on the floor, so that you save the life because it will take time for her to go to the bed and climb, even if you are telling climb on the bed, mm-mm she won't understand (Gabriel, 2015).

The quote above surfaces the reality of the material-discursive practices of obstetrics where spacetime mattering (Barad, 2007, 2012) is an entangled phenomenon. All relationships are entangled, such as in/with/in students' learning assemblages which includes the floor, the blood, midwives/doctors, blankets, beds, and other bodies. Barad (2010) writes about dis/orientating experiences, dis/jointedness, dis/continuity and the concept of cutting together/apart emphasising that through relationships and events, things and identities emerge rather than pre-existing as fixed entities and practices. Students are becoming-with many different bodies. Their learning is more than a separated act of developing competence. I propose that a spatial, temporal and material re/configuring calls for a different kind of responsibility that considers these dynamic entanglements.

Following on my reference to the floor above and the force it has in/with/in students' learning assemblages, I will now describe students' intra-actions with other material forces that emerged in my findings. I briefly note the impact of a girl wearing a condom, the weight and burden of substance abuse, then describe how analgaesics become unexpected tools of control and discrimination before moving on to larger issues and material forces enacted in various birthing practices that intra-act with student learning, such as the logbook. I then reflect on my research process to discuss the force of the drawing assemblages and what was generated from these intra-actions with research participants.

In my third focus group, a student expressed her surprise that even an item like a condom worn by a young mother-to-be, raised the ire of a midwife, sparking a vicious attack that left the student unresponsive, helpless and appalled:

Like this one girl, she had condoms on her wrist. And then either she was in pain, I think she was 14 or 15 and she was crying, she was very confused, didn't know what's going on. And the nurse said, 'If you actually put those condoms where

they were supposed to go, you wouldn't be in this position in the first place.' And then I'm just standing there, and then she's smiling pretending like it was just a joke – but it wasn't a joke, it was very, very, ja, inappropriate (student, FG 3).

The agency of the condom with the force to evoke such a response by the nurse was powerful. Without the presence of the condom, different relationships could have emerged. The condom⁵¹ became an active and integral element of the birthing event and affected the students' learning.

The burden of response-ability in obstetrics is compounded by substance abuse. Women in labour who are drunk or intoxicated on drugs (usually on Tik⁵² in the Western Cape) “present quite a challenge to everybody” and contribute to a much more difficult labour for all involved (clinician Ilse). The power and impact of the substances leads to instances of women displaying disruptive behaviours, becoming uncooperative to the needs of the midwives during the birthing process, and frequently ignoring their newborns. As a result, tensions are aggravated. Clinician Ilse explained:

They're usually quite aggressive: they default their clinic appointments or they don't book at all, or they [insist]... no, I'm going home, I'm signing myself out. And they don't take medical advice. Obviously because they're in hospital they're not getting their fix so then just want to go home and it's difficult (interview, 2015).

Students notice that many of the women who are substance abusers are those who are unbooked⁵³, adding to the nurses' frustrations. A student (2014, Block 4 reflection) recorded her disbelief of the situation when a midwife “yelled” at a labouring woman for “not listening”, accusing her of being a Tik user. The student felt herself freezing, felt overwhelmed with a desire to separate herself from the situation. When the student attempted to leave the room, she recalled being “reprimanded by another nurse who asked me to go back and do the delivery”. Such incidents leave students shocked by the hostility towards the patients and themselves, reducing their ability and capacity to productively respond. Midwife Kessie explained that in the past, women on Tik could be referred to Groote Schuur Hospital but now these women do not qualify for referrals and

⁵¹ Why the girl was wearing the condom was unknown.

⁵² *Tik* is the colloquial name for crystal methamphetamine, an addictive drug

⁵³ Unbooked mothers are considered high risk as they have not attended antenatal clinics for medical assessment nor benefited from educational opportunities offered by health facilities for their birthing event.

need to stay in the MOUs. She admitted that “it’s a big challenge that. We have to deliver them.” In this comment there is a sense of objectifying the women/baby-with-Tik. The use or refusal of analgaesics becomes a tool of power and control. Frequent instances of refusal to provide painkillers were witnessed by students who stood by helplessly. In FG 3 a student shared such an event describing the actions of the midwife:

She would give morphine only to patients that she knew from the area or that she liked, or especially if you are married – so if you are married where you had a supportive partner there, she’d be super nice to you, do everything for you; but if you were that 15- or 14-year-old that came alone, she didn’t actually care what happened to you. So I found that to be very, very disturbing.

The morphine was associated with a form of discrimination and consequently administered to some women and not to others. Similar judgement and separation with discriminatory practices was noted and observed by students at another facility where Pethidine was given to assist with labour pains to “patients that [the midwife] knew personally” while for others it had been refused. In FG 3 the student further explained that during “that whole week there had been so many patients who had asked, sister, can I have something for the pain? And she was like, ‘No, you’re in labour, you have to deal with it.’ The relationship of analgaesics with midwives was powerful and clearly selective, unsettling students and their sense of responsibility and desire for equity in health services.

6.2.1.1 Material agency: the force of food

Food security became an unexpected component to this study’s findings. Although it may seem irrelevant for student learning in obstetrics, it does have implications in terms of questioning how far responsibility extends with response-ability to such needs. It raises concerns about hunger, where even students themselves may be hungry.

The absence/presence of food played a vital role producing an affective force in the relationships of birthing facilities with patients, midwives, and students. Midwife Kessie’s generosity connected food with care and kindness, describing how she gave her own food to hungry women who came into the facility in labour. A severe lack of food in a hungry individual puts out a certain distinctive odour, as Kessie explained “you can smell

if somebody didn't eat, they smell ketotic⁵⁴. So that's an indication that a patient didn't eat or drink yet", and adding how resource constraints impact on food distribution in birthing facilities:

we're not like hospital where the patients will get food, a plate of food. The hospital will supply tea, coffee and milk, but that runs out, so we buy out of our pockets. Now can you imagine the patient delivers, you're exhausted and you would like a decent cup of tea. You don't get food. The point is the patients are in the community, so the family is supposed to bring food for the patient. But many patients are unemployed, there isn't food at home for them to bring.

Kessie explains how women in poverty have lesser capacity to act. It is further diminished further by their relationship and intersection with hospital practices, leading to more questions of responsibility. While food may seem insignificant to birthing practices, it does drive certain behaviours that can contribute to obstetric neglect and abuse. For example, in another facility, the force and desire for food propelled a woman to leave the labour ward and go downstairs despite being in the active stage of labour. Student Bongani (2015) talked about his stories in the labour ward recalling this particular one which he represented in his drawing (Figure 6.1) saying, "I think this was the one which at the time grabbed me". He explained how he coincidentally came across a woman he had previously assessed:

I was walking out of that assessment room because it was empty, and the elevator is opposite – and there was a lady there who was just standing... And she was crying, and her legs were open but she's not saying anything. So she was crying and I'm wondering what. And then she said, "Ahh!! My baby is coming is coming!!" And I freaked out. I remember and the sister down the passage was like, 'Get under her so that if that baby comes out you catch it and it doesn't fall on the floor.' I literally had to run, [chuckle in voice] oogh, and literally I actually lifted her dress and I saw the baby's head. So it was one of those – and I was lucky actually – so as the head was crowning, I told the sister and immediately – we had to actually get the bed to come out and put her on the bed rather than her walking because the sister was like ...

⁵⁴ *Ketotic* refers to a metabolic state of the body when fatty acids are converted into ketones rather than the normal process of glycolysis where energy is generated through a process that metabolises blood glucose.

Bongani's action in this birthing event was initially triggered by food and hunger. The relationship of the food, elevator, dress, labouring woman and bed all contributed vital material and affective forces resulting in the emergence of the neonate. There were multiple intra-actions in the performance of this birthing process. From an agential realism stance, the enactment of the birthing process was more than intentionality and independent choice by both the woman in labour and the student rationally choosing his response. A relational ontology supports an understanding that different forces are materialised in each encounter that is more than a human-to-human interaction.



Figure 6.1: Recalling the event outside the elevator (drawn by student Bongani)

Bongani's drawing (Figure 6.1) was created in two stages. First in class with a focus on the woman in labour crying in despair, feeling a sense of powerlessness, then later in our interview where more detail was added. He included the spillage of blood and amniotic fluid, added hair to the woman and then drew himself noting his "very long hands – because I was on my knees at this point" thus giving emphasis to his movement and

adaptability to the space in which he found himself, bringing a focus to the relationship of spacetime mattering.

In the next section I consider further the intensity of material forces and their relationships in students' learning assemblages and what this can mean for engaging with students' response-abilities. I refer to the intra-acting curricular forces acting in and through congealing assemblages as students are becoming-with others in their learning events. Material vitality is generally overlooked in a humanist perspective. When matter is considered to be inert and passive, without recognition of the "thing power" (Bennett, 2010), a limited perspective of the intermingling relationships emerges. I consider the implications put forward by Bennett (2010) that material bodies have a vitality with a "capacity ... not only to impede or block the will and designs of humans but also to act as quasi agents or forces with trajectories, propensities, or tendencies of their own" (p. viii).

6.3 Material-discursive practices in curricular activities

As indicated by the examples above, students' observations of prevailing practices entail their entanglement with other bodies, both human and more-than-human. Below I focus on relationships of spacetime mattering in students' learning encounters moving on to a more detailed description of the three most vital material forces that "glowed" (MacLure 2010, 2013a, 2013b) for me in my findings namely the curtains, the bed and the logbook.

Beyond the different people moving in and out of the birthing facilities, the environment and physical arrangements play an important role in what emerges in those spaces. At least three clinicians commented on the design of the public birthing facilities where efficiency for the workers was clearly prioritised over patient privacy and comfort. "it's just a straight walk through the labour ward ... safer because it [provides] easy access through to the patients" (Sarah). Clinician Derek (2015) explained:

when you think of facilities and how they're put together and how they're constructed, the focus is more on the worker in terms of creating something which allows for rapid moving from one patient to the other. You're not thinking of the individual mother having a baby and creating the environment which suits her. The environment suits the worker. So, I think that's why there are simply curtains that you can just pull open and closed.

The design and limited space is also not conducive to partners being present. According to Derek, the space and privacy issues are used as an excuse by some nurses to refuse

companionship to mothers in labour. In our workshop interactions and reflective commentaries, many students noted their concerns about partners being unnecessarily excluded from the birthing process. The space appears to give nurses the power to control the presence/absence of others, despite policies to encourage companionship during labour based on evidence that continuous support during labour and birth improves the outcomes for both mother and baby (International Childbirth Initiative, 2018).

Within each facility are numerous birthing accessories and forms of equipment that are used when medically necessary to support facility birthing practices. Apart from the instruments there are also basic aids such as sterile gloves. While the lack of equipment in some facilities played a pivotal role in students' response-abilities there were several encounters with the force of equipment/instruments that shocked students, leaving them unresponsive. In FG 3 a student noted "we ran out of gloves". I think it was particularly the sterile gloves that we ran out of, so PVs⁵⁵ were being done with non-sterile and sort of a sterile technique but with non-sterile gloves – so it wasn't actually a sterile technique at all." Such harmful and unethical practices related to "the deprivation of supplies" are not unusual in the resource-constrained environments in which the facilities have to operate (Rucell, 2017, p. 196).

Midwife Kessie referred to these conflicting messages for students, where objects such as vaginal bowls for PVs contributed to poor practices, saying:

We want them (referring to the students) to wear the protective attire. Because of sterility and aseptic techniques. We want them to prepare their delivery bowl properly so that at the end of the day sepsis and those kinds of things, the numbers can drop. But students have issues with those kinds of things. For them it's unnecessary.

Because of the mixed messages from different facilities, students learn that an object such as a vaginal bowl may not be necessary. What is deemed necessary in one unit seems unnecessary in another. While different ways of doing and being are not unusual in any practice, the combination of tensions with these uncertainties brings an additional force (and fear) on students that appears to limit their ability to respond to any wrongdoing. The bowl-student-vagina assemblage becomes a powerful force

⁵⁵ Vaginal examinations (known as PVs) are an integral part of obstetrics to determine the timing and movement of the immanent birth.

contributing to students' tensions. Student Alice yearned for more consistency and expressed her frustration at the different messages received in the learning process saying, "so the whole time, every time you do a delivery, the midwife is telling you something different. So you're constantly unsure".

Further examples that illustrated the significance of material agency in student learning included what they observed with nurses' activities, as well as articles of clothing. There were instances where midwives stayed at a distance from women in labour, drawn instead to the desiring force of other bodies such as television sets and tea/coffee mugs. Students noticed how these material objects held the nurses away, reflecting on these incidents in their class performances. Clinician Ilse confirmed these practices that led to the neglect of women in labour. Students were left to deliver babies on their own. Ilse said "I don't think it would benefit them to make a story up like that – so I think it's actually real". On many occasions in our classroom workshops, students have roleplayed such scenarios. If and when these nurses do appear and emerge from their restroom chairs, they are often rude and abrasive to both the students and labouring women, indicating their annoyance at being disturbed. Students may feel shocked and helpless in such circumstances. These students' experiences mirror findings from Pickles' (2015) research where she noted:

calls for assistance are left unanswered either because of resource shortages or intentional staff conduct (watching television, sleeping, talking, having tea or a meal); patients deliver without knowledge of what to expect and at times on their own (p. 9).

While Camille Pickles reports such behaviours as intentional, in terms of conduct, a relational ontology provides a different perspective by relating to 'thing power' (Bennett 2010). Apart from symbols of rank such as epaulettes worn by nurses, there are less obvious symbols of power in obstetrics. For instance, when students put on the thin white plastic aprons in the birthing facilities, the aprons play a significant role in their becoming professionals. Clinician Derek (interview, 2015) explained, "when they [students] do the delivery they obviously wear an apron; so that's part of the community of practice. You have to put on different clothes; you're becoming a different person in a way." Other signifiers of the community include stethoscopes and white jackets. Student Muhle noted how his white jacket helped him to stand on a pedestal of importance in the hierarchical positioning that a medical qualification provides (Figure 6.2). Without the jacket he felt he would have just been like anyone else in his disadvantaged community,

Langa. He explained, “putting on this magical piece of attire manages to do that, manages to put people where they can only see people down there and them up here”. The white coat also appeared to provide a force that distanced him from others, acting as a separating agent.

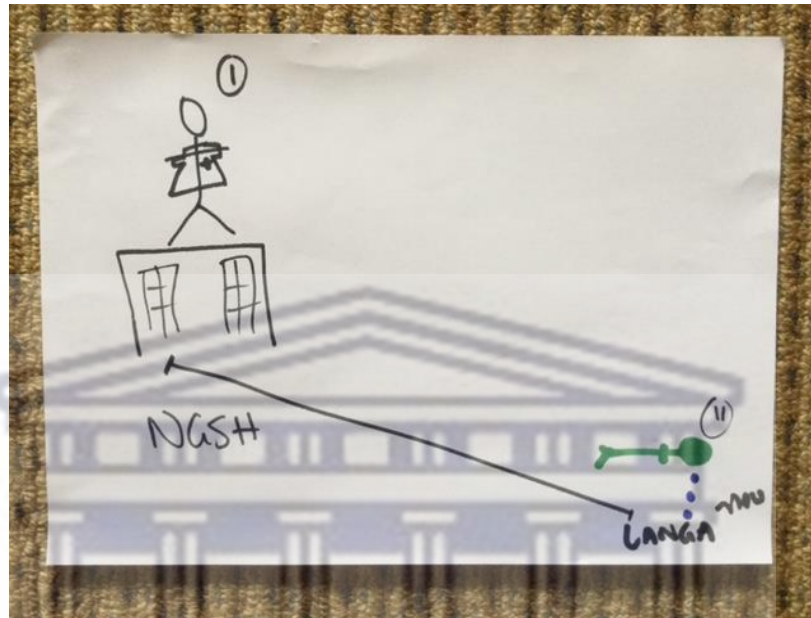


Figure 6.2: Student Muhle's impression of the power of his white coat

Like the apron and the white coat conferring status and a certain becoming-with the students, I refer to the literature on FNM, where Liza Mazzei (2013) writes about the force of certain pieces of clothing in an educational context. She relates her interview with academic Sera who reflected on an event in her undergraduate years. Sera bought a suit especially for a volunteer task at a Communications Association meeting. Mazzei (2013) explains how the suit gave Sera confidence and seemed to change how she felt, a different status through the entangled relations of human and more-than-human agents as “[s]uits are constructed to render an image on the part of wearer as conferring status, conformity, and confidence” (p. 780).

The examples above illustrate how matter matters for students in their obstetrics encounters when they are becoming-with their curricular tasks. Below I take a closer look at the students' relationships and assemblages with curtains, beds and the logbooks that impact on their learning and becoming.

6.3.1.1 *Curtains as seeping boundaries*

The students-curtains-women in labour form assemblages that both facilitate and constrain students' responses. Clinician George remarked how the curtains are part of the facility design for efficiency so that they can be simply opened and closed. Students regularly observe curtains left open with women exposed. In my FG with Year 6 students the discussions began with a student recalling her "terrible" experience noting that "it was horrible and I was on number fourteen⁵⁶". This student described watching midwives "saying unnecessary things ... even laughing ... [and] they left the curtains open" when a stillborn was delivered.

The material curtains in the public birthing facilities do not promote privacy. Clinician Freda remarked that "it's so easy to barge in; you can't knock on a curtain and [ask] may I come in?" The women-curtain-student assemblages were prominent in several students' narratives. In the Year 4 FG1, a student explained how a doctor set the curtains as a boundary marker to keep the students out and distanced after they challenged her about a disrespectful act:

So after that she was like mean to us: you can't watch procedures when I'm doing them. It says in logbook I need procedures. So what must happen?... The same doctor. And she was like, when I'm doing procedures don't even bother; you're outside the curtain, please close the curtain on your way out, thank you. We are told to watch procedures but then here's this person who's obviously bigger than me, telling me to step outside. I was like, no, I'm not going out, I'm meant to watch procedures.

In the Year 6 FG a student explained how the curtains rendered her powerless in helping a grieving mother (Figure 6.3). She was excluded from the process, misrecognised:

we saw this drawn curtain and we saw wheels. There was that sense of gloominess and hush-hush and nobody was speaking to anyone and nobody was explaining what's going on. And then they just brought out a green sheet and they covered the child in the green sheet; obviously the mother saw the child, and then the child was placed on this trolley and then was just left there for a while and then wheeled off.

⁵⁶ "Number fourteen" as noted by the student, indicates the importance of the number of deliveries. This number signifies to others in the FG that the student was one away from the desired fifteen deliveries.

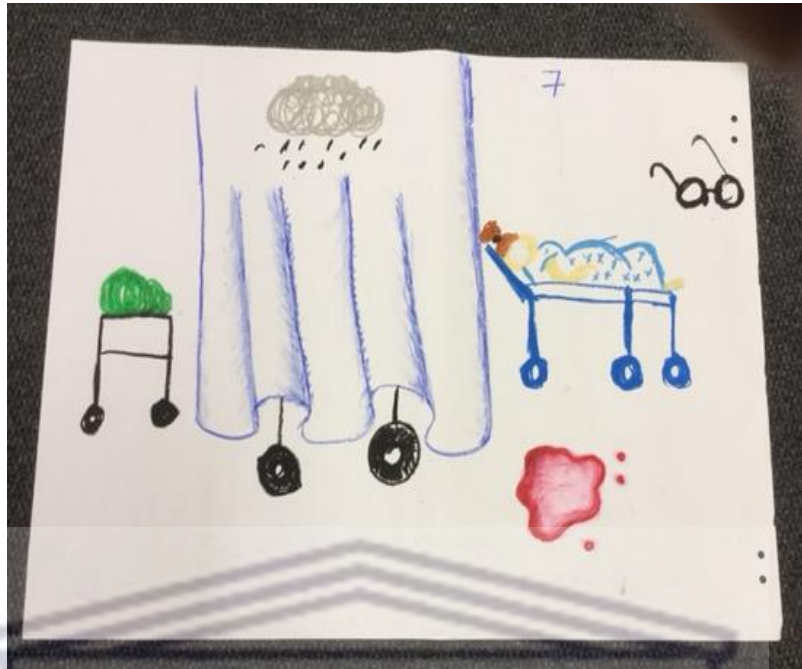


Figure 6.3: The blue curtain-with student enacting her sense of exclusion and misrecognition (drawn by student, FG 1)

What is apparent from the quote above is how prominent the agency of the material matter was in the event that the student describes (and draws). The agency of the curtains, wheels, green sheet, and trolley indicate how matter matters. A human-centred approach would dismiss these important forces influencing the student's ability to respond. The assemblage comprises much more than human-to-human interactions or the absence thereof.

6.3.1.2 The power of the bed

The bed plays a significant role in birthing. It was surprisingly foregrounded in many of my interviews with educators and the administrators, reminding me of my own experience of being placed in a lithotomy position on a bed with no choice but to obey the authoritative commands of the midwife and obstetrician.

Such restrictive practices are very different to the natural process of birthing which allows for many alternative positions for the active stage of labour. Student Alice felt a sense of joy when she noted how a large exercise ball in the birthing facility allowed the women to "do all the different poses in labour – so they could squat or they could sit or lie down; and they didn't have to be lying on a bed". This practice resonates with the Peruvian example described in Chapter Two where women resisted facility-based

birthing preferring to be free to choose a vertical position. In contrast, in this study, there appeared to be more students who helplessly watched women constrained to a bed. The material force of the bed, especially when connections were made to monitors, appeared to overpower other forces, leaving students at times feeling helpless and frustrated.

It was also an indication of the dominance of safety and surveillance measures that prevail in many facility practices where students learn. For instance, foetal heart monitors are frequently used on women constrained to their bed. The monitors are connected to the women's body with pads to detect the foetal heartbeat through ultrasound waves. The waves are transformed to visual displays on the monitor. Karen Barad (2007) refers to obstetric ultrasonography using it as an example of an apparatus that makes and remakes boundaries such as between "human and nonhuman, living and nonliving, visible and invisible, autonomous and independent, self and other" (p. 201), thus showing the dynamic and indeterminate nature of an apparatus. The interface of intra-activity between a foetus examined through ultrasound and the equipment illustrates the material-discursive intra-actions. Barad (2007) explains:

the marks on the computer screen (the sonogram images, sonic diffraction patterns translated into an electronic image) refer to a phenomenon that is constituted in the intra-action of the "object" (commonly referred to as the "fetus") and the "agencies of observation" (p. 202).

Among the consequence of the apparatus described above is that the mother's needs become less significant. She is just a part of the dynamic apparatus enacted in the birthing process:

Apparatuses are not preexisting or fixed entities; they are themselves constituted through particular practices that are perpetually open to rearrangements, rearticulations, and other reworkings. This is part of the creativity and difficulty of doing science (Barad, 2007, p. 2013).

A conversation about monitors emerged in our FG 3. Students had observed that when women were connected to monitors, they were forced to remain in a certain position, at times for lengthy periods. A student exclaimed that a CTG⁵⁷ "is not your chain, it shouldn't be your ball and chain". Another student shared witnessing that "a woman would be on her side for six or seven hours and they say, no, it's for the benefit of the

⁵⁷ CTG is the acronym for cardiotocography machine which measures foetal heart rate and uterine contractions.

baby". Such limited positioning and restriction on movement is not necessarily conducive to a comfortable labour. While a third student said:

Most of the women had to stay on the side ... because then the foetus has to actually be continuously monitored, so then the sister would say that it's best for the baby and she would be specific on the side as well. So the woman couldn't even change, she had to lie on the one side and she'd only be like six-seven cm dilated. And you'd be there with her and the contractions would get worse and worse and worse – and of course you want to change so you can be more comfortable – but then most of them weren't allowed. So that was also something that I couldn't really understand.

Such rules and practices confuse students. They respond by being compliant with those in authority who have more experience. While the monitors are extremely valuable in preventing complications, students are immersed in the indeterminacy of practice. Even in uncomplicated events they witness, women not given the options of alternative positions. When routinely used in medicalised birthing, students are limited in their own responses to women's needs and different options.

It's sort of everything that we're taught to help make birth more holistic and a more pleasant experience for women, like birthing positions for example, I didn't see that once, I didn't see one woman being offered what position she wanted to give birth in (student, FG 3).

The students' concerns about positioning resonates with the recently released Charter on the Universal Rights of Childbearing Women (White Ribbon Alliance, 2011) which notes in the first of ten criteria for mother-baby friendly birthing facilities that the unit:

Offers all birthing women the opportunity to eat, drink, walk, stand, and move about during the first stage of labor and to assume the position of her choice/comfort during the second and third stages, unless medically contraindicated (p. 96).

Clinician Sarah commented on the physical arrangements in the birthing units. She described how the positioning of the monitor readings were at one stage situated in a central area but later shifted to the individual cubicles. It was found that the collective recordings in a central space reduced the nurses' attentiveness and their responsiveness to the labouring women's needs:

at one stage where the CTGs the recording of the baby's heart, all came onto a central bank – so people sitting at the nurses' station could watch the CTGs, they could see eight CTGs. Now that's fine, you'll know when one's going wrong – the trouble is you don't know what the mom's doing. And they actually disconnected it eventually because they found the staff weren't going through to see the moms....And it's the difference an ICU where you have all the ECGs up at the central station and a labour ward where there should be comfort for a mom. And that's not just a CTG, that's a presence there.

6.3.1.3 “This logbook chase”

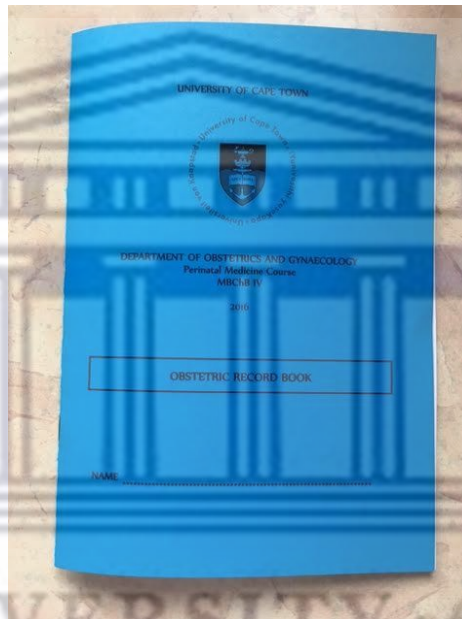


Figure 6.4: The cover of the student logbook at UCT (Annexure 7)

Below I expand on the force of the logbook (Figure 6.4) in student learning that became apparent in this study, and how it actually distracts students, limiting their responses to engage with relationships and responsibilities that can promote social justice. Student logbooks (see Annexure 7 for full logbook details) are used widely in medical education, particularly in the clinical years (Huang, Almeida & Roberts, 2012). The logbook provides a record of students' acquisition of knowledge and skills specifically relevant to the discipline. In the UCT obstetrics departmental logbook there is a special note for the birthing facility sister which states:

All that would be required is for you to sign the register below and grade the student after 2 calls at primary level and 5 calls at secondary level. Your signature would indicate that the student was present on the day indicated and

participated in the activities of the MOU (monitoring patients, performing deliveries, attending ANC, taking booking bloods etc.)

Putil and Lee (2002) claim that “Course-specific logbooks provide a means for monitoring student learning, both for the student and for the instructor” (p. 673). Such conceptions of the logbook consider it as an inert and passive object yet the signature-logbook-student becomes a dynamic apparatus that mediates the agenda of task-driven processes (Barad, 2007). The logbook diverts attention from issues of patient care and justice, often acting as a barrier to quality care. In my initial online survey, a student claimed “it’s difficult to advocate when you need the doctors and nurses to sign for you later”. The logbook became a prominent topic in the FG 2 with year 4 students. Below I refer to three participant comments:

I just felt like we kept having this 15 deliveries topic all the time – so that’s what everything was packaged in for me. So it was really difficult, like you must keep going there and I found that affected even the way you could interact with some patients. And I was really sad with that because, ja, you can see labour is real – like yoh, it’s very real for women. I was sad not to be able to interact with them as much as we would have wanted to do sometimes.

I think in a lot of cases we actually wanted to say something on behalf of the patient, but you can’t because there’s this logbook that you need to get signed and you know that if you say something, the sister might get upset and then you get a ‘dissatisfactory’, which affects your mark at the end of the block. So I think if we didn’t have that logbook constantly forming a boundary, then we’d be able to speak up for some patients.

I think logbooks can become stressful but it is important not to let them drive us.

The logbook-students assemblage plays a dominant role in student learning; a much broader role than anticipated as it appears to drive students’ thinking and acting. It is a powerful and significant actor in student learning. Clinician educator Hazel suggested that the logbook “takes on this magical kind of power” as it is in essence “a huge obstacle for all sorts of learning processes to take place”. Students find that completing the logbook takes priority. The need for the required ticks and signatures mitigates and undermines their efforts to offer care to women in labour and to respond to any injustices they witness.

The signature itself has undeniable agency, adding to students' stress in the block. In my interview with student Muhle (2015) he explained 'nurses don't want to sign, it's very difficult ... it feels like you're sort of held at ransom for signatures'. He expressed his intense dislike with the logbook system saying, "I don't agree on how the logbook is structured because it unnecessarily forces a student to focus on numbers rather than people". These sentiments were shared by other students, educators and midwives in this study. Clinician Doreen claimed "when you are so fixated on getting your 15 deliveries, your compassion goes down; or your observance or your consciousness around other people. Not all students". Clinician Hazel agreed, saying, "it generates enormous anxiety in students and therefore they're less able to participate and learn because they're anxious. And I think it's counter-productive to all pedagogical objectives". Yet the logbook and similar systems for accountability in learning are universal assessment tools used across many disciplines. My study findings indicate the intensity and the force of the logbook. Its relationship with students in their learning illustrates the mutual becoming-with the other through a continuity of varying capacities to act and respond to unjust practices. It influences students' power to act and be acted upon thereby carrying an affective intensity that is described further in the following chapter.

The sign-offs indicate that students have achieved the required skills and number of procedures to complete the course objectives (a task-oriented move for accountability). These signatures exclude the relationship issues embedded in the events of signing that reflect power and authority. There are frequently difficulties in attaining the necessary signatures with extra efforts that are made. Students learn to please those who are responsible for the signatures. They feel a dependency on those who hold the power for sign-offs. Sometimes students find themselves having to beg, plead, and "suck up" to midwives, as students have shared in our classroom discussions. Any conflict can result in a refusal to sign with unwelcome consequences. Therefore, students avoid any conflictual situations, limiting their ability to respond or challenge disrespectful behaviours by those with the power to provide signatures for the logbooks:

And I found myself sometimes compromising what I believe and the way I think patients should be treated in order so that I can get a signature or so that I don't conflict with the sister in charge or whatever doctor that was working there – because obviously the environment is very much determined by them (student, FG 3)

The signatures become determining forces for students' attitudes and behaviours as they move through their eight weeks in the learning block. A desire to achieve the necessary number of signatures appears to distract students' sense of responsibility in caring for women in labour. For some, the signature matters most - at a cost. A student in FG 2 admitted how he shifted from sticking to rules, to breaking them in order to achieve the course outcomes, "I ended up sleeping in my car most of the time with all the calls that I did and end up driving like a hooligan just to get deliveries done". This student compared his "maniac" driving to being in a Formula 1 race where a yellow flag signaled that he was doing something wrong, getting a penalty, taking risks in order to complete his logbook.

In FG 3 a student shared how even a patient had noticed the nurse's poor attitude and questioned the student whose explanation about her non-responsiveness related to the power of the signatures:

Why is this sister treating you guys like this? It's almost as if she was never in the position where she was a student.' And for a patient to say that and to see how badly we were being treated, it just spoke volumes to me – and we were like, ja, well that's just how it is. And I found myself sometimes compromising what I believe and the way I think patients should be treated in order so that I can get a signature or so that I don't conflict with the sister in charge or whatever doctor that was working there – because obviously the environment is very much determined by them.

In terms of ethics, the signatures also provoke irresponsible and unprofessional behaviours by students that are picked up by midwives. Gladys shared her frustration at the pressure put on midwives by the system when students insist on getting their signatures despite the inappropriateness:

So midwives don't want to sign for stuff they didn't (witness), and I think students, some of them feel but you were on duty. But I wasn't there when you did the procedure; I didn't see you see the PV, I didn't see you examine the patient, so how can I say that you've done it and that you're competent but I didn't see you?

The signatures become a point of conflict. Gladys added, "the other thing is also what they do is they ask their friend to look after the patient and do the things and then they

want you to sign". These kinds of actions demonstrate how students learn to be strategic with the curricular regulatory needs and arrangement which adds to the tensions and is problematic for institutional responsibilities as well as others around them. Similar incidents of dubious truthfulness have emerged with departmental action taken over false signatures.

The agency of the logbook operates in this environment and is also situated in the context of time pressures on students. Clinician Doreen described "the logbook chase" that adds stress to the curriculum that is already "very demanding". When a woman's labour does not progress as expected due to complication or other interferences that mediate against a natural birth, then a Caesarian section is performed. This means that students do not gain anything that is reflected in their logbook. Muhle admitted "You could spend 12 hours on call and have nothing, naught deliveries. You can monitor a patient from when she comes in, spend eight hours with her monitoring and she could go for a caesar ... and that counts against you because that's zero deliveries". In such cases the signature-logbook-student develops stronger intensity providing even more pressure on students to attain the necessary signatures. There have been anecdotal instances in the department when students have been pushed over the line of honesty, fabricating signatures to move on.

The logbook also has a vital gatekeeping role. Fiona, in her role as a departmental administrator, explained that students' marks are held back till their logbooks are complete, saying, "their marks won't be released unless the logbook is complete, that's the DP". The signed-off logbook is an essential component for students to acquire their Due Performance certificates to be allowed to write their exams. What matters is the collection of signatures. It opens the academic gate to allow students to pass through into their next learning block in the sequence of learning events that make up the undergraduate spiral curriculum.

Moving away from ticks and signatures in logbooks, in the next section I focus on drawings that were used in my research study and teaching. I discuss the materialising forces that emerged as research participants and students intra-acted with paper. My findings reveal how the drawing process opened up new insights that provided valuable information for this study.

6.4 Becoming-with drawings

Drawings were used extensively in my study with each research participant asked to supplement our discussion with a drawing. While many drawings, especially from educators, became organisational mappings of student-related activities and positioning, the assemblage of paper-pen/pastel-research participant yielded valuable insights from all research participants. In the section that follows I describe the act of drawing as an assemblage in my research and the work of drawings as material-discursive practices that opened up affective spaces to offer novel insights into exploring students' response-abilities. Drawings provided a tool for affective expressions, revealing more about what has been silenced in the obstetrics curriculum. As a pedagogical device the drawings contributed to building students' capacity and ability to respond to issues of injustice. I suggest that drawings enable new possibilities for intra-acting in troubling teaching spaces.

As research participants were becoming-with drawings, conversations were extended, as well as a noticeable triggering of affective forces and flows. On several occasions new insights emerged in and through the drawings. Without the drawings these add-ons would have been missed. For instance, midwife Gail (2015) changed the direction of her discussion with the drawing (Figure 6.5) moving into the problems of the medical hierarchy. She said, "what keeps coming back to me is a kind of little weird because it's not what I thought I'd drawn", expressing her surprise at what she drew, and actually laughing. She explained how her productive engagement with students is often disrupted and undermined by the intrusion of someone "who has more authority, more experience and is better educated ... has higher qualifications than I have ... then I think all of what I've said is minimised". She highlighted the patriarchal and hierarchical culture in the profession referring to "a little green man", who appears in the bottom right hand corner of the page, symbolising a male obstetrician who is undermining her enthusiastic efforts as a female midwife. Green is the colour most frequently used for scrubs⁵⁸ in operating theatres, where doctors take over control.

⁵⁸ *Scrubs* is the term for the protective clothing used by medical personnel in theatre.

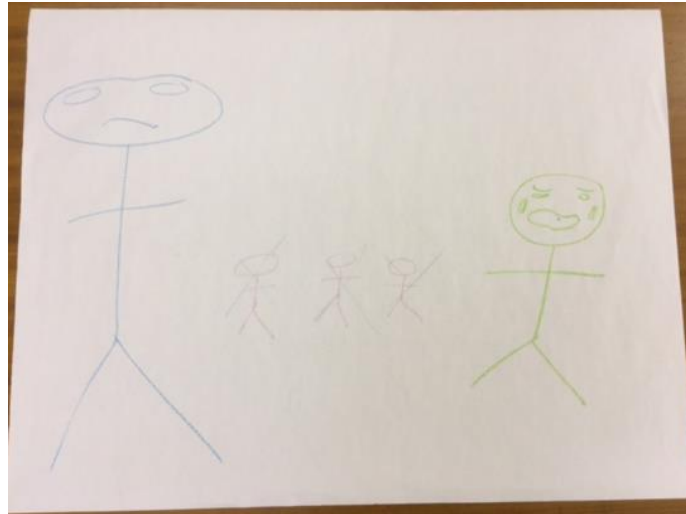


Figure 6.5: Midwife's sense of helplessness with the intrusion of "the green man" (drawn by midwife, Gail)

Two other educators shared their holistic perspectives and hopes for student learning in obstetrics through their very quick, simple drawings (Figure 6.6 and 6.7). Midwife Mervin explained how he seeks out a balance between knowledge acquisition and a more humane and ethical perspective in obstetrics. Similarly, from the drawing assemblage, clinician Doreen noted that "the essence of our conversation (referring to our interview) is about heart but on top of that it's about relationships". While both these educators were referring to human relationships, their intra-actions pointed out how obstetrics learning ought to extend beyond the acquisition of competence and expertise.



Figure 6.6: A scale to find balance in student learning (drawn by midwife, Mervin)



Figure 6.7: Explaining wholeness (drawn by clinician, Doreen)

6.4.1 Engaging more with the material vitality in the drawing assemblages

The materiality and agency of the different components of the drawing assemblages produced meaningful surprises. Below I describe how these forces contributed towards a responsive assemblage that has shifted and disrupted the status quo of a static, fixed curricular programme to agitate towards making visible that which has been hidden and silenced. The paper and drawing tools were noted as important components in eliciting materialising forces. Even the size of the drawing paper had an intensity that was significant and mattered, as will be explained in the example below where clinician Sarah switched to a smaller, more usual paper size similar to her A4 files and patient folders.

Drawings were requested from all research participants, which included students, administrators, nurses, and clinicians at all levels from medical officers⁵⁹ to professors. What was strikingly noticeable was the reticence and caution displayed predominantly by the experienced educators and practitioners who were engaged in this study and connected to student learning. On several occasions I found myself as the researcher offering encouragement to “just draw” and to alleviate anxiety and concern about an artistic production. In my interview with midwife Joan (2015), she giggled saying “I’m useless at drawing” as she blankly looked at the sheet of paper, then admitted, “I don’t even know where to start when I look at a piece of paper like this”. The force of colour helped to initiate the process as she connected with a grey pastel to indicate the

⁵⁹ A medical officer is a medical graduate who is registered with the Health Professional Council of South Africa but not a specialist.

movement of students into a “grey area” where there is “a mixture of a little bit of happiness here where it is safe and an awful lot of danger.” Then the red and orange pastels moved her to illustrate students’ anger and fire where there ought to be calm, followed through with blue for calmness leading to her demonstrating more eagerness and energy to fill the paper (Figure 6.8).



Figure 6.8: Drawing by midwife educator expressing her hope for students to feel the calmness after the fire and anger in midwifery (drawn by midwife, Joan)

There was some reticence with the process. Clinician Sarah (2015) seemed to feel intimidated by the large A0 sheet of paper and refused the opportunity to draw, explaining that it was not a form of expression that she was accustomed to. It seemed like the paper was separating itself from her, holding her at a distance with no desire to allow herself to move towards a process of becoming-with the paper. However, an alternative possibility with an A4 sheet of paper invited her in, with some persuasion from me thereby facilitating a drawing response (Figure 6.9). Through the assemblage of paper-pen-clinician, a flower emerged as a representation of the professional attributes expected from graduating students. I recognised the image as one similar to the Canadian competencies symbol which has a flower-like image with petals to represent the competency components of the CanMED⁶⁰ outcomes-based competency framework

⁶⁰ The CanMED framework indicates seven competencies needed in medical education namely, Medical Expert, Communicator, Collaborator, Manager, Health Advocate, Scholar and Professional (Frank & Danoff, 2007).

used in many medical training institutions globally. Clearly a representational form of communication was more comfortable and usual for this professional.



Figure 6.9: Reduced paper size appeared to be more desirable for drawing

The majority of students who volunteered as research participants eagerly connected with the papers and drawing equipment. Student Lesego's (FG 2) experience was exceptional. She explained that she had not been able to draw on the A4 sheet of paper handed out in class. It had disabled her by reminding her of her anger. The paper-pastels-student assemblage mimicked her helplessness at witnessing apparent abusive practices on a 15 year old girl. Lesego described how a vacuum delivery had been harshly performed without informed consent nor analgaesics. A vaginal fistula and fourth degree tear resulted, both of which were deemed preventable by the student.

The drawing assemblage appeared to produce repulsive forces maintaining a distance with separation of bodies. To compensate and to comply with the classroom task a drawing of a perineal tear was produced by Lesego's clinical partner (Figure 6.10).

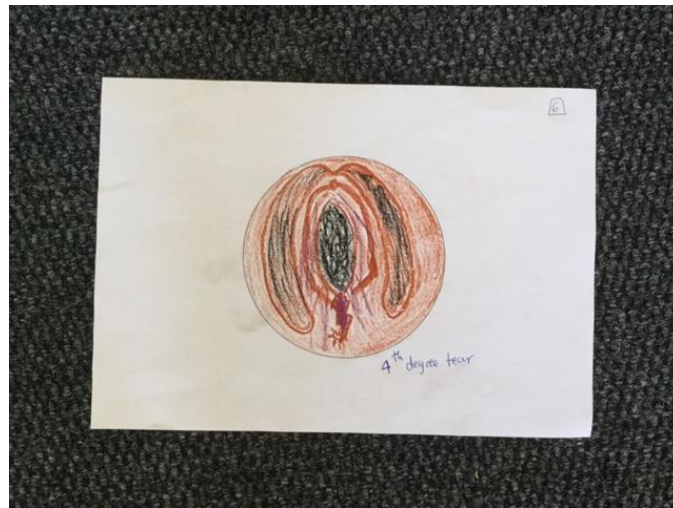


Figure 6.10: Drawing of perineal tear by Lesego's clinical partner

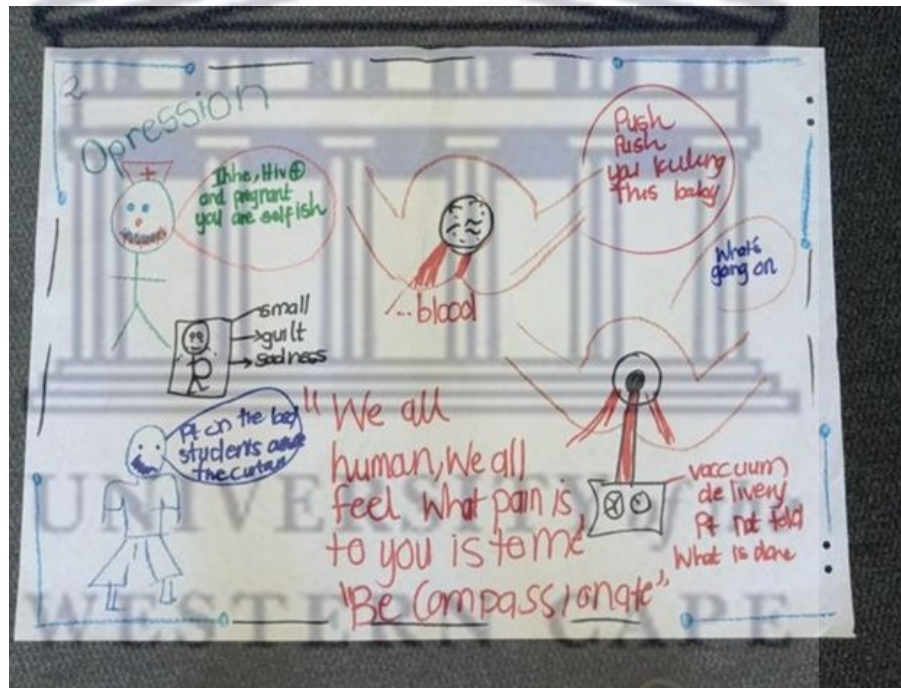


Figure 6.11: Lesego's drawing in FG 2.

Lesego's drawing of the vacuum delivery on a "petrified 15 year old girl"

At the focus group, three weeks later, when faced with a larger piece of paper, Lesego felt a release of tension that facilitated her movement into an assemblage with the paper and markers. She explained that "with this drawing I think I felt a bit better now; I can actually put it on paper". The drawing assemblage appeared to open up her held-back emotions with an increase in affective capacity that empowered her to share her experience and thoughts to a/effectively respond to her troubling learning encounter.

Only markers were used in her drawing where the dominance of red reflects how the materiality of blood stayed with her. It appears that the affective sensibility of blood and placentas have remained with her, as she explained:

Most of the time I just remember seeing blood and actually going to that sluice room and cleaning up; like people always think I'm joking, I say I can smell placenta and everywhere, all around me and the blood – I can smell it. When something even smells funny, I start, hmm, is it a placenta? [laughter].

Other students in the same FG agreed that the smell lingers on. It appears that the smell is haunting as it re/turns. In our introductory sessions, students write about how they have heard from other more senior students that the smells that emerge in obstetrics are an aspect of the curriculum that they will never forget

In terms of what the smells are doing, Manning (2007) encourages us to “to think of the senses as prosthetic devices, always more and less than single and singular bodies” (p. xxii). The act of drawing had moved the student group into becoming-with the many sensual affects that stayed with them. The blood, the trauma, the pain all became connected as Lesego shared:

I could see the face, the look on that girl's face, for me it was too much. And I'm still dealing with it of course, but one thing I must say, when I see that doctor, even 'till now, my blood boils. But I'm trying to control it because it was just so traumatic, hey, it was very bad, it was sad.

Each drawing process was an enactment, a collective process in which different assemblages were co-created by the prevailing material and discursive relationships. Such a relational conception of drawing is different to interpreting drawings as individual activities directed by choice and intention. My findings indicated how the dynamic assemblages of paper-pen/pastel-student/educator/administrator opened up in-between spaces that revealed more than anticipated, adding to and supplementing my data collection in interviews, FGs and the online survey. These traditional research methods draw mostly on language and text. When asking research participants to draw their thoughts referring back to their obstetrics learning/teaching, what became apparent was that the assemblage of paper-pastel/marker-hand-mind became entangled with thoughts and memories creating “a state of mutual becoming-with one another” (Lenz Taguchi, 2010, p. 107). As indicated by Gail, the relational process opened up new ideas and

stories. In terms of a Baradian relational ontology, drawings emerge as products of the entangled intra-actions between humans and more-than-humans.

Furthermore, the drawings constituted in this study have each become an apparatus that has been put to work in different ways, for instance in publications (Mitchell, 2016) and conference presentations and as a collective student resource. In terms of agential realism, apparatuses “enact what matters and what is excluded from mattering” thereby determining boundaries through the cuts that are made (Barad, 2007, p.148).

I take up the suggestion that an arts-based mechanism such as drawing be used as a pedagogic device to elicit affect with medical students. This kind of creative practice that closely and e/affectively engages with matter, can alleviate the separation and distancing of affect that is presently apparent in medical curricula. The drawing process becomes a data-in-the-making with students, enabling affective flows. It is “facilitating a shift towards a socially just pedagogy that can open up the precarious entanglement of teaching, research and learning” (Mitchell, 2016, p. 251). Such an overt turn to the affective domain provides alternative insights that can be affirmative, productive and render students capable and able to respond to unjust practices.

6.4.2 What are drawings doing?

The drawings opened up channels of thinking and doing. As a tool of multimodality (Jewitt, 2008b; Kress, 2010; Kuby, 2017; Wohlwend, 2011), the process of drawing produces different forces that interfere with each other in the unfolding of matter and mattering. I felt that the multiplicity of relationships enacted in the drawings in my study added more to my research findings than if I had taken up a representational interpretation of the drawings. As the research participants were becoming-with the drawings, the dynamic and collective process opened up more-to-come. I refer to Deleuze and Guattari’s (1987) “logic of connection” (St. Pierre, 2013a, p. 652) that places an emphasis on this ongoing process of becoming-with, indicating that there is more to come (St. Pierre, 2018). It is an expansive movement that differs from research and curricular activities that involve participants’ doing and being which actually brings closures and stability.

The students’ drawings in my study led to an active engagement with the material agency which “contributed to an improved understanding of student learning often

hampered by students' limited opportunity to express their affective responses" (Mitchell, 2016, p. 251). The drawings acted as a mediating tool to disrupt the status quo, to reveal what has been silenced. As Hickey-Moody and Page (2015) point out, arts-based pedagogies can position the agency of matter to resist dominant discourses.

6.5 Conclusion

In this chapter I have elaborated on the students' positioning in their obstetrics learning. My findings highlight how student learning is strongly influenced by the agency of materialising forces that can be detrimental to their flourishing, to their responsibilities and response-abilities leading to students' powerlessness to respond to the multiple acts of disrespect that they confront in their obstetrics rotation. The curriculum has a force on students' becoming-with others, both human and the more-than-human, through their curricular engagement where what matters, at times undermines their ability to respond. Consequent feelings of helplessness, guilt, and shame were revealed.

What is significant in the sections above is that material vitality contributes to the curriculum's powerful force. Students are not isolated, independent individuals but becoming-with multidirectional forces generated by the material-discursive practices in their curricular tasks, Humanist boundary-creating processes that contribute to distancing and separations appear to be limiting students' responsiveness to the disrespectful practices they observe.

I foreground the intra-actions of the curtains and beds in the birthing units and most importantly, the student logbook that does more than act as a record of student learning. My findings highlight the divisions and distancing evoked in/through with the curriculum. Such separations appear to perpetuate social injustices and students' unresponsiveness. A relational ontology can focus on the entwined relationships and the possible potentials for change, affirmatively contributing towards developing a socially just pedagogy,

The learning apparatuses configured through space and time entail materialising processes emerging from iterative intra-actions among health team members, women in labour, beds, curtains, drugs such as analgaesics, monitors, student logbooks and other material agents and bodies that form part of these apparatuses. Medical students are an embodied and embedded component of these intra-actions in their becoming-with others.

I then examined the enactments arising from the drawing assemblages used in my research process. The drawings revealed new thoughts and opened up different connections. I propose that the process of drawing-with students' experiences can constructively contribute to medical education. The advantage of acknowledging the entangled phenomena of material-discursive practice is an enlarged vision of student learning that can inform a deeper understanding of student response-ability, and an acknowledgement of the indeterminacy in learning when considering the agency of matter.

Furthermore, drawings offer a potential to work with/through an affective pedagogy that will be discussed in the following chapter. I move on to explore how attention to affect in a relational ontology may provide an alternative, productive way of engaging with curricular matters, and what matters in the obstetrics curriculum. I explain how the creative process of drawing with research participants became an immanent space for an affective methodology, initiating new insights into students' responses to their obstetrics encounters.

The logo of the University of the Western Cape, featuring a stylized classical building with six columns and a pediment.

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CHAPTER 7 - FINDINGS: OPENING UP IN-BETWEEN SPACES THROUGH DRAWING AFFECT

7.1 Introduction

Thinking and working with assemblages rather than isolated entities provides a novel approach to understanding response-ability in medical training encounters. As noted in the previous two chapters, assemblage thinking moves beyond conventional notions of individuals as independent, intentional and rational agents and entities. It foregrounds all relationships enabling an acknowledgement that matter matters and that objects cannot be distanced or separated out as passive and inert (Barad, 2007). Thinking with and through assemblages takes a move beyond notions of individual's doing and being as "the body is but one verging surface on the field of experience, where the body is always more than One" (Manning, 2010, p. 118).

In terms of student learning, matter's material force adds a significant role in the politics of learning in which students are becoming-with other bodies. There are important ethical implications when such an inclusive relationality becomes a central focus, "where things and matter usually perceived as passive and immutable, are instead granted agency" (Hultman & Lenz Taguchi, 2010, p. 539). Ethics is entangled in the complex relationships emerging with all students' learning experiences and cannot be separated out. Recognition of the ethico-onto-epistemological connections ought to be an essential component to curricular considerations. Practices of separation and distancing as indicated in my findings in Chapter Five, appear to limit students' actions by constraining their capacity to respond to unjust practices. The example of the force of the student logbook in the curricular assemblage of logbook-signatures-students illustrated how matter's agency contributes a force and becomes a determinant influencing the degree of intensity and level of capacity that students develop in their responses to curricular events.

In this chapter, I continue to interrogate student's responses in troubling students' clinical encounters through the lens of a relational ontology. My findings take me beyond the explicit in order to explore how an affective attunement can work towards rendering students capable in their response-ability to unjust practices in obstetrics. By bringing together my findings and theory as interconnected data more is revealed about what matters in students' learning in obstetrics. Through assemblage theory described in Chapter Three, and the theoretical framework of feminist new materialism (FNM), I first

describe the affective forces that became apparent in/through the drawings and more generally the research findings. I focus on the unfolding of relationships rather than products and practices of bounded individuals, Haraway's (2016) notion of *sympoiesis* (described in Chapter One) is helpful to understanding students' response-ability as it refers to a becoming-with, and making-with others.

In the section below I explain how the drawing process became a research and pedagogical tool for eliciting affective flows and connecting to students' stories in the research activities and classroom intra-actions. The power of the drawing/s is foregrounded. I then move on to focus on the affective forces emerging in the drawings and their connections with stories. Stories highlight how attention to affect may promote students' response-abilities in their obstetrics learning. I put forward that attunement to affect provides a tool for advancing social justice.

7.2 The work of drawing assemblages

7.2.1 Drawing affective forces: Affect emerging through visual data-in-the-making

In what follows I refer to three student drawings and two educator drawings that highlighted the circulation of affect and which "glowed" for me (MacLure, 2010; 2013a; 2013b). I then move on to thinking with the drawing assemblages exploring how drawings have shifted our classroom intra-actions as a pedagogical device towards developing a socially just pedagogy that has the potential to foster students' responsiveness to injustice.



Figure 7.1: Drawing despondency and unresponsiveness (student, FG 3)

A student's teddy bear-like drawing (Figure 7.1) was first produced in class then later described in our focus group. The black pastel-paper-student assemblage was explained as the student's disappointment and lack of ability to respond to what she witnessed. There were constraining affective forces leading to her sadness and unresponsiveness despite her sense of hopefulness and joy illustrated in the peanut-shaped baby and smiles portrayed on the ears. In terms of drawing artefacts by other students (in the research process and in our classroom), sad and tearful faces were not uncommon.



Figure 7.2: Different agendas and agencies (drawn by student, FG 3)

In a second drawing (Figure 7.2) emerging in the same FG, there were indications of the competing affective flows with spacetime mattering. The student shared:

the magical moment is when you hand the baby to the mother for the first time and if they're not still too shocked from the whole process, they have this beaming smile on their face, and you can almost see them like instantly bond with this baby, sometimes you can really see that ... But then in the background of my image here, I have a conflict over here between health professionals, particularly nurses and also medical – well, students or doctors. And this is something I saw not so much at [Facility X] but I saw it at [Y] MOU, where the sisters are very harsh when speaking to the patients; they don't speak with them as if they're caring ... The way they speak to them sounds like the woman should

know exactly what to do when they're there and that if they don't do it the way that the sisters want them to do then it's wrong and then they get reprimanded.

This student described how she observed the controlling, authoritarian relationships between doctors, nurses, students and women in childbirth. She contrasted the potential for a joyful birth experience with the ongoing harshness that prevails and that tends to remain distanced and out of sight. She explained further:

it seems that they have more pain and then when they have pain they scream, and then the sister shouts at them more because they're screaming. And then sometimes they start crying. Sometimes the Sisters tell them their partners can't come inside because they are performing ... Sometimes when a woman comes in, like for example if she's unbooked or if she hasn't attended an antenatal visit in a while, or, ja, there's some other situations I can't think about now, where the sisters, some just say, oh no, I'm not going to help you – which is an obvious violation of that right to healthcare and access to healthcare and things like that ... and telling a patient that you're not going to help them and ignoring them, well then labour is not making a safe birth. I didn't witness any of those situations but I'm sure in some situations it will affect the outcome of the birth, if not physically with illness or consequences, but psychologically for the mother. And maybe it will also affect the bonding of the child (student, FG 2).

The text above illustrates the student's affective sensitivity to the contrasting forces that she saw and heard and how the events unfolded. She recognised the consequences of disrespect in obstetrics.

Similarly, final year student Alice reflected on her memories from two years previously with her drawing below (Figure 7.3), recalling the impact of two very different birthing facilities:



Figure 7.3: The force of a ball-woman assemblage to a labouring woman in isolation (student Alice, Year 6, interview 2015)

For Alice, the exercise balls in the one facility provided a striking example of quality care and comfort for women in labour, assisting them to find different positions and rhythms of movement. Interestingly, in terms of the vitality and relationality of matter, the ball was the first item appearing on the sheet of paper in the drawing process. The drawing then moved on to memories of the second birthing facility where Alice felt appalled by the explosive, fiery nature of women's birthing experiences. The multitude of forces in which Alice was immersed included the labouring woman's biological forces intra-acting with the bed (though not visible in the drawing) which appeared to be a fiercely intense force constraining the positioning of the woman, also keeping her distanced from others and alone. Such an encounter vividly contrasted with the brightly painted blue walls in the first facility where a sense of calmness touched Alice. In the latter facility, women appeared to be kept at a distance and objectified. Alice explained where different parts of the woman's body were located while the drawing was in process. For instance, she noted 'that's her head down here somewhere, that's her arm closing her eyes'. Blood exploded and pain erupted (Figure 7.3, bottom right image). The intensity of the affective forces moved Alice. She expressed a need to change such encounters, both for the woman in labour and herself. She wished (in the third part of the drawing) "to be in the shadow of a good role model' enabling her to learn from a caring and confident midwife with the jacket acting as a connecting medium.

7.2.2 Moving beyond representation, meaning-making and interpretation of drawings

The drawings described above and in Chapter Six, touched me as the researcher, affected me and moved me. I acknowledge that my own drawing experiences and thinking have become tangled into the thinking/doing and becoming of this research and the consequent write-up. There has been a sense of re/turning as I mulled over the iterative reworkings of ideas and texts, both written and drawn. Barad (2007) notes that “writing is not a unidirectional practice of creation that flows from author to page, but rather the practice of writing is an iterative and mutually constitutive working out, and reworking of ‘book’ and ‘author’” (p. x).

A personal example of misinterpretation was a catalyst for driving my thinking away from the meaning-making frameworks and processes used to interpret visual artefacts. In 2014, I heard a lecturer reporting on my drawing (Figure 7.4) created to illustrate my anticipated PhD research journey. The image was created in the space of a professional development course on developing an educational research proposal for emerging scholars co-ordinated by the Cape Higher Education Consortium (CHEC) in 2013. The lecturer’s interpretation of my drawing artefact was misleading as it offered a perspective that totally missed the foremost message in my mind, that of driving a motorbike through my research journey. What the drawing was actually revealing, was an impossible adventure for me as my eyesight impairment limits my transport options.



Figure 7.4: My anticipated PhD journey through mountains and rivers, supported by the helping hands of my supervisors



Figure 7.5: Enlarged view of my motorbike ride, with the protection of a helmet

Yet, for me as the person actively connecting with the paper and crayons, I found the process of drawing liberating and revealing. It surfaced previously unthought of thoughts that felt empowering. This personal experience resonates with what I have observed with my research participants. Through my varied drawing experiences, I recognised that it was the process of drawing that offered opportunities for new meanings to be generated. It was not about the representation or quality of the product, known as the artwork or artefact. The art-in-the-making through the assemblage of paper-pastel-hand and more, became a force with an intensity that could elicit valuable insights. The drawings becoming active participants in the process of becoming-with others (Hickey-Moody, 2010; Lenz Taguchi, 2010).

7.2.3 Curricular constraints emerging through the drawing assemblages

The drawings revealed that students feel unprepared for the harsh realities operating in their clinical obstetrics encounters. Although curricular design aims to prepare students, my findings indicate that the theory in obstetrics appears to inadequately equip them for the reality of practice, with the force of the curriculum actually disconnecting and separating students, leaving them with a sense of isolation and disempowerment. A drawing (Figure 7.6) by a year six student in FG 1 highlighted this theory/practice divide explained through the binary of yin and yang forces.

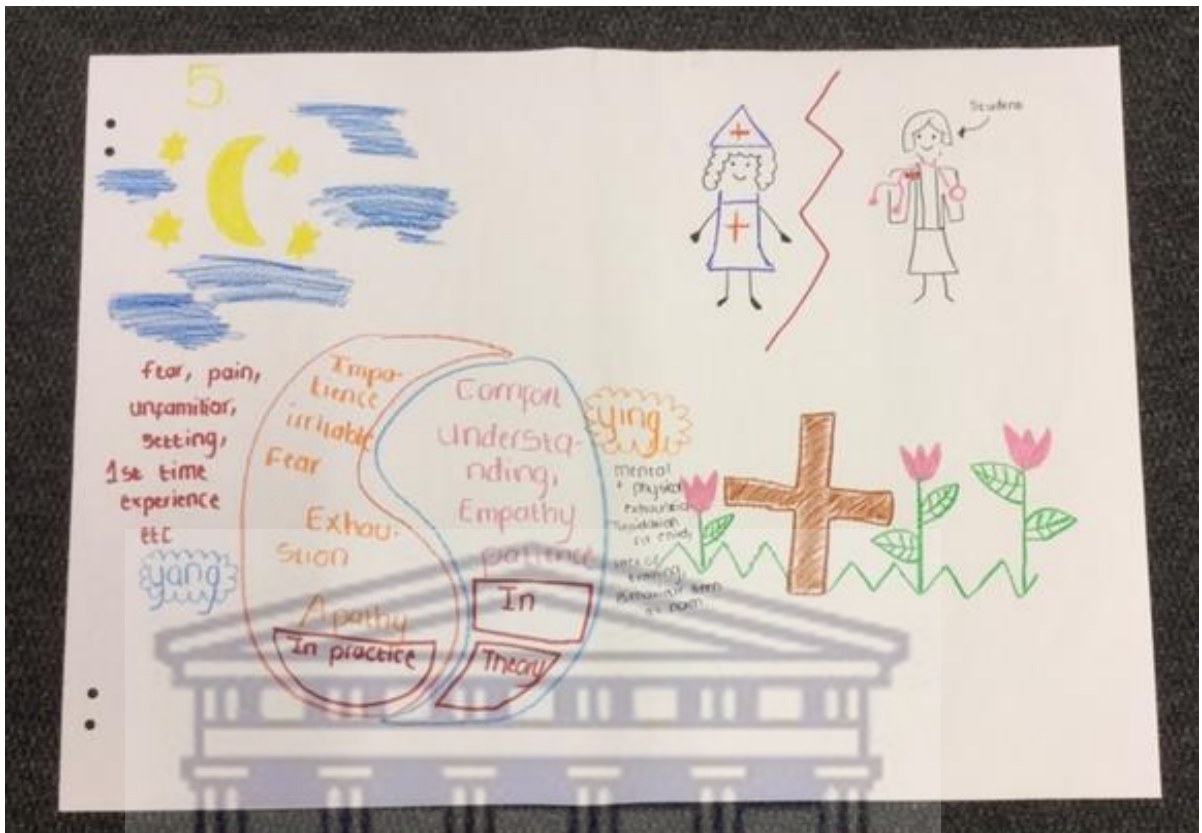


Figure 7.6: Constraining forces of binaries, separations and multiplicities (drawn by student, FG 1)

This student felt unprepared for the tasks and harsh relationships that she faced in obstetrics. She described her sense of powerlessness, feeling “stunned” as well as “indignant” at the time of witnessing a nurse

handling the patient really roughly – ag⁶¹, just telling her to lie on her back when the patient was in obvious pain, obviously uncomfortable, couldn’t do that at all – like she couldn’t help herself, she just couldn’t do it. The sister was yelling, just being honestly just horrible to the patient (student, FG 1).

The student sensed the midwives’ impatience with her, noting that “the midwives were not very accommodating of the fact that I had never done this before”. Yet later, this student’s reflections opened up more thoughts about her encounters. She developed a deeper respect for differences and multiplicities as she considered the nurse’s broader relationships as well as that of the woman in labour:

⁶¹ The term “ag” is a South African colloquial expression that denotes a hesitation in thinking. It is pronounced as *aagh*

And when I went back home to my room, I started thinking about what is it, like what are the many things that could cause somebody who was taught to be a certain way to behave in that way to another human being. And I was thinking well I guess there are a lot of factors that play into it. The sister probably was very mentally or physically exhausted; probably she was caring for the life of the child as well because she needed to do what she had to do for both the mother and the child ... So I started thinking it from the sister's perspective and then also bringing it back to the patient's perspective that she was not wilfully being uncooperative, it's just that the patient was obviously in pain. She was obviously also in fear because she didn't understand what's happening. She was in a very unfamiliar setting in a hospital that's not her home, and it was also her first time experiencing labour, so there were a lot of factors that played into why she was behaving the way she was, there were a lot of factors that played into why the nurse was feeling the way she was

In the quote above, the student highlights how the different forces acted in the birthing event. The intensity of fear and anxiety, the biological forces of the labouring body, the strangeness of the event as well as the environment, were contributing factors that interacted. The emergent, intensely stressful situation was unhelpful for the process of labour and student learning. By thinking in terms of a relational ontology one can recognise how the multi-directional and different forces intersect as they are co-constituted in each student's experience.

The student illustrated how her reflection and re/turn to the incident enabled by the materialising force of her relationship with her room, raised her awareness of previously hidden forces, opening up new thoughts. She became conscious of the normalisation of poor practices and relationships and how there is a limited appreciation of the emotional tensions or affective sensibilities circulating in the birthing space. The student's sharing in the FG appeared to make a positive impact on others, adding to their affective responses. I felt the increase in energy and affective flows among the group participants as conversation became more animated and responsive to students' encounters. Her attunement to affect was rendering others capable.

Below I refer to drawings (Figure 7.7 and 7.8) by a student (FG 2) and educator Gretel. These drawings emphasise the force of the curriculum. They use the metaphor of a racetrack to depict the medical undergraduate curriculum.



Figure 7.7: Formula 1 racetrack (drawn by student, FG 2)

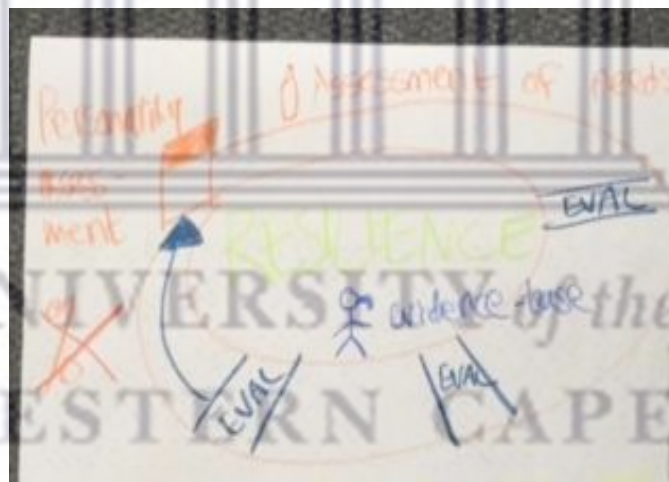


Figure 7 8: Gatekeeping of assessments on the racetrack (drawn by educator Gretel)

As noted in the previous chapter, the student perceived the curriculum as a Formula 1 racetrack driven by the forces of individual competitiveness and motivation to complete curricular outcomes in the allotted time slot. Gretel, on the other hand, used the racetrack as the symbol of the segmented, separated stages of the curriculum in which evidence-based practices such as evaluations and assessments take up a linear, measured sequence. Such chronos time (Braidotti, 2013), also known as “clocktime” is described as “numbered movement” by Kohan (2015, p. 57). Linear time is structured

and ordered (St. Pierre, 2018). What is striking, is the intensity of speed and time and how that matters. It illustrates the intra-acting forces of space, time and matter that generate a different becoming than what the curricular designers may be anticipating. Behaviours emerge from the relational processes of spacetime mattering (Barad, 2007). Interestingly, the racetrack metaphor relates to the representational meaning of a curriculum mentioned in Chapter Three, as a “course to be run” (Wallin, 2010, p. 3).

My findings and philosophical inquiry focus more on aion time, as described in Chapter Five. However, such a different conception of time “is really challenging to think about” because educational institutions are so committed to working with chronological time (Wok, 2015, interview with Kohan, p. xxii). But measured, linear time appears to obfuscate important aspects of teaching and learning such as affect which permeates students’ learning experiences and their response-abilities. My findings illustrate how new possibilities can emerge through students becoming-with drawings. Zembylas (2017) refers to Tolia-Kelly noting that it is “critical to think plurally about the capacities for affecting and being affected, and specifically how these capacities are differently forged, restrained, and embodied” (p. 403). We need to attend to the affective potentialities of events and their associated but varied ethical and political significance in educational interventions (Zembylas, 2017).

7.2.4 Drawing/s affect in classroom intra-actions

Alongside my research activities, a drawing task was also brought into our classroom face-to-face intra-actions. The drawings became a generative and productive activity as reflected by student workshop feedback comments such as, “It made me think of something that really impacted me in a big way” (2015: Block 3). For some students the activity and movement of drawing was therapeutic and playful. It triggered memories as pastels and colours connected and re/turned to their past experiences. “It was fun, especially because some of us have not drawn in years and it is a nice way to express yourself” (2015: Block 2).

However, the drawings were not without difficulties, as noted by student comments such as, “I struggle to represent things in illustrations” (2015: Block 1) and “I wasn’t sure how to interpret my feelings in a drawing” (2016: Block 1). More insights were revealed through my workshop evaluation question: *You were asked to draw a visual representation of your learning during this block – how was this for you?* The students’ responses are visually represented in the word cloud below (Figure 7.9).

Despite the difficulties, the class drawing process appeared to open up an in-between space, releasing feelings that were previously concealed, invisible or untapped, as occurred during my research intra-actions. The collective drawings created an assemblage with students that made visible and channeled the affective forces impacting on student learning. Students noted, “It was helpful in expressing my feelings which I could not really express in words” and “It captured my mixed emotions well because sometimes they cannot be captured well in words” (2015: Block 2). There was a sense of fun and flourishing as students were becoming-with the paper. A student wrote that it was “refreshing to put mind and emotion to paper” (2016: Block 4) indicating that the paper helped bring together what may have felt separated before. Resonating with my own experiences, the drawing assemblage fostered fresh thoughts and emotions to mingle and diffract in an enabling manner. It was an empowering process for some students, especially those whose first language is not English. This opportunity to affectively engage with thoughts and curricular experiences without the written language acting as a barrier was appreciated by students saying “I feel like I can express myself more easily through art” (2016, Block 2) and “A good visual outlet to express myself” (2016, Block 3). What was particularly pertinent for my study was how affective intensities emerged through the drawing process. A student (2015: Block 1) noted that the drawing task was “very innovative, was a great way to expose inner-underlying subconscious thoughts”; the drawing gave power to the student to think more deeply.

In both the research and classroom drawing activities, the process and relationships with/through the drawing assemblages provided opportunities for the emergence of affirmative affective responses to students’ troubling experiences. There was an opening up of flows of affective intensity through the desire to reveal and to release different emotions. The drawing task became a “pragmatic unfolding” of an event. Rather than using the term assemblage, as mentioned earlier in Chapter Two, Erin Manning explains such a generative event as an “[a]gencement that connotes a doing doing itself” (Manning, in Massumi, 2015, p. 157). I propose that drawings can foster students’ response-ability in troublesome learning encounters. This teaching intervention described above is an emerging process towards rendering students more capable in their response-abilities. Stories have become an integral component to the pedagogical process.

7.3 The work of stories in revealing affect

The drawings in and with this study opened up spaces for more to come that included more stories to be told. The stories from Bongani about the woman birthing outside the elevator, from Lesego about the young girl's trauma, from a focus group student participant about racing after the ambulance to get his delivery, were just a few of the many stories that enriched this research which has become a story in itself. Stories tell stories and multiply with more stories. I draw on Donna Haraway's (2016) work where she asserts that:

It matters what matters we use to think other matters with; it matters what stories we tell to tell other stories with; it matters what knots knot knots, what thoughts think thoughts, what descriptions describe descriptions, what ties tie ties. It matters what stories make worlds, what worlds make stories (p. 12).

In working with and through issues of responsibility/response-ability, stories have provided an avenue for eliciting affective flows. Each story is an open apparatus for more to come. Stories do matter (Despret & Buchanan, 2016; Gachago, 2016; Haraway, 2016; Motala, 2018; Olsson, 2009; Sellers, 2013; Springgay & Freedman, 2009; Tsing, 2015 and others). In the different stories and events related to students' experiences, power emerges, becoming an inherent component revealing different levels of powerlessness.

I was struck by the intensity of affect emerging from students' stories. There was a noticeable movement of affective sensitivities. Even at the start of this project when Dr Wendy Orr's story (mentioned in Chapter Two) triggered a deeply felt response from students there was an intensive affective flow that led to more student responses when listening to each other's stories. Furthermore, there was a significant appreciation by students in telling their stories and in hearing the stories from other students. As Haraway (2016) and others (Tsing, 2015; Despret, 2004, 2008, 2015) point out, stories promote flourishing for living and dying in troubling times and, "I think it is important for people to reveal their stories in order to share the load & normalise the feelings" (student: 2015: workshop feedback, block 1). In her work with non-human animals and humans, Despret (2015) illustrates how stories inform and create links between events. Different impressions and consequences result from different stories. There is always more to come as "each student narrative is a treasure chest with much to offer" (Rutberg & Gauferg, 2014, p. 116).

During the period of this research study, more senior medical students came as invited guests to our introductory student sessions in the computer laboratory, sharing their stories, which were often riveting for us all (Figure 7.10). One such student described how he witnessed a midwife using her elbow for fundal pressure⁶⁴, a harmful practice that can lead to iatrogenic⁶⁵ complications. He explained his sense of helplessness and inability to respond. His story was powerful, stayed with students and later resonated with their own experiences of feeling a sense of numbness and powerlessness, a lack of capacity to take action.



Figure 7.10: Final year student sharing his story (2016)

Similar disturbing students' stories started this research project and continued to inform it. The stories and students are enfolded and entangled with spacetime matter. While patients' stories (and some doctors' stories) are widely known, with social media now amplifying the production and sharing of these narratives, medical students' voices have been largely hidden until the recent student protests at South African universities nationwide (Luescher, Klemenčič & Jowi, 2016). Students' insights and stories into curricular matters and university experiences are becoming more visible (Case, Marshall, McKenna & Mogashana, 2018) and now include harrowing stories from medical graduates such as Maria Phalime (2014) in her book and Yumna Moosa (2016) in her YouTube video. Apart from their fear of consequences such as personal

⁶⁴ Fundal pressure is no longer permitted, though clearly still practised. It is a manual technique in which pressure is put on the uterus to speed up the second stage of labour. Malvasi et al. (2018) suggest that medico-legal implications are limiting the release of data related to the continuation of these practices.

⁶⁵ Iatrogenic refers to any complications that arise as a result of medical treatment.

victimisation, there are professional concerns around privacy and confidentiality that are strongly linked to the medical profession. Yet, personal stories provide deep and far-reaching explanations of professional practices and can open an avenue for a response-able pedagogy promoting students' capacity to respond to the unexpected.

7.4 What about affect?

Within the hierarchy of medicine there is limited acknowledgement and accommodation for affect as measurable outcomes and evidence-based practices are essentialised. It appears that professional curricula focused on the attainment of knowledge and skills, with an epistemological dominance, tends to block affect, in essence to tune it out. Creative outlets tend to be held outside of the evidence-based curriculum that is geared towards individual competence in acquiring the skills to become good doctors. Thinking and becoming through/with assemblages provides opportunities to open up a different perspectives to my research and teaching. Such collective thinking-doing moved a concern from individual responsibility to collective responses that included the more-than-human forces. As noted in the previous chapter, students' encounters became stories which in/formed students' becoming, providing a motivating force to open up affective spaces and evoke intensive affective flows. Furthermore, drawings, as data-in-the-making, captured stories and worked further with them.

7.5 Affect permeates all encounters

In my interview with clinician Sarah, she revealed the material-discursive forces that a/effect all those present in the birthing units saying, "it was quite interesting that it wasn't just having good facilities, it was the spirit that was in the facility that's so important". This "spirit" that Sarah refers to can be viewed as an affective intensity. According to Slaby, Mühlhoff and Wüschner (2017) affect "is the vital core of an affective arrangement, it is what dynamically links its elements and demarcates it from the surrounding ambient" (p. 5). Yet, such a dynamic force appears to be largely disregarded in medical curricular.

As explained in Chapter Two, affect is perpetually elicited as a force in and through assemblages where multiple forces are intra-acting in the entangled relationships. In my research findings, affect has surfaced as a highly relevant component of students' response-ability. It is pertinent for considering students' responsibilities and response-ability, despite its apparent invisibility. Affect is always present, seeping through and

circulating in clinical encounters, with a marked intensity in a speciality such as obstetrics.

7.6 Constraining and enabling affective forces towards response-ability

Affect is what returns, not the subject. Affect returns as the force of becoming ...
Affect is never exhausted: it modulates across metastable fields of experience in the making, amplifying matter in its in-forming potential (Manning, 2010, p. 126).

The strong influence of affect surfaced unexpectedly in this study. It was revealed in multiple ways including my own re-turning⁶⁶ to the drawings where affective sensitivities were felt. Different movements facilitated an attunement with the relationships emerging from the research data and students' experiences. As the researcher, I acknowledge that affective forces pulled me in, turned me around, as I unfolded, enfolded and continue folding with and through the findings, a mutual becoming (Mazzei, 2013).

These relational movements were enacted in aion time in the research and teaching assemblages. What is apparent is that affect permeates all aspects of curricular engagement although it is usually hidden in medical training. An affective sensitivity is pertinent in considering students' responses and response-abilities. McCormack (2003) points to the close relationship between sensitivity to affect and a different kind of ethics that extends beyond a rule-based ethics, claiming that "attending to and through questions of affect allows encounters with spaces of practice to have a life and force before and beyond the deliberative and reflective consistencies of representational thinking (p. 490). By drawing out affect and moving beyond representation, the students are reflecting in a manner that affectively engages with deeper ethical concerns. For instance, a pair of scissors has multiple meanings when thinking through the assemblage of students-labouring-woman-scissors-midwife/doctor. In this study there were numerous references to the power of a pair of scissors. While sterile scissors are

⁶⁶ Re-turning is a term introduced by Barad (2014) that refers to a process of turning over and over again. It is more than a reflection on the past. It is an "iteratively intra-acting, re-diffracting, diffracting anew, in the making of new temporalities (spacetime-matterings), new diffraction patterns (p. 168).

made available in birthing packs to enable episiotomies⁶⁷ to be performed when necessary, they also take up affective forces with their material agency within the birthing assemblage. Apart from cutting a labouring woman's perineum when indicated, these scissors were observed by students as punitive and threatening tools of power to insist on compliance with commands when women appeared to be uncooperative. The vitality of the scissors became a driving force influencing midwife/doctor/students' behaviours and responsibilities. The materiality of the scissors and their relationships contributed different intentions and enactments than anticipated. These intra-actions illustrate that it can be unhelpful to separate material objects such as scissors from discursive practices, such as those witnessed by students, as they contribute an intensive force shaping students' responses. In my study students reported observing scissors suddenly appearing for an episiotomy without information to the labouring mother or her consent and frequently without analgaesics in order to wield power to increase the midwife's punitive treatment. Furthermore, scissors were held over women in labour as an affective force intensifying their fear to claim their subservience to the midwife's instructions. Students watched such actions in horror with limited ability to respond with the intensity of affective forces appearing to hold students back, also perpetuating the silence surrounding the disrespectful practices in obstetrics (Nora, reflective commentary 2016; several workshop performances 2015, 2016).

Student responses to disrespectful practices are limited by threats they receive. In my first FG, a fourth-year student shared how midwives warned her not to report on them, saying "you'd better not write about us this time, you'd better not say the sisters were bad; you'd better give us good reviews, give us good reviews in front of our patients". This warning came despite her other good experiences at the birthing facility. Such limitations imposed on students' ability to take action to advocate for quality care promotes a sense of fear of possible consequences, diminishing their power to act. Furthermore, some students witnessed affective trickery and felt "shattered". A student recalled a conversation to obtain informed consent for an emergency Caesarian:

if you don't have the c-section your baby is going to come out deformed and what-not; and then your husband's going to leave you because you're not producing normal babies for him and so he'll leave you for a younger girl (student, FG 2).

⁶⁷ Episiotomy is the medical term used for cutting the perineum to create a wider opening for the neonate's passage into the wider world. It is a procedure to prevent tearing of the woman's vaginal tissue.

Witnessing such threats is traumatic for students who tend to respond by distancing themselves and staying silent. Yet they are immersed in the intensity of affect in these learning moments. Student Bongani observed that “frustration tends to boil over onto the mom” ... “midwives’ or the nurses’ frustrations would boil over onto the patients” (interview 2016). The high level of tensions in the facilities are entwined with students’ diminished affective capacity to respond. Many students have shared their sense of helplessness and their inability to act, which interferes and conflicts with their urge to be responsive, caring and to act responsibly. They find themselves caught in the in-between space of interfering forces.

Affective forces and flows are powerful and can redirect responses. I recall a particularly meaningful and moving moment when student Bongani’s (2016) story changed. He explained in our interview that the drawing created in class was one experience that emerged as an interesting event that he shared on the paper at that time. In the interview he continued to supplement that drawing adding an explanatory text. However, in further intra-actions when he became a support person in our introductory sessions with the students, he spoke about and shared another incident of extreme violence and harm. In the first event the student can be seen as a hero as he managed to catch the baby and avoid it from falling onto the floor when he engaged with a woman in labour outside the elevator where she had returned from fetching some food for herself as she had felt hungry. In the second example, he stood by the event powerless, helpless and later feeling guilty explaining that he had stood by silently witnessing inappropriate and potentially harmful behaviour by a healthcare professional. Sharing his story became a release for him, a sense of freedom from that affective constraint of guilt.

What has been striking in this study, has been the vitality emerging from the opening up of affective spaces for engagement on these difficult issues. The movement of energy is palpable. As Haraway (2016) points out in her book *Staying with the Trouble*, collective thinking and acting can render others capable, as opposed to avoiding troubles through binaries of otherness. By enhancing the affective flows in the in-between space of different students’ experiences, a new energy and growing capacity to respond is evident, as demonstrated by the workshop feedback comments like, “Knowing that other students go through the feelings that I go through and how they handle those situations, gives me options on how I can work around those and develop my own coping strategies” (2014, Block 2) and “to know that I’m not alone in my feelings, and that it’s

not a weakness to be sensitive to these situations (2016, Block 4). There is a sense of expanded capacity to act as students feel a becoming-with others, rendering each other more capable with a release from individual separation and even constraining forces such as guilt and shame.

There has been a noticeable shift reflected in students' feedback over the past five years. Initially, students appreciated their troubling experiences being heard, then learning about the support mechanisms available to them within the faculty, such as the Professional Standards Committee. Later, it was apparent that students valued being present with each other and each other's stories of troubling encounters. The material-discursive apparatus in the classroom space worked to co-create a collective sense of shock and bewilderment at the abuse that was so prevalent. At times, students have felt restrained, considering their experiences as private and personal. As we delved deeper into the present practices, there were noticeable shifts. The emergence of affective forces became an empowering act and catalyst for taking action rather than distancing themselves from the troubles. A student noted, "It is also a great platform to acknowledge the activities and be reminded that it is not OKAY – DO NOT CONFORM to the norm" (2014, Block 1).

7.7 Developing response-abilities towards an affective attunement

Student differences can be an important tool for engaging with affective intensities. What is intensively alarming and disarming for one student may be comfortable for another. For instance, clinician Tim pointed out how societal perspectives can impact on students' responses. He referred to students' different backgrounds indicating the different levels of acceptance of certain behaviours that may influence students' responses, which resonates with the wider societal issue of violence which are disproportionately higher in poor communities, becoming normalised there. Tim said:

it depends on where you grew up, it depends on what you're exposed to, what you think and what you accept as being normal behaviour. And I think our less privileged students would be inclined to be more accepting of more aggressive behaviour as being normal, whereas our more privileged students would be completely appalled at something that would be passed off by another student. (2016, interview)

In terms of a relational ontology, Tim pointed out how the intensity of affective forces arising from the same intra-actions will vary with each student. This spectrum of different

levels of acceptance and normalisation of disrespect in obstetrics is exposed in our classroom performances and in students' reflective commentaries. The student diversity tends to enrich their learning experience. Moreover, by using the Google Docs platform for sharing reflective commentaries, I have amplified the intensive force of students' reflections. The different texts have been put to work to act as a catalyst for promoting change (Mitchell, 2017). The texts have moved students and contributed to rendering others capable. A student noted that, "it was good to hear how the same experience was observed differently" (2016: Block 1).

Such sharing and working together rather than apart as separated individuals, provides untapped opportunities for students to render each other more capable in their capacity to respond to unjust practices. Their differences become positive differences that enhance their responsiveness by working together rather than apart. This process was reinforced by encouraging students to discuss their experiences with their critical friends⁶⁸ (Costa & Kallick, 1993), which was usually their clinical partner. By diffracting their perspectives through and with each other, new insights were gained as a student said, "This worked well, it was something new. It allowed for one to look at a situation in a light that one might not see it. It thus enhances the learning experience" (2017: Block 4).

My findings demonstrate that students' capacity to respond falls into a continuum that conveys varying levels of ability in terms of their responses which are influenced by what matters and the different relationships emerging in students' learning. This "response-in/ability"⁶⁹ is a consequence of the intersection of forces, where some forces contribute to increasing students' capacity to act and others constrain them.

7.8 Responding with a socially just pedagogy

By opening up affective flows that can render students capable through their relationships with others there is a potential to promote transformative practices in which students feel they have the ability to respond to the prevailing injustices in obstetrics. Engagement with affect in which affirmative affective flows can be facilitated, works towards developing a socially just pedagogy. Socially just pedagogies aim to examine

⁶⁸Working with a critical friend is an empowering pedagogical tool to enhance making sense of an event through alternative perspectives - a collective, affirming process that is generative through difference

⁶⁹ Jacqui Goldin suggested this term to me.

“what sorts of knowledges are valued and devalued and whose voices are prominent in education” (Bozalek, 2018, p. 396). Whether in the research process or our class workshops, there were instances that illustrated the value of building such relationships to develop the capacities for students to become response-able. As the researcher and facilitator, I was touched by a student’s response to our focus group:

I just want to say thank you for inviting us to be here, because when [student X] told me about this I didn’t know what to expect but I'm glad that I came here because I feel like having these reflections actually helps in terms of – you sort of get to learn more about yourself and what your own mistakes might have been; and like you also learn from other people about how to approach things better. So I actually walk away now feeling like I've learned something and feeling very proud of myself as well to have been a part of this because I feel like sharing this interaction as well might have influenced other people to look at things in a different way. (student, FG 1).

The act of sharing is enhanced through creativity and indeterminacy, both of which have provided a productive pedagogical approach for engaging and responding to troubled knowledge in this study. According to Bozalek (2018), such aspects of a socially just pedagogy are more impactful for responding to issues of social justice than traditional structured learning outcomes. What is particularly pertinent to this study is the power of affective assemblages. As Hickey-Moody (2013) points out, “affect is what moves us. It’s a hunch. A visceral prompt”; and a “starting point” that can change bodily capacities (p.79). Through her work in popular art and dance, Anna Hickey-Moody refers to pedagogical connections with sensual bodily capacities such as touch and smell (that also permeate birthing practices) claiming that an affective pedagogy through art can “change a body’s limits” and can “extend subjectivity and connect subjects to society in new ways” (p. 88). Yet art-based pedagogies are unusual in curricular activities for medical students, and difficult for some students, as indicated earlier in this chapter. But I propose that an attentiveness to material-discursive relations such as in art-based affective assemblages can foster students’ responsiveness, and their power to act thus rendering students more capable to address social injustices in their knowledge-making activities, as needed in their obstetrics encounters. What has become apparent is that when students are part of a loop of communication and affirmative relationships, they develop more desire and capacity to be response-able. A socially just pedagogy needs to engage with affect notwithstanding the possible discomforts for both students and educators (Zembylas, 2006).

7.9 Conclusion

This chapter began with an acknowledgement that assemblages are co-constructed in students' curricular activities through their becoming-with others, both human and more-than-human. The entangled and dynamic relationships determine students' experiences and their capacity to respond to practices they observe in their clinical obstetrics encounters. I refer to my research findings illustrating the material-discursive enactments that emerged in/through the study. Students themselves are not discrete entities moving through different isolated spaces, time slots, and material objects but rather becoming-with others through their entangled intra-actions that are dynamic and non-linear. These relationships are all integrally related in the practices that are enacted, cutting boundaries together and apart at each moment of practice, which constitutes varying degrees of intra-actions on a continuum (Barad, 2007).

I focused on the process of drawing which became a revealing mechanism and process for opening up new insights, making visible the materialising forces acting with/in students' becoming. Drawings also became an active pedagogical device for classroom teaching as they opened up and facilitated affective flows in order to share hidden aspects of students' learning. What became clear was that the medical curriculum's prioritising of the acquisition of knowledge and skills, is, at times, at the expense of other vital aspects of care such as responsibility and students' response-ability.

Affect emerged as a prominent force in the relational networks of student learning. By creating openings for affect in different encounters, in aion time, affective sensitivities emerged releasing intensive forces that were previously hidden and constrained. An affective methodology is consistent with post-qualitative research extending thinking beyond what is present and representable.

By describing the constraining and enabling affective forces prevailing in student learning in obstetrics, I suggest that attunement to affect in the relationships of students becoming-with others (both human and more-than-human) can generate transformative possibilities in terms of response-ability for students (and educators). Such affective moves can foster ethico-onto-epistemological responses towards promoting social justice in obstetrics and towards students flourishing amidst the challenges they may face in their obstetrics learning.

The findings referred to in this chapter and the previous one, demonstrate that affective pedagogical practices offer an avenue for shifting what has become habitual and has led to students' unresponsiveness. Drawings can act as a powerful force in promoting students' ability to respond in difficult encounters. I propose that arts-based research and teaching can contribute new possibilities for reconceptualising what a curriculum can do to a/effectively engage with difficult knowledge and address prevailing social injustices by enhancing students' responsiveness with their capacity to respond.



CHAPTER 8 - CONCLUSION: MOVING FROM INDIVIDUALISM AND HUMAN EXCEPTIONALISM TO ASSEMBLAGES AND BECOMING-WITH OTHERS

8.1 Introduction and overview

[T]here is a troubling asymmetry at the heart of teaching and learning practices, on the one hand creating a path for new ways of thinking and making while on the other imposing forms of knowledge that do violence to the bodies they purport to address (Manning, 2018, p. 114).

In this research study my concern focused on the responsibilities connected to pedagogical practices involving medical students in their initial obstetrics training. I investigated how an alternative theoretical perspective could possibly advance social justice by addressing the facilitating and limiting components of students' ability to respond to unjust practices they may observe -- their response-ability. The study was situated in a difficult relational space where troubling encounters are enacted and become lasting events in students' learning experiences.

In the first chapter I located the study in the disciplinary field of medical education, describing how medical training has moved beyond the biomedical model to shift into deep concerns and teaching practices that extend accountability and responsibility to wider societal issues. In the second chapter I opened up the issue of obstetric violence indicating how extensive it is and the impact it has on many stakeholders including students. Then I introduced the theoretical concepts of feminist new materialism (FNM) and posthumanism to put to work a relational ontology that goes beyond humanist interpretations and meaning-making. I suggested that assemblage thinking may offer a valuable lens for engaging with the multiple injustices faced by students in their obstetrics learning. A relational ethics may contribute meaningful possibilities for enabling students' ability to respond productively. Chapter Four described my methodology and how I navigated through the administrative and organisational needs of the research study, including ethics approvals. The next three chapters highlighted my findings to answer the research questions, which then led on to this conclusion.

The research traversed an in-between curricular space where theory intersected and intervened with the practices witnessed by undergraduate students in their fourth year at

the University of Cape Town (UCT). The main research question asked what forces render students in/capable in their responses to injustices they may witness in obstetrics? I used the theoretical concepts of a relational ontology to contribute a novel approach to issues of responsibility, particularly related to students' responsibilities and their response-abilities in obstetrics, and how they can be rendered capable or what obstacles are creating forces that diminish their capabilities to respond. In the sub-questions I explored firstly, what matters in the curriculum, secondly, how the material-discursive force of the curriculum plays a vital role in students' response-abilities and how it renders students in/capable in their responses, and thirdly, how attunement to affect can positively contribute towards rendering students capable in their response-ability to unjust practices in obstetrics. Issues of responsibility and response-ability were foregrounded through the research process with connections to responsibility of the medical profession, of training institutions, health facilities and students themselves. The study findings illustrated how the forces of all of these actors, and more, are intimately related and entangled in spacetime-mattering. Responsibility entails more than independent, individual choices as students' in/actions emerge from the intra-actions of multiple forces. What matters in the curriculum cannot be separated out, as it is an emergence of the collective and relational curriculum-student assemblages. Students and the curriculum are not separate, defined entities but emergent and entangled in the dynamic relationships that are co-constituted at each moment of every encounter. What has become evident through this research process is that these indeterminate relationships of students becoming-with others (both human and more-than-human) are crucial elements with deep ethical and political concerns in/for pedagogy in terms of students' responses, particularly to injustices they may witness.

This study did not take the route of conventional research processes of initial problem identification followed by a defined and structured process to present a solution to the complex issues of disrespect in obstetrics. What became apparent was that by proposing a solution, the study may close down any questioning around current practices by providing an answer as a static and stable entity. When we move away from binaries such as subjects versus objects, minds versus emotions to a relational ontology where spacetime-mattering is an entangled, generative process, there is no definitive solution to "fix" unwelcome behaviours. The relationships are complex and ever-changing which differs from familiar notions of fixed identities and human intentionality. Furthermore, the foundational problem of obstetrics violence that students witness has

so many ramifications and systemic forces impacting on its continuation that a lasting solution is not within the scope of this study.

My research intentionally contributed provocations that disrupted the status quo with and through alternative theoretical insights. For instance, multimodality and visual data-in-the-making opened up new connections and directions for flows of thinking about affective intensities in relation to responsibilities. My experimental approach aimed to find different ways of working/thinking through which I questioned humanist and anthropocentric understandings of students' learning experiences amidst the disrespect in obstetrics. Response-ability is a novel concept in medical training. It places emphasis on the relationships that unfold between different elements, both human and more-than-human, rather than what is produced or practised by a bounded individual. The emphasis is on process rather than the product of learning through sympoiesis, the process of "making-with" others, as mentioned in Chapter One (Haraway, 2016). The drawings created in this study were inspired by Haraway's (2016) use of images in various forms to illustrate the impact of entangled relationships and the level of flourishing that is generated. Such collective becoming seems to conflict with individual competitiveness that is so inherent in curricular matters in medical education and that tend to be driven by measurable assessments and learning outcomes.

At the start of this study I set out to collect data about student learning in obstetrics and to discern how the requirements in their fourth-year obstetrics curriculum at UCT related to promoting social justice and quality health for all. Information was gained from the course handbooks, student logbooks, an online survey, interviews, and focus groups. Further information was gleaned from interactions with students through their reflective commentaries and our classroom performances. The research process ran in tandem with my teaching workshops with five groups of approximately 45 students annually. My methodological moves to post-qualitative inquiry shifted to go beyond conventional humanist research. I argued in Chapter Four that such an approach is limiting. A consideration of social relationships with just human interactions is a reductive perspective that misses important forces and intensities that shape obstetrics learning and practices. Assemblage thinking opened up a different version of the relationships that mattered in student learning. The multiplicity of relationships cannot be predicted as they are generated by the prevailing forces at each moment in time.

It was apparent that any judgement or evaluation could be unhelpful. A different and affirmative perspective was needed to delve into the troubles of disrespectful maternity practices. Rather than a data analysis with common themes and classifications, differences were foregrounded to discern how relationships mattered. Relationships are collective becomings-with others, including the more-than-human. Using the arts-based method of drawing added an extra dimension to examining the relationships in/through this study, as well as providing an intra-activity to evoke expressions of affect.

The post-qualitative, non-representational analysis in this study took a move away from any examination of dualisms (such as cause/effect, reason/emotion) to rather take up an exploratory path to understand the different forces impacting on students' responses to the injustices they witness, their response-in/ability. Included in these forces was the intensity of material forces. Matter matters, whether it is the curriculum itself or components of it such as the student logbook. Objects are not passive but play an intensive role in shaping who we are and what we do. This agential force of matter and associated affective intensities and flows tends to be excluded from traditional research methods. In response to my second sub-question, I demonstrated how material-discursive intra-actions are generated in students becoming-with others.

I acknowledge that this study started in the messy middle, staying with the trouble (Haraway, 2016). The experimental process involved risks and troublesome encounters. Springgay and Truman (2018) claim that for different worlds to be created, we need to work differently with the unease (as quoted in Chapter Four). Students' narratives reflected their positioning within a system where injustices have become normalised as accepted practices. While coping strategies such as resilience and reflection are promoted as mechanisms to endure the stresses in training and practice, such reactive responses allow the continuation of current practices. For instance, students' silences and distancing were noted as frequent responses to them finding themselves amidst shouting by midwives, blaming and shaming of women in labour or hearing a woman being told that she is killing her baby.

8.2 Research questions

Below I refer to my three sub-questions and the research findings then move on to describe what this study brings to the field of medical training. The theoretical framework of a relational ontology that is framed by feminist new materialism provided a channel of

thinking, doing and becoming-with others towards reconfiguring socially just pedagogical practices where students can be rendered more capable in their response-abilities.

8.2.1 What matters

The first of my sub-questions asked what matters in the obstetrics curriculum in terms of undergraduate medical students' experiences and responsibilities. I explored how what matters in the curriculum impacts on students' responses in their obstetrics block and beyond. The current designed curriculum carries the conception of a stable, independent curriculum that guides a defined practice of learning as a product with pre-determined learning outcomes. My research findings demonstrate how individual students strategically adapt to the institutional needs in terms of what matters, such as the ticks on the course logbook that have an intensity and force shaping students' behaviours. For instance, students recognise their own vulnerability in the current hierarchical system where power issues play out in both the educational institution and health facilities. Separations and distancing have become an integral part of medical training with entrenched binaries such as cause/effect, rational/emotional and subject/object, possibly contributing to the perpetuation of poor practices becoming normalised and hidden.

Students demonstrated how they become entwined in the culture of silence and separation in order to acquire the logbook ticks. I put forward that an attunement to matter and how matter matters in the emergence of different relationships in student learning, has important implications for the curriculum and issues of responsibility. What matters to students as they are becoming-with the curriculum has a strong force on students' responses to injustices they may observe.

The obstetrics curriculum appears to have a beginning and an end marked by the duration of the learning module. Referring to the metaphor used by two research participants, students are setting off at the start of the obstetrics block as if they are hurtling down a racetrack (their perception of the curriculum), which is a measured course in linear time in which individual competitiveness is emphasised and marked by students reaching the defined goals, such as the 15 deliveries needed in obstetrics in 2015.⁷⁰ Such chronos time is problematic and contributes to students' tensions, limiting their ability to respond to injustices. I propose that each moment ought to matter. In

⁷⁰ Following the students protests in 2016, this number was reduced to ten.

order to develop a socially just pedagogy that can foster students' abilities to respond to unjust practices, aion time becomes an important consideration. The curriculum ought to be considered as an open-ended apparatus that moves with bodies including women, students, babies, midwives, doctors, and more-than-human bodies such as beds, monitors, curtains and food that are relating to each other, shifting in and out of assemblages of encounters that form a crucial element for issues of responsibility in the cyclical process of students becoming.

Using drawings as data-in-the-making opened up unexpected insights. For instance, the power of the paper-marker-assemblage was transformative in the focus group with student Lesego. The agency of the paper contributed to the release of her story that captured the essence of the tensions faced by students in their obstetrics learning. The enactment of the drawing became an affective intensity that revealed the anger and shock emerging from the curricular task when Lesego watched helplessly as a 15 year old girl endured preventable harm and disrespect. The injustices of the event mattered to Lesego with the intensity of the affective forces staying with her. It was the power of the drawing assemblage, a relationship of spacetime mattering in our focus group that enabled Lesego to voice her distressing experience, eventually rendering her capable to respond to the injustices she had witnessed.

In terms of potentials for teaching, reactions like Lesego's cannot be planned or predetermined. It is about opening up spaces of possibilities for different relationships to emerge, an objective of a socially just pedagogy, where socially responsive outcomes can be generated through the ethico-onto-epistemological intra-actions. Unlike current learning encounters that tend to stay with students as a mark on their body or a "scar", a symbol of witnessing wrongdoing, a pedagogical acknowledgement of relationships through open, unregulated spaces can work through/with the troubles as intra-acting productive forces.

8.2.2 What the curriculum is doing in terms of student responses

My second sub-question refers to the matter of inaction or lack of responsiveness when students are faced with injustices in obstetrics. I asked how the curriculum as a material-discursive practice can render students' in/capable⁷¹ in their response-abilities? My

⁷¹ in/capable is a Baradian (2007) way of using a forward slash to avoid binaries. It implies here that there is a continuum of capability, not either capable or incapable or both, but an indeterminacy regarding capability.

focus was on engagement in curricular matters in terms of the in/justices students witness in their obstetrics learning.

Current pedagogical practices are centred on humanism, providing a limited perspective of the complex relationships in which students are immersed. This myopic vision of a human-centred approach, confines students to rational, atomic, and independent entities who can exercise choice in terms of what they do or do not do. It refers to responsibilities as regulated obligations for measurable outcomes of accountability.

My research study highlights the importance of assemblage thinking as students are enmeshed and continually emerging from the entangled relationships co-constructed in their learning. Students are not learning in isolated silos but in relationships in which they intra-act with both human and more-than-human bodies. These dynamic material-discursive relationships and inherent forces determine how students respond with their curricular tasks which comprise emergent intra-actions of the curricula-student assemblages. There are a multitude of forces causing students to be unresponsive to the injustices they witness despite an awareness and sensitivity to injustice. Thinking in terms of separations appears to exacerbate students' challenges, as demonstrated in Chapter Five.

My study findings indicate that students' ability to respond is limited by their relationship with numerous elements such as the logbook and a signature, the curtains in the facilities, and assessment practices. In Chapter Five, I noted that the student logbook is a very relevant agentic body enmeshed in clinical practice and learning. I explained how the current logbook-student-midwife/doctor assemblage is problematic, producing an affective intensity that seems to constrain many students, at times inhibiting their desire to respond to unjust practices. Furthermore, the sequence of learning in which one disciplinary rotation follows another is also driving and shaping students' responses as each individual needs to achieve the requisite learning objectives. Learning emerges from spacetime mattering that intra-acts to generate students' experiences in their knowledge-making processes.

It became clear that the material-discursive practices in curricular activities impact on students' response-abilities. To reveal what has been silenced and hidden, I used drawings and students' reflective commentaries on Google Drive to open up different possibilities. Both were put to work as agentic material forces in a collective effort to fold

into and unfold the events of students' encounters. Stories emerged with an intensity to transform static memories and incapacities. The material-discursive entanglements and arrangements appeared to facilitate students' capacity to be response-able. I argue that separation and distancing constrains students' responses and limits their affective sensitivities to their encounters.

8.2.2.1 A relational ethics

Because ethics is so deeply entrenched in a relational ontology and relevant to examining the material-discursive practices of the curriculum-student assemblage, I refer back to Carol Taylor's (2018) five orientations of a posthumanist, new materialist ethics mentioned in Chapter Three to further unpack students' responses towards enacting social justice in obstetrics

1. The affirmative process taken in this study has been productive in raising awareness, moving from notions of individual trauma and troubling encounters to collective forces that are pushing for change.
2. By considering student learning amidst the entanglements of the ethico-onto-epistemological processes that make up the current curricular arrangements, their immersion into injustices occurring in obstetrics is far more complex than a personal matter. It is co-constituted by the relationships of multiple materialising agents.
3. Affect is present and intensely circulating with a speed and intensity that a/effects students' learning. The study foregrounded how attention to affect can be an enabler for students to become more response-able.
4. An ethical concern for social justice to be enacted emerged in the study. Rather than ethics as a separated subject with principles and ideals, it ought to be implemented in and through the process of care, as put forward by Tronto's (1998) ethics of care. One of the many contributing factors for the present challenges in obstetrics was a focus on training, both for midwifery and medicine. Current training is frequently taught as a dehumanised, regulated, mechanical process.
5. Intra-actions matter and offer deeper insights than an examination of human interactions. Students are in relationships with other humans as well as other bodies such as the logbook, beds, cardiac monitors and curtains. The materialising forces of matter shape students' experiences and influence their ability to respond to injustices. Students' response-abilities are determined not by self-regulation and determination but by the emergence of patterns of forces

constantly changing and interfering with each other, a diffractive process. For instance, when a logbook determines students' focus and lack of focus, there can be detrimental consequences.

8.2.3 Affective attunement

The third sub-question asked how an affective attunement can work towards rendering students capable in their response-ability to unjust practices in obstetrics. The study findings demonstrated that the flows of affective forces impacted on students' capacities, some limiting (for example, the signatures in logbooks), others enhancing their abilities to respond to the injustices they witnessed (for example, the process of drawing and stories shared). As I explained in Chapter Three, affect is more than emotion. Emotions and affect in medical education have tended to be unrepresented with the dominance of the rational positivist approach.

Yet, affective flows and forces circulate through students' learning encounters, taking up a significant role in determining students' responses to unjust practices. What was striking was the intensity of fear generated by the power differentials in the clinical and educational settings, as well as students' concerns related to any obstacles that could limit their movement through the linear curriculum or other forms of victimisation that appear to render students powerless and incapable of responding to unjust practices.

How affect plays out in clinical encounters is an ethical concern as it impacts on how students respond to what they witness. The potential elicited by affect added an important ethical consideration for each situation in practice. In disturbing the status quo of current practices, where affect appears to be dismissed or not acknowledged, my research findings have highlighted as well as worked with, the affective forces circulating in students' learning. My study involved opening up affective spaces which proved to be productive, both for the research and teaching intervention. To reconfigure pedagogy, I propose a different curriculum that purposefully incorporates opportunities for the expression of affect as a process with potential to foster students' responses to injustice. It is more than knowing about affect but a feeling/doing/becoming and moving with affect.

The drawings opened up spaces for affective flows both in the research intra-actions and in the classroom where further affective intensities were elicited through different kinds of performances such as role-plays and music. An affective sensibility became an

affirming force that was generated in these spaces. Students were affected by the indeterminate potential for capacity-building in their becoming-with others. The knowledge-making and sharing processes became entangled rather than separated through processes of othering. Through a sensitivity to affective flows in the pedagogical interventions, affect became an integral component and agential force of students' ethico-onto-epistemological experiences, rather than closed out, distanced and ignored. Creating a space for expressions of affect with drawings became a socially just pedagogical device for addressing students' troubling moments related to their exposure to unjust practices.

By examining the research data using a relational ontology that is affirmative and entangled with human, other-than-human, and more-than-human actors, affect emerged as a neglected force by curricular developers and educators in medical training. Affective responses are produced by the material-discursive practices generated by the unpredictable assemblage of curriculum-student-facility-birthing experience. By opening up spaces that can facilitate affective flows I have enabled a multitude of expressions of affect which tended to generate a sense of freedom towards bringing out more possibilities (Bonta & Protevi, 2004). In other words, affect can be a resource to contribute to the public good as it has a liberating effect where the intensity of forces can disturb silences and inactivities. The uncertain, dynamic affective movements and flows appear to play a very important role in shaping students' response-abilities and driving their curricular engagement yet remain concealed within conventional static and defined structures.

8.3 What contribution this study brings

The fourth-year undergraduate medical students' curricular experiences at UCT catalysed this study. Their encounters with others are threaded through this research project providing deep insights of practices that have tended to be silenced. Motivated by an affirmative and ethical concern, this study claims that the materialist theoretical lens of a relational ontology can provide new insights for pedagogical practices related to students' clinical encounters. I argue for the importance of attending to an early portion of students' clinical curriculum at which point they have not yet reached or been entrenched in an apparent culture of helplessness and scepticism.

I propose that in order to promote students' response-ability in curricular considerations we need to move beyond humanist, individual interpretations. An appreciation of

assemblage thinking through affective sensibilities provides an avenue to engage relationally, ethically, collectively, and productively with the current material-discursive practices. This study's theoretical grounding in FNM opens up a different perspective to addressing students' engagement in curricular matters. My research has taken an alternative pathway that projects to the future in terms of students' becoming-doctors-with-others and their responsibilities, which are connected to their response-abilities. Traditional methods of research that are humanist and individualist have been questioned, as well as representations of students' learning. The future is in the present as narratives of witnessing disrespect can continue with a force into further professional practices. Graduation from medical school does not bring closure to students' learning experiences which instead stay with them in their future becomings.

An unanticipated surprise in this project has been the force and intensity of visual images used in my resources, presentations, in this document, and in my data collection with all participants. Whether through expert illustrations, drawings, photographs or other mediums, newness and the unexpected has been made visible. These processes illustrate what multimodality can do in promoting response/able pedagogies. Rather than constructing separate concepts and entities, there has been an iterative entanglement of experiential data-researcher-participants, opening up spaces in-between, attempting to capture the movements within, across different spaces. Rather than following linear processes, time is in the events themselves that constitute the past, future and the present.

8.4 Reconfiguring pedagogical practices and response-ability

A relational ontology in the theoretical framework of FNM helps re-orientate our responses to the future through the present by bringing a different and inclusive approach to responsibility and works towards developing a socially just pedagogy that engages in/with the troubles. By taking up assemblage-thinking in which students are becoming-with the curriculum, new possibilities are created that have the potential to foster students' ability to respond in their troubling encounters. This new and different way of thinking is deemed necessary to promote a change to current practices. It offers an opportunity to reconsider students' curricular engagement that goes beyond technical, linear and static processes. Much of the present practices involve distancing of students as illustrated in Chapter Five, which is problematic as it places an emphasis on individuals as atomic entities, individualising the burdens and tensions in health facilities.

Vital material forces play out in student learning as the entanglements of spacetime mattering become important ethical considerations. For instance, in the public health birthing facilities, the assumption that the nurses and doctors working there will provide quality teaching to students and quality care to the patients appears to be unrealistic. What is occurring is that students are immersed in the multiple forces of troubling encounters. There appears to be a limited regard for the burdens already placed on healthcare workers. In my introduction I referred to Tronto's notion of privileged irresponsibility as a problem related to the medical curriculum and an issue which appears to exacerbate the power differentials operating in the institutions and different disciplines. There is a connection with the ongoing legacy of apartheid which has normalised forms of othering and appears to give less value to the poorer women who are using the public health facilities. Furthermore, the construction and design of the public health facilities undermines attempts to provide quality care. For instance, students notice the force of curtains separating beds as opposed to walls and how the curtain fabric acts as a fragile and porous non-barrier to any attempts at privacy that would promote the dignity of women in labour. Moreover, birthing women in our public health facilities have limited choices and alternatives, neither do students who need to be present and engaged in these spaces to acquire the necessary logbook ticks.

8.5 Troubling research entanglements

This study was not without its difficulties. Below I describe issues related to the process, the sensitive topic of abuse in obstetrics, and the emergent pedagogical challenges.

In terms of process, my participant population for interviews and FGs was largely located through connections between colleagues with snowballing as my recruitment method. I acknowledge that such close associations did influence my findings. For instance, at the second birthing facility, there was minimal disclosure about the problems of poor practices at that facility, yet students' stories shared in class and online, indicated several incidents of abuse that they witnessed in that same space.

My access as the researcher and entry into the Midwife Obstetrics Units was challenging due to the interdisciplinary politics and bureaucratic processes set up by the provincial health department. The power struggles between medicine and nursing as well as between the different facilities complicate open communications.

This study could be viewed as an intrusion on the flow of everyday practices. There is a fragile and delicate relationship between training institutions like UCT and local birthing facilities. As noted in Chapter Five, there is a deep need for acknowledgement and appreciation of each other's roles and responsibilities as opposed to Tronto's notion of privileged irresponsibility which allows or gives a pass to those in power who are actually maintaining the hierarchical culture that undermines students' ability to respond to poor practices.

There have been unhelpful repercussions when nurses have felt that the students were acting as "spies" reporting on their in/actions, an unintended consequence of promoting the advocacy role and responsibility of the students. Such detrimental consequences appear to invoke more fear and anger from all stakeholders. I propose that a relational ontology can provide a theoretical reference tool to enable all stakeholders to work collaboratively together to uphold respectful maternity care, promoting less separation and hierarchical distancing of both humans and more-than-human bodies. The University of Cape Town's Department of Obstetrics and Gynaecology gave immense support to my study and to students as well as midwives in the facilities to help settle the disruptions that occurred.

The topic of this study cuts into a risky space of silence. The dominant discourses and established practices have tended to conceal obstetric violence despite its prevalence in public health birthing facilities where UCT students learn their skills and their responsibilities towards patient care (and globally). Obstetric disrespect in terms of student learning is a sensitive topic that is more frequently ignored or side-stepped, hence the on-going silence.

The topic of abuse and disrespect is challenging in itself and how can one quantify it? Moreover, some students, like the nurses, may be facing abuse themselves. While support was offered to all research participants and all students in my classes, the prevalence of gender-based violence and domestic violence in our society is alarming and is likely to invade our professional spaces, as discussed in Chapter Two.

In this study I used the theoretical underpinning of a relational ontology to acknowledge that the apparatus of student learning is complex and unstable. There is a dynamic material arrangement that is enacted through multiple intra-actions rather than purely human-centred decision-making. It creates boundaries that are not static nor closed, that

rather move and shift with spacetime mattering opening up to the multiple forces and possible contributions. In staying with and in the trouble of student learning amidst poor practices, I was taking risks.

What comes to light is that affective forces are enabled in sharing incidents of good deeds but are far more constrained and restrained when related to traumatic events that may expose students' inability to act. More effort and affective sensibility is needed to engage with such tight knots of entanglements in order to facilitate affect to emerge. Bongani's story and how it changed at different moments, illustrates this movement.

8.5.1.1 Teaching space

The entanglement of spacetime mattering is highly relevant to student learning. For instance, time pressures are very real to medical students who are required to work with a loaded theoretical and practical curriculum. Some students are strategic in taking the quickest route to comply with curricular requirements to achieve the requisite assessed outcomes. Their input in performances and reflective commentaries (that are not connected with marks or percentages) are superficial and limited. A concern for issues of responsibility or response-ability or social justice is not in their ambit of relevance as their primary goal is to graduate. The force and intensity of chronos time for these students far outweighs aion time. My study does not extend to these issues of prioritising or to discern and evaluate issues of buy-in or vested interests.

Although reflection is advanced through the curriculum, the opening up of students' difficult issues seems to be an unfamiliar practice. There is a sense of personal vulnerability prevailing, which is understandable in the competitive environment of medical training. For instance, students resisted sharing personal written reflections if they felt they had chosen an ill-advised action in responding to an event. What became evident was that students' trust cannot be taken for granted, whether among their peers or towards the educators. For instance, some students preferred their reflective commentaries to be uploaded anonymously by me on our shared Google Drive folder.

8.6 My own response as researcher/educator

In the Department of Obstetrics and Gynaecology at UCT, the sounds, movements and vibrancy has radiated through the usually quiet corridors. The loud noises from students' performances (such as the role-plays, music, poetry, and videos) alerted others to a different set of workshops which disrupted the calm setting and business-as-usual of the

department. There has been an arousal of curiosity by other educators and administrative staff, some coming in to join discussions and offering contributions towards the continuation and progress of these transformative opportunities. Rather than a defensive stance, incredible support at every level within the department and faculty has been received, including funding made available to present at local and international conferences. These presentations and consequent publications have given exposure to this research and intervention -- an ethical response that has enabled the project to grow.

The students' collective affective capacity became a creative force of possibilities which triggered this research project. Olsson (2009) points to the fragility of thinking that opens up chaos, referring to the "magic moments" which constitute lines of flight where new thoughts emerge. These moments were experienced with students in the classrooms, in my readings, engagement with colleagues and all the research participants. Through the many different channels in the research process I have attempted to embrace possibilities and potentials drawn from encounters that moved me.

Stories do matter and have an affective force that can be captured in pedagogical processes. The findings in Chapters Five, Six and Seven describe examples of stories from students, midwives, and clinicians. However, I moved beyond the value of the story to the ethico-onto-epistemological significance of the assemblages in student learning and the impact the interrelationships where multiple forces are circulating as students are becoming-with others. Sensitivity to the affective forces became an important and relevant component to student learning. Curricular intra-activities in obstetrics are material-discursive practices with ethical and political implications that determine students' relational capacity to respond to troubling encounters.

8.7 Cultivating a conclusion, yet more to come ...

Disrespect in obstetrics is a reality in South Africa and internationally. Undergraduate medical students at UCT are immersed in their curricular encounters that reveal the inconsistencies between the ideals of quality health care for all and the violent practices evident in South African public health facilities, most notably in obstetrics.

This thesis is made up of multiple narratives interrelated with theory to highlight a matter of concern in student learning and to explore related issues of response-ability. My findings report on students' responses in/through/from their obstetrics learning

encounters, supported by the concerns of midwives, educators and others connected to their learning. Although students are taught to have a sense of responsibility in their being students and becoming doctors, there is a mix of forces that play out in their curricular events. I put forward a new way of thinking that moves beyond human-centred individualism. The curriculum forms multiple assemblages of which students are a part and have a relationship with others. In these relationships between human and more-than-human forces, affective intensities emerge that can disempower students' capacity to respond to injustices they may witness, referred to as response-in/ability, or empower students with varying degrees of capacity.

Disrespect and abuse of women in labour is a shocking reality in obstetrics and cannot be ignored in curricular matters. Obstetrics violence ought to be a priority health concern in South Africa and other countries. It should be made more explicit in terms of social accountability and social justice of medicine in general and medical training. Medical education has a responsibility to explicitly engage with the ethico-onto-epistemological relations that currently prevail in obstetrics learning. Through this study I propose that an affective posthuman sensibility guided by the theoretical stance of FNM can contribute a different and affirmative appreciation of the entangled forces contributing to students' becoming and their response-abilities. In terms of curricular matters, our attentiveness as educators ought to be with the curriculum rather than about it, in order to co-create and reconfigure pedagogical practices.

"Cultivating response-ability requires much more from us. It requires the risk of being for some worlds rather than others and helping to compose those worlds with others" (Haraway 2016, p. 179).



Figure 8.1: Looking back to the road ahead. Composing and co-constituting our worlds with others (Photo taken by Veronica Mitchell)

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ANNEXURES

1. Postscript
2. Information sheet
3. Ethics consent form
4. Focus group questions
5. Interview questions
6. Online Survey using Google forms
7. Student logbook
8. List of publications emerging from this study
9. Visual resources created and related to study



1. Postscript

Reflecting on my theoretical conundrums

In my research proposal and ethics submission I put forward my plan for an objective and reflective research project that was in line and conforming to the traditional institutional requirements. It was based on Design Based Research (Herrington, Reeves & Oliver, 2010) suggesting that through structured, determinate and iterative steps, I would propose new principles for managing and finding a solution to the disrespect in maternity care faced by medical students. However, the multifaceted nature of disrespect in birthing facilities and the expansiveness of the occurrence of such practices only became visible to me as I delved deeply into the topic, thereby making my intention to find a solution unrealistic. Rather than aiming to develop a pedagogical practice as a solution, I turned to new theoretical approaches to find an innovative, more meaningful and supportive perspective to engage with a justice-to-come. Posthumanism provided an affirmative, alternative, different lens to the troubling matters associated with student learning in the relational communities of their workplace clerkships. It takes into account a notion of subjectivity where bodies are not separate/d entities but “both embedded and embodied, and have relational and affective powers” (Braidotti, 2019, p. 42). The posthuman knowing subject is a relational being “in constant negotiation with multiple others and immersed in the conditions that it is trying to understand and modify, if not overturn” (Braidotti, 2019, p. 42). Posthumanist theories go beyond human-centred anthropocentric thoughts.

Barad's (2007) philosophical approach of agential realism then caught my attention and shifted my thinking to work with relationships and the movements that are enacted to generate who we are and what we do. Hence, my original data collection strategy (in line with representational ways of doing) changed to become a non-representational methodology in which multiple forces were recognised. I attempted to attune to the emergence of newness which understandably led to unresolved tensions that are evident through the thesis.

As I immersed myself in the research process, I moved through the zigzagging openings that both qualitative and post-qualitative approaches enabled the study to take on. This meant that at times there were two separate narratives or a separation of data and

theory as opposed to the intention of plugging theory and data into each other. Such was the in/determinate movement of the research assemblage.

My study may be criticised for taking a path away from evidence-based practices that are the usual benchmarks for scientific studies especially related to medical research. Such an essentialist and positivist approach assumes that entities can be represented as given. A more ethical stance, according to Barad (2007) and more recently, Mauthner is to work with agential realism. Mauthner (2018a) claims that:

the ontological assumptions that underpin knowledge-making practices are a matter of ethical concern because it makes a material difference to the world whether practices enact a world of fixed and pre-existing entities, or a world of ongoing processes of materialization that leave open the possibility of contesting and reconstituting existing configurations of the world (p. 54).

My post-qualitative methodology and mode of inquiry moved beyond representations of what is currently known. The data became unmeasurable and not replicable. Furthermore, the concept of affect added to the ontological indeterminacy and non-essentialism. The findings were emergent and dynamic noting ethical concerns through a posthumanist orientation. Through FNM my research project was able to examine the multiple forces involved in the boundary-making processes that a/effect the intra-actions involving the students and other bodies with consequent responses that are enacted and pertinent to their response-abilities. For instance, the force of curricular assessment practices in the form of the logbook separates students from challenging the injustices they observe.

Barad's (2007) concept of ethico-onto-epistemological practices was a core feature of my engagement with the entangled phenomena as I examined issues of accountability, ethics and responsibility which were immersed in on-going and multiple relationships with students. I drew on assemblage theory which does not assume pre-existence of reality.

Although the notion of diffraction is a key component of Barad's relational ontology, I put it aside to focus on what matters and can matter for new ways of approaching students' experiences. I purposefully cut back on my theoretical insights on diffraction to avoid losing readers not familiar with the specialist terms used in posthumanist that can be referred to as "jargon" as I did not want this to distract from the key elements of my

study. However, my earlier work through a diffractive lens provided - and continues to provide - valuable insights into the students' shared reflective commentaries and the associated affective forces and intensities that emerge (Mitchell, 2017).

As Mauthner (2018b) notes there is no for the recent ontological turn that brings in feminist new materialisms (FNM), rather several perspectives are being brought forward by different theorists. For instance, matter is viewed as an object with power and vitality by Jane Bennett (2010) but for Karen Barad (2007), matter materialises through a dynamic relational process as there is no "given-ness of any-'thing'" (Mauthner 2018a, p. 52).

A feminist new material approach was advantageous in my study as it introduced a novel and alternative perspective to students' engagement with their troubling encounters. I considered FNM to bring a different ethical perspective to student learning as it takes inquiry further than conventional human-centred approaches that tends to favour rationality and binaries related to individual intentionality. By examining the material-discursive practices through an experimental lens, I suggest the potential for different ways of considering the issue of respectful maternity care and student response-ability in their knowledge-making processes.



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2. Information sheet

PARTICIPANTS' INFORMATION SHEET for students

UNIVERSITY OF CAPE TOWN
Department of Obstetrics & Gynaecology
Health Sciences Faculty
Private Bag X, Observatory,
Cape Town, South Africa
Tel: +27 21 404 4485
Fax: +27 21 448 6921

UNIVERSITY OF THE WESTERN CAPE
Department of Physiotherapy
Faculty of Community and Health Sciences
Private Bag X 17,
Bellville 7535, South Africa
Tel: +27 21-9592274
Fax: 27 21-9593117

Project Title: Developing a socially just pedagogy for health care practitioners:
A design-based research project in Obstetrics

What is this study about?

This is a research project to be conducted by Veronica Mitchell at the University of the Western Cape. I am inviting you to participate in this research project because you have completed your Year 4 Obstetrics rotation / you are teaching Year 4 University of Cape Town (UCT) students in their Obstetrics rotation / you are a midwife working with Year 4 students in the birthing facilities. The purpose of this research project is to develop an innovative teaching intervention that can foster social justice in maternal care and enhance students' responsiveness toward injustice. Information about the experiences of abuse, neglect and disrespect (ANAD) observed by students, educators and midwives in the birthing units can facilitate a collaborative effort to address this ongoing concern in health care delivery.

What will I be asked to do if I agree to participate?

You will be asked to answer questions on a survey form / participate in an interview / participate in a group discussion / draw an image depicting an experience. The study will be conducted online / in a private room in the Health Sciences Faculty (UCT) / in a private room in the birthing facility. The survey is likely to take 10 minutes of your time. The interview / focus group / image is likely to take 30 minutes. Questions to be asked are included in the attached Appendix A and B.

Would my participation in this study be kept confidential?

I will do my best to keep your personal information confidential. To help protect your confidentiality, I will ensure that any information will not be personally identifiable. I will use password protected computer files, coding of names to ensure anonymity, and store hard copies of information in a locked cabinet. The online surveys are anonymous and will not contain information that may personally identify you. If I write a report or article about this research project, your identity will be protected to the maximum extent possible.

In accordance with legal requirements and/or professional standards, I will disclose to the appropriate individuals and/or authorities information that comes to my attention concerning child abuse or neglect or potential harm to you or others.

What are the risks of this research?

There may be some risks from participating in this research study. A project exploring abuse, neglect and disrespect in maternal care is an uncomfortable topic that may arouse negative emotional consequences such as regret, guilt and fear. Support will be available. This study draws on the emotional elements of teaching with discomfort in a collaborative way to develop a socially just educational intervention as opposed to follow punitive measures to address these challenges.

What are the benefits of this research?

Your involvement in this study may enhance student learning and help to improve the care of women in Obstetrics facilities. The benefits to you include being an advocate for change in advancing women's rights and maternal care. It will also equip you to face other difficult clinical situations where disjuncture of ideals and reality occur. Beyond personal benefit to you, the results of this study may help the investigator change teaching practices for Year 4 medical undergraduate students who will be our future doctors.

My hope is that other people may benefit from this study through an improved understanding of the complexity of responding to challenging situations in clinical encounters. The anticipated benefit to society from this research is that all women will feel nurtured and respected in a compassionate and caring birthing facility rather than exposed to ANAD.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify. Refusal or withdrawal from the study will not affect the participant's current or future academic career.

Is any assistance available if I am negatively affected by participating in this study?

If you feel negatively affected by the research, counselling and support will be available to you through a referral. For students this could be the student wellness clinic or head of the UCT Professional Standards Committee, for midwives and educators, other support will be made available.

What if I have questions?

This research is being conducted by Veronica Mitchell, Department of Physiotherapy at the University of the Western Cape.

If you have any questions about the research study itself, please contact
Veronica Mitchell, Department of Obstetrics and Gynaecology, UCT
Ph 083 635 9917
veronicaannmitchell@gmail.com

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

At UWC
Prof Anthea Rhoda

Head: Dept of Physiotherapy
University of the Western Cape

Private Bag X17
Bellville 7535
arhoda@uwc.ac.za

Prof Jose Franz
Dean: Faculty of Community and
Health Sciences
University of the Western Cape
Private Bag X17, Bellville 7535
jfrantz@uwc.ac.za

Head: Department Obstetrics &
Gynaecology
H45 Old Main Building, Groote
Schoor Hospital, Observatory 7925
lynette.denny@uct.ac.za

Prof Marc Blockman
Chairperson: FHS Human Research
Ethics Committee
Room E52, Old Main Building,
Groote Schoor Hospital,
Observatory, 7925
Tel: +27 21 406 6338 Fax: +27 21
406 6411
Marc.blockman@uct.ac.za

At UCT

Professor Lynette Denny

This research has been approved by

- University of Cape Town's Human Research Ethics Committee
 - Reference 280/2014
- University of the Western Cape's Senate Research Committee and Ethics Committee
 - Registration no 14/5/16



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2. Ethics informed consent form

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-9592274, Fax: 27 21-9592271

Department of Obstetrics & Gynaecology

Health Sciences Faculty

University of Cape Town

Private Bag X

Observatory

Cape Town

Consent for students to participate in research

Project Title:

Teaching towards socially responsive healthcare practitioners:
A design-based research project

You are asked to participate in a research study conducted by Veronica Mitchell from the Department of Obstetrics and Gynaecology at the University of Cape Town.

You were selected as a possible participant in this study because you have completed your Obstetrics practical experience in Year 4 of the UCT undergraduate medical programme.

During your Obstetrics rotation, you came into contact with vulnerable women in labour and you worked alongside other health care team members. Your experience interacting with the women in labour and different healthcare providers is valued.

Purpose of the Study

The aim of this study is to explore how a curricular intervention can influence the responses of students to promote social justice.

Process

If you volunteer to participate in this study, I will ask you to participate in one or a number of the following:

- To participate in a brief survey. Questions are designed to gain insight into

your experiences at a student in the Maternal Obstetrics Units.

- To be interviewed one-on-one with me with an audio tape used to record the interview. The interview will last approximately half an hour. It will take place in one of the tutorial rooms in the New Learning Centre or any other private area of your choice. If you wish you may be given a transcript of your interview to review and comment on to ensure accuracy.
- To be interviewed in a focus group with four of your colleagues
- To draw an image that reflects your experiences and to explain what you draw. Your explanation may or may not be recorded as above.

Potential Discomforts

The results of this research project that is directed from the University of the Western Cape (UWC) will be shared with other educators and researchers in presentations and publications.

Some of your free time will be used in this process. I will aim to be as time-conscious as possible to adhere to the agreed time and timing.

Some of your reflective comments may be critical of the Faculty and the facilities where you worked which could upset your supervisors. To protect you, all information and quotes will be anonymous.

Potential Benefits

Your experience as a student engaged in the Faculty curricular tasks is important and meaningful for present and future practices. The lessons learnt and recommendations from this study can assist the Faculty and the health facilities to better facilitate students' learning and to improve maternal care. This study can transform teaching practices and guide future policies to empower women in labour to realize their rights during a period of extreme vulnerability.

Payment

There will be a token payment for your time in participating in this study.

Confidentiality

Any information that is obtained in connection with this study and that can be identified with you will remain confidential. Transcripts of recordings will use numerical coding.

This research project report is part of my Doctoral study. It is likely to be presented to other educators, clinicians, facility managers of the involved clinics and Government stakeholders. The report will not mention any details (name, age, position, gender, and race) that may be used to identify exactly who were the participants in the study.

Participation and Withdrawal

You can choose whether or not to be in this research project.

If you volunteer to participate in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions that you wish not to answer and still remain in the study.

Contact details

If you have any questions or concerns about the research study, please feel free to contact me at any time as per the details below.

I agree to participate in the research,
Teaching towards socially responsive healthcare practitioners: A design-based research project

I understand that my participation is entirely voluntary. The procedures used to ensure my anonymity have been explained to me with my full understanding. My participation in this research can be terminated at any time if I so wish.

I agree that I have not been coerced or persuaded to participate in this research project. I do hereby give / not give my permission for this interview to proceed and to be recorded.

Signed Date

Thanking you

Veronica Mitchell

Ph 021 686 2849 / 083 635 9917 nicamitch@mweb.co.za

Department of Physiotherapy
University of Western Cape
Faculty of Community and Health Sciences
Robert Sobukwe Rd
Bellville 7535.

Should you have any questions regarding this study and the rights of research participants or if you wish to report any problems you have experienced related to the study, please contact one of my research supervisors:

Dr Michael Rowe
Department of Physiotherapy

University of the Western Cape
Private Bag X17, Bellville 7535

Ph 072 514 2309
mrowe@uwc.ac.za
Prof V Bozalek
University of the Western Cape

Private Bag X17, Bellville 7535
Ph (021) 9592274
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3. Focus group questions

FOCUS GROUP QUESTIONS TO STUDENTS POST OBSTETRICS

Project Title:

Developing a socially just pedagogy for health care practitioners:

A design-based research project in Obstetrics

4th /5th/ 6th Year Medical Student

Intention:

I wish to explore students' perceptions of the facilitating and hindering factors that influence responses to disrespect in the Maternal Obstetrics Units. By drawing on students' insights, I plan to develop an educational intervention.

A focus group offers an opportunity for participants to discuss similar experiences, to generate critical comments and alternative perspectives towards "an exploration of different types of solutions" (Kitzinger, 1995. p. 300).

Instruction to students:

The reality is that human rights violations (HRVs) occur too frequently in our health system despite our progressive Constitution.

My hope is that in this Focus Group you will feel comfortable to share your experiences and to collectively discuss the influences that enabled or disabled you to respond to discomfort in the birthing facilities.

1. Tell me about your Obstetrics rotation
(To explore the context)
 - a. Describe the good and not so good experiences that you had
 - b. How would you interpret the behaviour of those people influencing your experiences?
2. How did our teaching intervention around abuse in Obstetrics influence you?
(To examine our educational intervention)
3. What would you consider from this intervention (face-to-face and online) has helped you in your role of advocacy for change?
4. What would you consider from this intervention (face-to-face and online) has not assisted you in your role of advocacy for change?
(To elicit feedback on the intervention)
5. What are your perspectives in terms of collaboratively and collectively working on issues of ANAD in Obstetrics?
(To investigate the collective and collaborative efforts towards change)
6. Do you have any recommendations for furthering social justice in maternal health care?

4. Interview questions

QUESTIONS TO PRACTISING MIDWIVES

Project Title:

**Developing a socially just pedagogy for health care practitioners:
A design-based research project in Obstetrics**

Intention:

I wish to explore midwives' perceptions of the facilitating and hindering factors that influence responses to disrespect in the Maternal Obstetrics Units. By drawing on midwives' insights, I plan to develop an educational intervention.

Explanation to educators:

While good practices prevail in the Obstetrics units, the on-going reality is that human rights violations (HRVs) occur despite our progressive Constitution. My hope is that you will feel comfortable to share your experiences and to collectively discuss the influences that facilitate and limit student learning and their responses to discomfort in the birthing facilities.

1. Tell me about the students' Obstetrics rotation
(To explore the **context**)
 - a. Describe the good and not so good student experiences that you have observed
 - b. How would you interpret the influencing factors?
2. How do you suggest that we can work together to develop a teaching intervention around abuse in Obstetrics?
(To examine our educational **intervention**)
3. What would you consider could be the facilitating and limiting factors to promote women's rights and student learning?
4. Have you noticed any change in the students' advocacy roles recently?
(To elicit **feedback** on the intervention)
5. What are your perspectives in terms of collaboratively and collectively working on issues of ANAD in Obstetrics?
(To investigate the collective and collaborative efforts **towards change**)
6. Do you have any recommendations for furthering social justice in maternal health care?
(To offer an opportunity for participants to give their recommendations - giving recognition that human rights is a vertical thread that runs through the medical curriculum from first year upwards)

5. Online Survey using Google forms

Research Survey on Obstetrics Learning

DEPARTMENT OF OBSTETRICS AND GYNAECOLOGY
UNIVERSITY OF CAPE TOWN (UCT)

SURVEY TO INFORM PhD RESEARCH PROJECT
SUPERVISED THROUGH THE UNIVERSITY OF THE WESTERN CAPE (UWC)

Project Title: Developing a socially just pedagogy for health care practitioners:
A design-based research project in Obstetrics

Dear Medical Student

This survey request is reaching you because you are presently a student in the Health Sciences Faculty at UCT and you have completed your first Obstetrics rotation in Year 4 and participated in a health and human rights workshop with your peers and myself as a facilitator.

Your experiences interacting with the women in labour and different health care providers, is valued. This survey is designed to identify appropriate technology tools to use for engaging with students' experiences and to draw on your insights to inform improved teaching and learning. This survey is linked to 16 questions on a Google form. It is likely to take 5-10 mins of your time to complete.

Your completion of this survey will help me to understand your engagement with the Obstetrics curriculum in the birthing facilities in order to progress with my PhD research project. The purpose of this study is to develop an innovative teaching intervention that can foster social justice in maternal care and enhance students' responsiveness toward injustice.

While good professional practices are well established, information about experiences of abuse, neglect and disrespect (ANAD) in the birthing units can facilitate a collaborative effort to address ongoing concerns in health care delivery.

To help protect your confidentiality, I will ensure that any information will not be personally identifiable. I will use password protected computer files with coding of names to ensure anonymity. Confidentiality is assured through coding.

Your participation in this survey is completely voluntary. You may choose not to take part at all. If you do decide not to participate, you will not be penalized in any way.

This study has been approved by the University of Cape Town's Faculty of Health Sciences Human Research Ethics Committee (Ref 280/2014), and the University of the Western Cape's Senate Research Committee and Ethics Committee (Ref 14/5/16).

A detailed information sheet is available at
<https://docs.google.com/document/d/1JGZIS2aOmbcGBFklpuS2iBvlnVvve0eHSRF-ThoimE/edit?usp=sharing>

If you have any questions or concerns about the research study, please feel free to contact me at any time as per the details below.

Thank you
Veronica Mitchell (ph 083 635 9917)
veronicaanmitchell@gmail.com

Please answer the following questions as accurately as possible

* Required

1. Please indicate your informed consent for participating in this brief survey *

Mark only one oval.

- Yes
 No

2. Demographic information

Gender

Mark only one oval.

- Male
 Female
 Other: _____

3. *

How old are you?

2. Technology tools *

What technology device/s do you use often (every day)?

Check all that apply.

- Mobile phone with internet access
 Mobile phone without internet access
 Notebook / laptop
 Tablet
 Desktop
 None of the above

4. Technology tools *

Which is your preferred communication tool?

Mark only one oval.

- Mobile phone with internet access
 Mobile phone without internet access
 Notebook / laptop
 Tablet
 Desktop
 None of the above

6 Tool for engaging with difficult encounters *

Please suggest what channel of communication you would prefer for sharing challenging experiences with colleagues, educators and other health team members?

Mark only one oval.

-

- WhatsApp
- E-mail communication
- OSCE station
- Face-to-face class engagement
- Online space such as Google Drive
- Faculty Professional Standards Committee Incident Report [process](#)
- Would prefer not to share

7. Please offer a reason for choosing this method of communication *

8 YOUR EXPERIENCES IN YEAR 4 OBSTETRICS PRACTICAL ROTATION The next series of questions are about your initial learning in the Maternal Obstetrics facilities *

8. Before your 4th Year Obstetrics practical, did you have previous experience in Obstetrics?
Mark only one oval.

- Yes
- No

9. In Year 4, how would you rate your experiences in the Maternal Obstetrics facilities during your 8 weeks in Obstetrics? *

Mark only one oval.

1 2 3 4 5

very challenging in terms of relationships excellent experience with exemplars of good practices

10. Did you observe abuse, neglect or disrespect during your Obstetrics rotation? *

Mark only one oval.

- Yes Skip to question 11.
 No Skip to question 15.

You are at this page because you answered "Yes" to the previous question

11. If yes, how many times would you estimate that you observed abuse, neglect or disrespect? *

Mark only one oval.

- Once or twice during the 8-week rotation
 Once or twice a week
 Daily
 Frequently per day

12. Did you respond in any way to the abuse, neglect and disrespect you observed? *

Mark only one oval.

- Yes
No

13. What action did you take? If you chose not to respond, what stopped you taking action? *

Reflecting on your behaviour at the time

14. What feelings did you experience when you observed abuse, neglect or disrespect?

Reflecting on your emotional response at the time is valuable

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Skip to question 16.

You are at this page because you answered "No" to the previous question

15. What feelings did you experience when you heard about abuse, neglect or disrespect from your colleagues? *

This can refer to our formal class interaction in the workshop, the reflections shared on Google Drive or to informal conversations that you may have had together.

Skip to question 16.

Reflecting on the Obstetrics rotation

16. Thinking back on your whole immersion in the Obstetrics rotation, how do you feel now as you reflect on that learning experience? *

17. Abuse, neglect and disrespect has been a longstanding problem in Obstetrics *

Are you aware of any factors that might contribute to abuse, neglect and disrespect in Obstetrics?

18. Do you regard abuse, neglect and disrespect as a private matter or an issue that ought to be publicly challenged? *

Mark only one oval.

- Private
- Public

19. Whether private or public, please elaborate on your choice *

20. Your views and suggestions *

Your insights and experiences can contribute to changes in the curriculum and practice. If you are willing to engage in a one-on-one interview or a small group discussion to facilitate the development of an alternative teaching intervention, please give your contact details below. The time commitment is 1 hour, when convenient to you (and others in the group). To enable a comfortable space, food and drinks will be provided. A shopping voucher will compensate you for your time.

Mark only one oval.

- Willing to engage in an interview
- Willing to be part of a Focus Group
- Neither of the above

21. If willing to be interviewed or to join a focus group, please offer your email address below

22. Do you have any recommendations to improve students' capacity to respond to abuse, neglect and disrespect in Obstetrics?

Powered by



6. Student Logbook (anonymised)

TOPICS FOR OBSTETRIC TUTORIALS

✓

Indicate whether these were completed or not

- | | | |
|-----|--|--------------------------|
| 1. | Anaemia in pregnancy | <input type="checkbox"/> |
| 2. | Analgesia in labour | <input type="checkbox"/> |
| 3. | Antepartum haemorrhage | <input type="checkbox"/> |
| 4. | Breech delivery-including external cephalic version | <input type="checkbox"/> |
| 5. | Caesarean section | <input type="checkbox"/> |
| 6. | Renal disease in pregnancy | <input type="checkbox"/> |
| 7. | Diabetes mellitus in pregnancy | <input type="checkbox"/> |
| 8. | Episiotomy | <input type="checkbox"/> |
| 9. | Female pelvis and fetal skull | <input type="checkbox"/> |
| 10. | Fetal distress | <input type="checkbox"/> |
| 11. | Forceps delivery and vacuum extraction | <input type="checkbox"/> |
| 12. | Heart disease in pregnancy | <input type="checkbox"/> |
| 13. | Shoulder dystocia | <input type="checkbox"/> |
| 14. | Induction of labour | <input type="checkbox"/> |
| 15. | Intra-uterine death | <input type="checkbox"/> |
| 16. | Intra-uterine growth restriction | <input type="checkbox"/> |
| 17. | Management of normal labour | <input type="checkbox"/> |
| 18. | Maternal mortality | <input type="checkbox"/> |
| 19. | Mechanisms of normal labour | <input type="checkbox"/> |
| 20. | Minor disorders of pregnancy | <input type="checkbox"/> |
| 21. | Multiple pregnancy-including internal version and breech extraction | <input type="checkbox"/> |
| 22. | Obstetric emergencies, including collapse in Obstetrics | <input type="checkbox"/> |
| 23. | Occipito-posterior position, face and brow presentation | <input type="checkbox"/> |
| 24. | Perinatal mortality | <input type="checkbox"/> |
| 25. | Postpartum haemorrhage | <input type="checkbox"/> |
| 26. | Prenatal counseling | <input type="checkbox"/> |
| 27. | Preterm labour and premature rupture of membranes | <input type="checkbox"/> |
| 28. | Prolonged and obstructed labour | <input type="checkbox"/> |
| 29. | Proteinuric hypertension and eclampsia | <input type="checkbox"/> |
| 30. | Reproductive failure | <input type="checkbox"/> |
| 31. | Rhesus iso-immunization | <input type="checkbox"/> |
| 32. | The abnormal puerperium | <input type="checkbox"/> |
| 33. | The normal puerperium | <input type="checkbox"/> |
| 34. | Transverse and oblique lie and presentation and prolapse of the cord | <input type="checkbox"/> |
| 35. | Trial labour | <input type="checkbox"/> |
| 36. | Tumours in pregnancy | <input type="checkbox"/> |
| 37. | Ultrasonography in Obstetrics | <input type="checkbox"/> |
| 38. | Urinary tract infection in pregnancy | <input type="checkbox"/> |
| 39. | Vaginal examination in Obstetrics | <input type="checkbox"/> |
| 40. | X-rays in Obstetrics | <input type="checkbox"/> |

PROGRAMME

Obstetrics is a practical subject, best learned from personal experience with antenatal and postnatal patients and in the Labour Ward. Students are therefore expected to get involved in the work of the Maternity Hospital or Midwife Obstetric Unit.

1. Practical Obstetrics

To comply with the Duly Performed (DP) requirements for this course, the following are mandatory:

- Attend at least 6 of the 8 lecture series days. Registers will be kept.
- Deliver at least 8 patients under supervision and examine the newborns immediately after delivery.
- Perform at least 8 vaginal examinations in labour.
- Care for at least 5 patients in the first stage of labour.
- 1 case presentation to medical officer/registrar/consultant for which a minimum score of 60% is required. The case must be typed- up and must include a discussion of +-300 words with at least 3 references.
- Do at least 5 calls during the block: 3 at secondary hospital and 2 at MOU. If 5 calls have been completed AND 6 or more deliveries were conducted, the student may participate in the end of block assessment. The assessment week can be used to complete deliveries. Marks will not be released until all DP requirements are met.
- Attend and participate in at least 3 Obstetric ward rounds at a secondary hospital.
- Attend 5 Obstetric tutorials given by either student interns or clinicians. To avoid undue repetition of topics a list is provided of subjects on page 2 of this logbook that must be covered during the Obstetric block.

All cases must be signed by the supervising Doctor or Midwife.

2. End of Block Assessment

MCQ and OSCE with both Obstetrics and Neonatal components

STUDENT IN-COURSE ASSESSMENT

(A minimum of **5 calls** to be signed off and graded by the senior doctor/sister after each call)

Rate the student in the following categories:

Poor = < 50% Satisfactory= 50-60% Good= 65-75% Excellent= >75%

Call 1: Hospital/MOU: _____

Date:

A) Professionalism (punctuality, dress, attitude etc.)

Poor	Satisfactory	Good	Excellent
------	--------------	------	-----------

B) Conscientiousness (careful, thoughtful, decent, thorough etc.)

Poor	Satisfactory	Good	Excellent
------	--------------	------	-----------

C) Clinical skills (history-taking, examination- and procedural-skills etc.)

Poor	Satisfactory	Good	Excellent
------	--------------	------	-----------

Comments:

Name and signature _____

Call 2: Hospital/MOU: _____

Date:

A) Professionalism (punctuality, dress, attitude etc.)

Poor	Satisfactory	Good	Excellent
------	--------------	------	-----------

B) Conscientiousness (careful, thoughtful, decent, thorough etc.)

Poor	Satisfactory	Good	Excellent
------	--------------	------	-----------

C) Clinical skills (history-taking, examination- and procedural-skills etc.)

Poor	Satisfactory	Good	Excellent
------	--------------	------	-----------

Comments:

Name and signature: _____

Call 3: Hospital/MOU: _____

Date:

A) Professionalism (punctuality, dress, attitude etc.)

Poor	Satisfactory	Good	Excellent
------	--------------	------	-----------

B) Conscientiousness (careful, thoughtful, decent, thorough etc.)

Poor	Satisfactory	Good	Excellent
------	--------------	------	-----------

C) Clinical skills (history-taking, examination- and procedural-skills etc.)

Poor	Satisfactory	Good	Excellent
------	--------------	------	-----------

Comments:

Name and signature _____

Call 4: Hospital/MOU: _____

Date:

A) Professionalism (punctuality, dress, attitude etc.)

Poor	Satisfactory	Good	Excellent
------	--------------	------	-----------

B) Conscientiousness (careful, thoughtful, decent, thorough etc.)

Poor	Satisfactory	Good	Excellent
------	--------------	------	-----------

C) Clinical skills (history-taking, examination- and procedural-skills etc.)

Poor	Satisfactory	Good	Excellent
------	--------------	------	-----------

Comments:

Name and signature: _____

Call 5: Hospital/MOU: _____

Date:

A) Professionalism (punctuality, dress, attitude etc.)

Poor	Satisfactory	Good	Excellent
------	--------------	------	-----------

B) Conscientiousness (careful, thoughtful, decent, thorough etc.)

Poor	Satisfactory	Good	Excellent
------	--------------	------	-----------

C) Clinical skills (history-taking, examination- and procedural-skills etc.)

Poor	Satisfactory	Good	Excellent
------	--------------	------	-----------

Comments:

Name and signature:



UNIVERSITY *of the*
WESTERN CAPE

CARE OF PATIENTS IN FIRST STAGE OF LABOUR

No	Date	Name of Patient	Folder No.	Hospital / MOU	Signature of Doctor / Midwife
1					
2					
3					
4					
5					

NORMAL VERTEX DELIVERIES

No	Date	Name of Patient	Folder No.	Hospital / MOU	Signature of Doctor / Midwife
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

VAGINAL EXAMINATIONS IN LABOUR

No	Date	Name of Patient	Folder No.	Hospital / MOU	Signature of Doctor / Midwife
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

CASE PRESENTATIONS

No	Date	Name of Patient	Hospital	Signature	Mark %
1					
2					
3					

OBSTETRIC WARD ROUNDS AND TUTORIALS ATTENDED

Please indicate which hospital:

A

B

Note to the doctor doing the ward round/tutorial:

Please sign this register at the end of each ward round/tutorial

Signatures indicate that the student was present and played an active part

WARD ROUNDS

DATE	NAME	SIGNATURE

TUTORIALS

DATE	NAME	SIGNATURE

MIDWIFE OBSTETRIC UNITS (MOU)

Note to Sister-in-Charge

It is necessary for the Department of Obstetrics to certify adequate participation by the medical students in the activities of the MOU. We would greatly appreciate your assistance in this regard. All that would be required is for you to sign the register below. Your signature would indicate that the student was present on the day and participated in the activities of the MOU (monitoring patients, performing deliveries, attending ANC, taking booking bloods, etc.)

Please note the following:

- Students attend lectures on Mondays in weeks 3, 5 and 6 of their block.
- Students at
- Some may request to stay for the weekend.

MOU Day visits to A, B, C and D facilities				
Day	Date	Sister's Name	Signature	Comment

7. List of publications emerging with/from my PhD project

Mitchell, V. (2015). Using the Keynote App as a Research Tool: A Case Study in Medical Education. Chapter 4. *iPads in Higher Education: Proceedings of the 1st International Conference on the Use of iPads in Higher Education (ihe2014)* Eds: N. Souleles, C. Pillar. Cambridge Scholars Publishing. Newcastle upon Tyne.

Mitchell, V. (2015). The Human Rights Key: An innovative tool for teaching health and human rights in the health sciences. *African Journal Health Professional Educators*. 7(1), 39-42.

Mitchell, V. (2016). A case study In Chapter 8 student mobility: a problem and an opportunity. In K. Bin Abdulrahman, S. Mennin, R. Harden, & C. Kennedy (Eds.), *Routledge international handbook of medical education*, Oxford: Routledge.

Mitchell, V. (2016). A Diffractive Exploration of Affect: Learning, Research and Teaching in Obstetrics. Special edition of *The South African Journal of Higher Education* on critical posthumanism, new materialisms and the affective turn for socially just pedagogies in higher education, 30(3), 235-254.

<http://www.journals.ac.za/index.php/sajhe/article/view/654/258>

Bozalek, V., Mitchell, V., Dison, A. & Alperstein, M. (2016). A diffractive reading of dialogical feedback through the political in Higher Education, *Teaching in Higher Education*, ISSN: 1356-2517. 1470-1294. doi: 10.1080/13562517.2016.1183612

Bozalek, V., Bayat, A., Motala, S., Mitchell, V. & Gachago, D. (2016). Diffracting socially just pedagogies through stained glass. Special edition of *The South African Journal of Higher Education* on critical posthumanism, new materialisms and the affective turn for socially just pedagogies in higher education, 29(1), 201-218.

Mitchell, V. (2017). A nomadic research journey: Blogging with an iPad and taking a critical posthuman perspective. Chapter 1. *Proceedings of the 2nd International Conference on the Use of iPads in Higher Education*. (Eds): B..F. Baab, J. Bansavich, N. Souleles & F. Loizides. Cambridge Scholars Publishing. Newcastle upon Tyne. iPads in Higher Education Proceedings of the 2nd International Conference on the Use of iPads in Higher Education (ihe2016) ISBN(13): 978-1-4438-9973-4

Mitchell, V. (2017). Diffracting Reflection: A Move beyond Reflective Practice. *Education as Change*, 21(2), 165-186.

<https://upjournals.co.za/index.php/EAC/article/view/2023>

Bozalek, V., Dison, A., Alperstein, M. & Mitchell, V. (2017). Developing Scholarship of Teaching and Learning through a Community of Enquiry, *CriSTaL* 5(2), 1-15.

Bozalek, V., Bayat, A., Gachago, D., Motala, S., & Mitchell, V. (2018) A pedagogy of response-ability. In V. Bozalek, R. Braidotti, M. Zembylas and T. Shefer (Eds.). *Socially just pedagogies in higher education: Critical posthumanist and new feminist materialist perspectives*. Bloomsbury.



8. Visual resources emerging from this study

My visual images

My frustrations in teaching human rights to medical students through a set programme led to the innovation of an heuristic, entitled, 'The Human Rights Key'. The story and process of conceptualising and using this visual tool is published in the African Journal of Health Professions Education (Mitchell, 2015). The Key supports students' understanding of the relationships between spheres of influence and discrete legal instruments, emphasising the importance of education as the connecting medium. In 2011, I introduced a novel reflective tool titled, the Six Step Spiral for Critical Reflection (SSS4CR) which is explained in my publication in Education as Change (Mitchell, 2017). The SSS4CR has proved to be a valuable tool to guide students in their reflective process following their obstetrics block. Both visual tools are now available as open educational resources on the UCT Open Content Repository.

The Key with different themes is available at <https://open.uct.ac.za/handle/11427/6599>
And the Spiral is incorporated into a website covering the broader topic, Probing Professionalism towards Positive Practice at <https://open.uct.ac.za/handle/11427/6600>.



The Human Rights Key

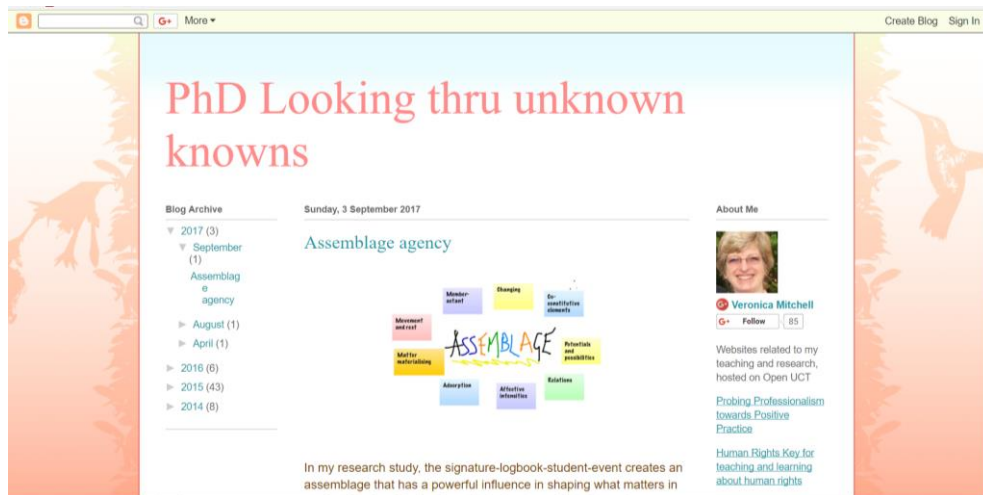


Six Step Spiral for Critical Reflection (SSS4CR)

Probing Professionalism website title page

Ipad-researcher-drawings

During the time spent on data collection in this study, I felt my own movements with/through the visual-data-in-the-making. The process of drawing became an irresistible force for me as the researcher. I felt the energising e/affect of images, enhancing my own agency and initiating a series of blog posts developed over 18 months on Blogger at <http://phd4veronica.blogspot.co.za/>



Screenprint of a blog post

Further encouragement to work and experiment with visual data was gained from the texts and video recordings of Manning and Massumi related to their SenseLab project, that they describe on their website as “a laboratory for thought in motion” (<http://senselab.ca/wp2/>) as well as input from visual artist and colleague, Elmarie Costandius who showed me how to creatively “play”, by introducing a multimodal approach that can open up a dynamic process of experimentation, an expanded form of material thinking and doing (Bolt, 2007).

Video recordings with Professor Lynette Denny

- 1 Insights into Obstetrics: the need for change
<http://youtu.be/-jGp2DNjuOw>
- 2 Speaking out about hierarchy and vulnerability
<http://youtu.be/kwBDT1JEIYW>
- 3 Collaboration, Teaching and Learning - tensions
<http://youtu.be/BssaHmkEBr>
- 4 A vision for great doctors
<http://youtu.be/aIKJrHfA1dw>