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Chapter 1

REFLECTIVE POSITIONING: THE IMPACT OF CONVERSATIONS IN THE SOCIAL AND CULTURAL ENVIRONMENT OF MIDWIFERY PRACTICE SETTINGS ON PROFESSIONAL LEARNING FOR STUDENTS

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ABSTRACT

Literature reviews on the topic of reflection and reflective practice encompassed midwifery, nursing, medicine, allied health, education and professional education. This investigation also included socio-psychological theories by leading authors such as Benner (nursing), Schön (professional education) and positioning theory by Harré and others. Positioning is a psycho-sociological ontology in which individuals metaphorically position themselves within three entities: people, institutions, and societies, where conversations are constructed and make an impact upon the social world. The social and cultural structures and interactions developed in Archer’s morphogenesis were examined in terms of the impact of possible encounters and the transformational effects of learning experiences in practice settings. These bodies of work provided the theoretical framework for the author’s research of students’ experiences in midwifery education for postgraduate students from which selected excerpts with three participating students and their supervising midwives are presented. These excerpts are related to reflective practices and the professional conversations conducted between students and midwives. It was found that reflective positioning applied in midwifery education by students can serve as an analytical tool in explaining social and cultural elements of clinical placements to influence and transform their learning. The potency of conversations that occur in everyday moment-to-moment interactions do contribute to students’ induction in professional midwifery practice and their identity formation as a midwife.

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INTRODUCTION

This chapter presents a literature review of midwifery, nursing, medicine, allied health, education and professional education, including socio-psychological theories. The work by Benner (nursing) and Schön (professional education) were central to this investigation of reflective practices and in relationship with the work by Harré and others who promote positioning. The social and cultural structures and interactions developed in Archer’s morphogenesis were examined in terms of the impact of possible encounters and the transformational effects of learning experiences in practice settings. These bodies of work provided the theoretical framework for Phillips in her doctoral research of students’ experiences of their professional learning in midwifery education, specifically related to the Graduate Diploma of Midwifery, Melbourne, Australia. This research was undertaken using a case study approach for qualitative research design over an academic year and conducted as a series of interviews with ten participating students and their supervising midwives over the course of an academic year to learn about their experiences. The excerpts of three students and their supervising midwives are presented pertaining to each of the student’s experiences in midwifery practice settings and their conversations with their respective supervising midwives related to the delivery of care.

The connection between reflective practice and positioning was made on the basis of the author’s experience as a midwife and understanding of the professional conversations that midwives typically engage in. The conversations that were of particular interest were those conducted between both midwives and students midwives in practice settings and where students were and continue to supported in a supervised model of learning. This model is referred to as ‘preceptorship’ throughout this chapter and midwives providing support of students are called ‘preceptor/midwives’. As a consequence of this arrangement or similar models of student support, midwives have and continue to influence student professional learning through the moment-to-moment interactions of conversations related to everyday midwifery practices. The impact of midwives upon students is through induction to professional practice and as role models in practice settings. Midwives therefore, influence each student in their professional identity formation as a future midwifery practitioner. In this process of induction into professional practice each student employs a variety of strategies, whether consciously or unconsciously, to position themselves to achieve the best possible learning opportunities and where reflective practice is encouraged.

MIDWIFERY EDUCATION

There are three pathways in midwifery education in the state of Victoria, Australia. They include first, a postgraduate course, the Graduate Diploma of Midwifery available only to registered nurses and described as a ‘pre-masters’ course; second a Bachelor of Midwifery (undergraduate) and; finally the combined undergraduate degree course, Bachelor of Nursing/Bachelor of Midwifery. All three pathways are subject to each graduate submitting an application for endorsement as a midwife by the legislating authority, the Nurses Board of Victoria (NBV).
The NBV influences the design of course curricula through mandating the prescribed number of practice hours and minimum experiences the student of midwifery is compelled to achieve. When each student successfully completes both course and mandated practice requirements, an application for endorsement as a midwife can then be made by graduates to the NBV. The Graduate Diploma of Midwifery is generally considered by nurses as a pathway to a second career, where established nursing knowledge and skills are enhanced and where the focus of care is shifted to the predominance of healthy childbearing women. Professional indiction into this second career is critical so students learn best practice in the delivery of care for childbearing women and their families.

In Australia ‘reflection’ has been promoted in clinical teaching for both nursing and midwifery education, since the 1990s to link teaching of theory and practices (Taylor, 2006). The national authority, the Australian Nursing and Midwifery Council promotes reflection in midwifery education as it is understood to facilitate induction into professional practice, promote professional development, and appraisal of practice (ANMC Australian Nursing and Midwifery Council, 2006).

**LITERATURE REVIEW**

Reflection in its application for professional education has had wide rhetorical use over many years by a number of notable authors from a variety of disciplines. For example, Schön (1983, 1988, 1991) (adult education and management); Mezirow (1991, 1994, 1996, 1998), (adult education); Boud, Keogh and Walker (1985) (adult education) and Shulman (1987, 1998) (teacher education); Benner (1984); and Benner, Tanner and Chesla (1996) (nursing education), are some of the prominent figures who have characterized in reflective practice by drawing heavily on Deweyian pragmatism and, more recently, on the critical social theory of Friere and Habermas.

Benner’s characterization (Benner et al., 1996; Benner, 1984) is of particular relevance for both nursing and midwifery education. Her model comprising of five developmental levels or stages of reflective competence (novice, advanced beginner, competent, proficient, and expert levels), has contributed significantly to competency based frameworks for curricula of nursing and midwifery.

A specific purpose of the promotion of reflection within midwifery education has been to uphold active adult learning, not only from the theoretical context but also from clinical placements and learning experiences. The purpose of reflection, succinctly presented by Taylor (1998, p. 134) is for all learners in practice (nurses and midwives) “… to reflect on their practice worlds …” whereupon individuals can create meanings from clinical experiences to support their professional knowledge.

In summary, reflective practice has been held to:

- Bridge the gap between theory and practice with the expectation that it leads to articulation and development of knowledge embedded within practice (Smith, 1998; Davis, 1998; Kuiper & Pesut, 2004).
- Encourage the practitioner to not only acquire knowledge but also generate a cycle of learning that is similar to the action research process (Rolfe, 1998).
• Support the practitioner in the examination of her/his decisions and the application
  knowledge acquired within practice (Heath, 1998).
• Develop skills such as self-awareness, description, critical analysis, synthesis,
  evaluation (Heath, 1998; Thompson & Rebeschi 1999; Yost, Sentner & Forlenza-
  Bailey, 2000), or transformative learning (Mezirow, 1991).
• Afford insights through professional conversations with the preceptor/midwife.
  Guided reflection is typically conducted within problem-based or situated learning
  environments and strongly advocated by Schön (1988, 1991); Mezirow (1991);
  Benner (1984); and Benner et al. (1996).
• Promote learning, that health care providers practice with moral integrity and
  professional commitment to maintain standards of safe practice (Ferrell, 1998;
  Lumby, 1998; Gustafsson & Fagerberg, 2004).
• Create records that can be referred to at a later stage to appraise and reinforce
  learning, (Taylor, 2000, 2006).

PSYCHOLOGICAL AND SOCIAL MEANINGS

In the literature related to education, nursing, and midwifery, there is an assumption that
there is a universal meaning and significance in reflection as a cognitive activity. The
development of practical reasoning at this intersection of individual purposes and social
action is fundamental in this literature review.

A variety of viewpoints have placed emphasis on reflection as a social or political act, as
opposed to it being a psychological act. Dewey (1933) considered reflection and thinking to
as the process of executive or higher order ‘thinking on their feet’ in performing a specific
task through ‘reflection-in-action’ and ‘reflection-on-action’. The pedagogical model
promoted by Shulman (1987), also after Dewey, spoke of appraising advanced reasoning that
encompasses comprehension, transformation (preparation, representation, selection, and
adaptation), instruction, evaluation, reflection, and new comprehensions. Shulman (1987)
described reflection as “… what a teacher does when he or she looks back at the teaching and
learning [of practical content] that has occurred, and reconstructs, reenacts, and/or recaptures
the events, the emotions, and the accomplishments” (p. 18). He was principally concerned
with reflection as a tool for psychological analysis of the teacher’s pedagogical knowledge
reflection as a transformational process whereby each learner develops opinions based on
previous experiences to create new meaning from new experiences. Reflection here plays a
key role in the transformation of personal social meaning(s), a process that is grounded in the
transformation theory (Mezirow 1998) based upon values, moral issues, and feelings.

TYPES OF REFLECTIVE THINKING AND LEARNING

It is presumed that individuals who are capable of thinking are also capable of reflection
on experience and learning from these experiences. As a complex phenomenon, superficial
practices can be opposed to deep practices in reflection. Superficial learning is also referred to as the ‘surface approach’ by which individuals tend to memorize information, usually for the purpose of examinations. Conversely, individuals employing the ‘deep approach’ are making a conscious decision to explore and understand a problem, and arrive at a solution (Boud, Keogh & Walker, 1985). The deep approach is, therefore, a deliberate act of reflection and, as presented by Boud et al is described as a solitary and private exercise.

Wellington and Austin (1996) identified five orientations of reflective practice in a useful taxonomy based on the distinction between the immediate demands of a task (from no immediate reflection) to transformation, in which reflective narratives become more deliberate and meaningful. Figure 1 provides a diagrammatical representation of the five orientations of reflective practice, all of which are typically adopted in the everyday conversations of students and midwives.

Gonzalez Rodriguez and Sjostrom (1998) argue that the promotion of a variety of reflective practice activities for adult learners is essential because there are diverse intellectual levels, as well as the need to recognize and acknowledge past experiences. Critical social thinking is considered to be fundamental for professional practice where demands in health care services are dynamic and challenging (Thompson & Rebeschi, 1999).

In other taxonomies, Kemmis (1985) and Hatton and Smith (1995) related reflection to meeting social need through action as teachers and learners. They drew upon the trichotomy of ‘technical, practical and emancipatory’ needs explained by Habermas (1976). Problem solving of the ‘technical kind’ is the most prevalent type and is typically observed amongst new graduates in professional practice. A second type, practical deliberation, refers to appraisal of a situation and subsequent decision-making, and the third, speculative thought, occurs when emphasis is placed upon transformative critical reflection.

Along with ‘critical reflection’ there is reference to ‘transformational reflection’, terms that are implied to have a shared meaning. Both are applied by Kemmis (1985) in the promotion of learning from social actions. The terms reflection and critical reflection are often used interchangeably in the literature, but Hatton and Smith (1995) found instances of the latter to be relatively rare compared to the descriptive reflective accounts in student teacher journals. Hatton and Smith (1995) defined critical reflection as “… involving reason giving for decisions or events which takes account of the broader historical, social, and/or political contexts” (p. 41).

For Mezirow (1991), critical self-reflection occurs when an individual has conducted an assessment of problems and reassessed their personal meaning and perspective. This process incorporates the following:

When the object of critical reflection is an assumption or presupposition, a different order of abstraction is introduced, with major potential for effecting a change in one’s established frame of reference. Assumptions upon which these habits of mind and related points of view are predicated may be epistemological, logical, ethical, psychological, ideological, social, cultural, economic, political, ecological, scientific, spiritual, or pertain to other aspects of experience.

(Mezirow, 1998, p. 186)
Lumby (1998) also postulated that the space between critical reflection and re-visioning leads to transformation “… when one views the old with new eyes, seeing possibilities not previously imagined.” (p. 95). Personal transformation has been the desired explicit or implicit outcome in the professional development literature. This process is undertaken in a variety of settings in universities or workplaces, for example, through students’ journals, group activities, ‘debriefing’ sessions or the conversational sharing of stories or narratives. Through these diverse settings and methods of learning leads to the exploration of theories related to ‘tacit knowledge’.

Figure 1. Orientations to reflective practice.
EDUCATING TACIT KNOWLEDGE

The concept of tacit knowledge was introduced by Polanyi (1958) who argued that it “…exceeds the powers of articulation…” (p. 92). This is understood to mean, for example, that previous learning and perceptions are influential factors on one’s actions, even though the individual concerned may be at a loss to explain such actions. Further, skills developed in this manner may be lost altogether if they are not continued to be related to action (Schön, 1983, 1988; Boud, Keogh & Walker, 1985; Kemmis, 1985).

Schön (1988, 1991) applied the term ‘technical rationality’ to refer to an implicit problem-solving ability that arises from the influence of positivist epistemology in those professions aligned with science or applied science, such as medicine. It is understood that such professionals have an existing body of technical knowledge and expertise, the exactness of which defines their profession. Schön described this as tacit knowledge, problem solving using implicit knowledge rather than explicit knowledge, which he saw as important components of technical rationality.

Fawns (1984) described a cycle of reflection incorporating self-analysis (planning, transacting and reviewing) applied to teacher education, stimulated by conversations related to professional praxis. This cycle encompassed three elements of Polanyi’s (1958) personal knowledge; theoretical and disciplinary knowing through ‘skilful-tacit knowing’; ‘common sense or value knowing’; and ‘skilful knowing’. These forms of knowledge, the ‘what, why and how’, are found in the dialogical cycle of reflective practice in problem-solving for professional learning. Butler (1992) was concerned with the uncovering of the self by the process of reflection that, he argued, must take place prior to the formulation of action that leads to the Schön processes. Butler’s analysis of this improved insight into personal and professional domains awareness is theoretically supported in using Gadamerian hermeneutics (Silverman, 1991).

Johns (1998), a nurse academic, described professional intuition as the manifestation of tacit knowledge — “a knowing that is deeply embodied but unable to be expressed in rational ways” (p. 3). Taylor (2000), Johns (1998) and Rolfe (1998) observed that a nurse with twenty years experience should not be assumed to be an expert practitioner and their professional intuition is developed from experiential knowledge, but not necessarily from simple exposure to situations. Heath (1998) argued that qualified nurses perform at different levels related to their understanding of formal theory and exposure to diverse experiences that contribute to reflective decision-making processes. Clearly not all experiences in practice are diverse, and not all activities would require reflective analysis by the practitioner.

The term, practical knowledge’ is embedded in social sciences and it is articulated in discursive acts and actions. Giddens (1979) equates practical knowledge with Polanyi’s tacit knowledge. It was Giddens who characterized practical knowledge as containing internalized rules, resources, and beliefs that guide social interactions without conscious attention to those rules and beliefs.

The social setting for professional praxis in reflection was described by Boud and Feletti (1991) as ‘problem-based learning’, where they saw it as an approach to structuring the curriculum that “involves confronting students with problems from practice which provide a
stimulus for learning” (p. 21). To develop professional competence, it is expected that students require more than knowledge in subjects relating to their future profession. While critical reflective practice is understood to be essential for effective problem-based learning, the psychological process of learning and the ‘problem’ itself is often not theorized. Self-directed learning, communication skills, critical reasoning, logical and analytical approaches to problems, reasoned decision-making and self-evaluation are required for problem-based learning, but do not constitute it. Although there is not a clear definition of these skills within the context of nursing or midwifery education, professional problem-solving is established, for example, in Benner’s phenomenological stages. The highest level of reflection is embodied knowledge that is equated to Dewey’s executive intelligence (Benner, 1984; Benner et al., 1996).

Yost et al. (2000), for example, described reflection as a problem-solving process in which an experienced individual attempts to make sense of a challenging situation. The individual concerned identifies areas of practice requiring scrutiny, determines goals for improved practice and undertakes actions to achieve the identified goals. The aim of problem-based learning is to modify and enhance professional practice through the progression of problem-solving, resulting in the reconstruction of knowledge.

With reflective practice, confusion may emerge with problem-based learning related to the terminology associated with different applications in curriculum planning. Ross (1991) found these meanings in the literature. They include: (a) ‘problem-oriented’ curricula, where problems are used as selection criteria for contents and method; (b) ‘problem-based’ curricula, where students work on problems as part of the course; and (c) ‘problem-solving’ curricula, where students are given specific training or development experiences for solving problems. The word ‘specific’ in this context was a relative term.

**Reflection and Professional Dialogue**

While the work by Schön, Shulman and Benner are primarily concerned with the codification of social, psychological, and technical knowledge of professionals, Van Manen (1994), Sockett (1993) and others have placed emphasis upon the ethical dimensions of decision-making of professionals. Professionals observed to make decisions often do not attempt to articulate explicitly the rationale for their actions. According to Schön (1983, 1988), this is often tacit, embodied in a particular context such as previous experiences in conversations that equate with reflection. This suggests that Schön’s reflective practice is not an individual construction, but rather a social-professional dialogue in which logical and moral knowledge can be achieved through a process of undefined inductive acts in particular social settings. The mentor role in social constructions of professional identity is acknowledged, but also undeveloped in the professional induction of a neophyte.

Greenwood (1998), an Australian nurse academic, made a related observation when she criticized Schön’s model because it does not acknowledge the ‘reflection-before-action’ or the preparation process that usually occurs before an action is undertaken in social settings. However, dialogue between a mentor and a student may occur in preparation for action that may be indistinguishable from reflection on action.
Watson (1998) and Heath (1998) argued for guided reflection in its application to the Benner model whereby novices require rules from supervisors, while advanced beginners require guidance in an individualized process designed to provide genuine opportunities for dialogue between the supervisor and the learner concerned. Kemmis (1985) and Knights (1985) however, stated that reflection simply does not occur unless another person is involved. They argued that reflection is primarily a social event, but did not locate this in practice.

Magnussen Ironside (1999) observed that supervisors share experiences with learners through dialogue. Situations are created for thinking that is typically ‘reflective’ and ‘reflexive’ with new possibilities opened to the learner. While the differences between reflective and reflexive are not developed, the outcomes include dealing with clinical problems that also embody understanding of ethical concerns related to patient care. Yost et al. (2000) and Hatton and Smith (1995) identified the necessity for multiple dialogues whereby reflective abilities could be enhanced, for example, by seminar instruction (group reflection), critical thinking dyads (supervisor and the learner together), peer collaboration, and structured verbal guidance.

Fitzgerald and Chapman (2000) drew attention to aspects of the Schön model that placed emphasis upon skill development in specific social contexts of practice to promote competence in order to assist the new graduate to meet standards of professional work. This application of situated reflective practice could be considered to be in opposition to a holistic reflective approach in practice. Shulman (1998) explained reflective practice as a mechanism for learning from experience and the development of new theories and critical thinking that is situated and transforming. Learners may be provided with the opportunity to discuss their thinking and establish connections between course activities and practice that could illuminate their knowledge and skill development as a cycle of learning. Benner et al. (1996) and Benner (1984) presented the argument that the practitioner who is more skilled has advanced understanding of situations within practice and is able to provide appropriate and effective nursing care. Rich and Parker (1995) argued that claiming the apparent benefits of reflection enables the learner to ‘uncover knowledge’ in specific clinical situations and assists with the delivery of care using knowledge gained from previous experiences. It could be said that knowledge is not only uncovered, but rather it is only gained from explicit and implicit workplace conversations. Professional practice is, therefore, developed through a process of situated learning; the basis for professional development of which, even the experienced practitioner, may be unaware (Benner, 1984; Benner et al., 1996). This type of reflective practice education is proclaimed to produce a ‘connoisseurship’ (authentic knowledge of a craft), which Polanyi (1958) coined as ‘ineffable’, yet for Eisner (1979) it is a paradigm of professional culture.

**METHODS TO PROMOTE REFLECTION**

Methods to promote reflection include written and dialogical activities and have been considered separately.
Written Reflection

A variety of labels have been applied to individual written reflective narratives within the educational context, for example, journals, diaries, record books, portfolios, verbatims, sociological diaries, dossiers and logs (Walker, 1985; Rich & Parker, 1995).

Story telling is a powerful technique for nurses and midwives who have a “… rich oral tradition …” (Taylor, 1998, p. 139). As Australian nurse academic, Koch (1998) puts it:

People live stories, and in their telling of them reaffirm them, modify them, and create new ones. Constructions of experience are always on the move. Stories, when well crafted, are spurs to the imagination and through our imagination participation in the created worlds, empathic forms of understanding are advanced.

Stories can make nursing practice visible. Stories can make us proud practitioners. Stories can show where we as health care professionals have gone wrong. Story telling can be therapeutic. Stories can inform social policy. Stories can facilitate change in organizations.

(Koch, 1998, p. 1183)

Koch (1998) presented a plea for the person in research in the health care system that is increasingly being dominated by the rhetoric, technology, and market forces. Walker (1985) claimed that both oral and written narratives allow individuals to express themselves in their unique manner and identify development, leading to a sense of empowerment on the basis of a growing body of self-awareness as a result of reflection. This was supported by Lumby (1998) in a statement that the “… written word can be a powerful and simultaneous act of knowing and doing, leading to a transformed and collective wisdom” (p. 94). Lukinsky (1990) also claimed that the written word assisted the individual in the identification of concerns without the responsibility for information exchanged in the course of conversations with others. However, Fitzgerald and Chapman (2000) observed that rhetoric or written reflection has the potential to produce, “… obstruction to radical learning and [be] out of tune with emancipatory pedagogy” (p. 12).

Writing about experiences is generally considered, in both midwifery and nursing education, as a mechanism to promote learning by a process of critical analysis and evaluation (Paterson, 1995). The word ‘experiences’ is applied to incorporate other terminology such as ‘clinical incidents’ or ‘clinical events’. Regardless of the nomenclature applied to writing in portfolios, journals, dossiers or clinical logs, the fundamental key to writing is the process of problem-solving that links to self-awareness related to the individual’s professional practice (Walker, 1985). A clinical incident could be a situation in which a student felt concern about components of care or issues that emerged following the delivery of care. It may be about the student’s own perception of care and their participation in it or the participation of other health care providers. It was believed that writing a short description of an incident would assist students in the critical analysis process and would impact upon practice development (Brown & Sorrell, 1993).
In an article about reflective writing, Bolton (1999) described the power of journal writing for medical practitioners in the following quotation, which could also be applied to the midwifery practitioner.

Writing is different from talking or thinking: It can have a far deeper reflective and educative function. Writing enables the writer to express and clarify experiences, thoughts, and ideas that are problematic, troublesome, hard to grasp, or hard to share with another. Writing also enables writers to discover and explore issues, memories, feelings, thoughts they hadn’t acknowledged.

Why does writing have this power? Writing stays on the page unchanged, so it can be worked on the next day or year, and then extended. Unlike thinking and talking, written thoughts and ideas can be organized and clarified at this later stage.

(Bolton, 1999, p. 243)

Reflective journals may assist in the clarification and extension of individual thoughts, thereby providing the teacher/supervisor with insight into the learner’s professional development (Collier, 1999) and in particular decision-making processes (Bolton, 1999). In this sense, it is to be a professional journal rather than a personal diary. Koch (1998) argued that the aim of the journal writing should be to keep an account of daily activities that may help practitioners address some disturbing or troublesome practice-based issues, developed upon analytical skills rather than just description of events. Lumby (1998) and Hatton and Smith (1995) acknowledged that writing in ‘professional journals’ developed upon descriptive accounts rarely moves learners to critical reflection. Yost et al. (2000) suggested strategies that could reduce the application of a lower form of reflection to include encouragement to utilize questions such as: (a) what do I mean? (describing); (b) what does it mean? (informing); (c) how did I come to this? (confronting); and (d) how might I do things differently? (reconstructing). Other specific instructions could be presented to the learner as guidelines, to promote critical reflection, such as the time, place, actions and feelings involved. Brookfield (1990), Smith (1998), and Taylor (1998, 2000) suggested different strategies such as dialogical practices to promote critical reflection. Phillips and Morrow (2008) promote the application of reflective practice in midwifery education using online modalities, rather than hand written journals. This is designed to encourage students to use their ‘private space’ as an ongoing journal and available to lecturers on a continued basis rather than at the completion of the semester. This access by lecturers is advantageous for students in that there is early identification of potential issues, rather than later.

**Dialogical Reflection**

Dialogical reflection, often conducted with for example midwives in their function as a ‘preceptor’ (to guide and influence students during their placements in maternity practice settings) and described by Lumby (1998, p. 101), “… offers a stepping back from the actions or events …” and is often conducted within a social context with mentors or preceptors. Taylor (1998) stated that “coaching in reflective processes also encourages co-operative communication between the instructor and participants” (p. 139). Reflection of this type is assumed to be a form of dialogue with one’s self as well as others, with examination of
possible reasons that cause concern in practice (Hatton & Smith, 1995). The aim of dialogue is to allow learners to ‘externalize’ thinking skills and develop a clearly thought out point of view (Yost et al., 2000). Within this context, support from for example, a preceptor can play a key role in the process of guided reflection for nursing education and practice. Johns and McCormack (1998) found that “reflection-on-experience provides the supervisor with a rich feedback of practitioner performance and effectiveness, although this information depends on the extent of the practitioner’s disclosure” (p. 64).

Although it is not theorized in this literature review, participation in conversations related to institutional practice is held to be a potent mechanism amongst peers and colleagues. Lumby (1998) acknowledged that the benefits are conditional because the participating individual should know “… how to make sense of the stories without destroying their meaning …” (p. 100). Lumby suggested that the individual should be encouraged in discussion in educational programs to reflect upon the narrative, and to question the key aspects within the narrative. The stated assumption is that it will promote meaningful learning outcomes, specific to the individual concerned.

Hatton and Smith (1995) found that either written or dialogical reflections are sometimes rejected by some students and supervisors simply as an academic pursuit that can be perceived to be a diversion from the development of technical skills. In addition, Hatton and Smith observed in practice that the lack of time, opportunity, and adverse reactions of peers often severely hindered or inhibited effective personal dialogical reflection. They noted ‘critical friends’ often responded adversely to expressive feelings and issues related to best practice, which may also inhibit discussion and damage self-engagement. The place of reflective practice in education programs and research often appears to lack integrity, cohesion and human authority. A research framework, with attention to the person and the context without at any time losing focus on each entity is required. Benner’s iconic development of the phenomenological stages for reflective practice in nursing education provides an excellent foundation, (Benner, 1984; Benner et al., 1996) but even this requires elaboration of a discursive model of transformational action.

**Benner’s Stages of Reflective Practice for Professional Competence**

Benner’s (1984) model is based upon the narratives of nurses and refers to the actual on-the-job behaviours of experienced nurses who were considered to be experts by their peers and supervisors. Developed on the basis of narrative descriptions from newly qualified and expert nurses to capture both clinical and ethical judgments, Benner (1984) developed five stages of practice according to the Dreyfus model of skill acquisition (Benner et al., 1996; Dreyfus & Dreyfus with Athanasiou, 1986). The five stages of practice served as a guide for nurse administrators in the allocation of workloads for nurses and for nurse educators to support situational learning rather than “task analysis, competency lists and applications of abstract scientific concepts thought to be related to nursing” (Benner, 1984, p. vi). Benner’s groundbreaking phenomenological research on nurses, their experiences, and their comprehensions, provoked many questions pertaining to the complexities of practical knowledge and professionalism.
Merleau-Ponty observed that all knowledge occurs through perception of the world in which the person “… is not a pure thinker but a body-subject, and that any act of reflection is based on that pre-personal, anonymous consciousness which is incarnate subjectivity” (Langer, 1989, p. xv). Skills, therefore, are acquired by dealing with situations and they in turn determine individual responses in dealing with situations. The model of skill acquisition developed by Hubert and Stuart Dreyfus, placed the phenomenology of skill acquisition in relation to how the world is transformed as skills are acquired is grounded in Merleau-Ponty’s existential phenomenology (Dreyfus & Dreyfus in association with Athanasiou, 1986). Figure 2 provides a summary of the characteristics for each of the five stages of the Dreyfus model of skill acquisition.

This model of skill acquisition later, adapted by Benner (1984) for professional nursing practice, is also grounded in Merleau-Ponty’s existential phenomenology (Benner, 1984; Benner et al., 1996).

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<tr>
<th>Stages</th>
<th>Summary of each stage</th>
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<td>Novice</td>
<td>“The novice learns to recognize various objective facts and features relevant to the skill and acquires rules for determining actions based upon those facts and features” (p. 21). It is further stated that elements of a situation can be treated as relevant and objectively since these elements are “context free” and where rules can be applied regardless of what else is happening. The beginner is like a computer in following a program.</td>
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<td>Advanced beginner</td>
<td>With the advanced beginner, “performance improves to a marginally acceptable level only after the novice has considerable experience in coping with real situations” (p. 21). As a consequence of prior experiences the advanced beginner learns to recognize new elements “situational” to distinguish them from context free elements.</td>
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<td>Competence</td>
<td>As a result of more experiences “… a competent performer with a goal in mind sees a situation as a set of facts. The importance of the facts may depend on the presence of other facts” (p. 24). This means that the competent at this stage no longer follows rules and seeks new rules and reasoning procedures to decide upon a plan or perspective. These rules do not come as easily as the rules given to beginners in texts and lectures. Competent performers must decide for themselves in each situation what they plan to choose without being sure that it will be appropriate action for a particular situation.</td>
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<td>Proficiency</td>
<td>The proficient performer becomes deeply involved in tasks while intuitively organizing and understanding tasks. The performer’s theory of the skill, as represented by rules and principles, will gradually be replaced by situational discriminations accompanied by associated responses. The proficient performer, after seeing the goal and the important features of a situation, must still decide what to do.</td>
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<td>Expertise</td>
<td>The expert usually knows what to do due to a repertoire of situational discriminations to achieve goals. The expert is distinguished from the proficient performer through their ability to make more subtle and refined discriminations in the world of skillful activity, where the expert has learned to identify those situations that require action from those demanding another. The expert reduces situations into subclasses, each of which shares the same action. This allows the immediate intuitive situational response that is characteristic of expertise.</td>
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Further research was conducted by Benner over a period of six years and involved 130 hospital nurses to address questions that emerged from the initial research. This subsequent research was an interpretive study of nursing practice in critical care units conducted between 1988 and 1994. Benner et al. (1996) claimed the findings enhanced awareness of “…distinctions between engagement with a problem or situation and the requisite nursing skills of involvement, knowing how close or distant to be with patients and families in critical times of threat and recovery …” (p. xiii). According to Benner et al. these can be learned over time and experientially. Benner et al. argued that clinical judgment is a technical-rational process of professional practice that incorporates the identification by the nurse of what is good and right (requiring moral judgment), and is reliant upon extensive practical knowledge (intuition and tacit judgment), and is referenced to the nurse’s emotional responses related to the practice issues. The five stages of professional development that Benner (1984) described include novice, advanced beginner, competence, proficient and expert. The stages are briefly characterized in figure 3.

<table>
<thead>
<tr>
<th>Stages</th>
<th>Summary of each stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Novice</td>
<td>The rule-governed behaviour typical of the novice is extremely limited and inflexible since they do not have any experiences of a situation and refer to rules to guide them in practice. “Beginners have had no experience of the situations in which they are expected to perform” (Benner, 1984, p. 21).</td>
</tr>
<tr>
<td>Advanced beginner</td>
<td>This level is typical of newly graduated nurses who manage to cope with common situations, to note the recurring meaningful situational components that are referred to as “aspects of the situation” (Benner, 1984, p. 22) in the Dreyfus model. In an explanation of the term ‘aspects’, Benner (1984) stated Aspects, in contrast to the measurable, context-free attributes or the procedural lists of things to do that are learned and used by the beginner; require prior experience in actual situations for recognition. Aspects include overall, global characteristics that can be identified only through prior experience. For example, assessing the patient’s readiness to learn depends on experience with previous patients with similar teaching-learning needs. (p. 22)</td>
</tr>
<tr>
<td>Competent</td>
<td>The competent level is typified by the practitioner who has been in practice in the same setting for a period of time, for example, as stated by Benner for two to three years and “when the nurse begins to see his or her actions in terms of long-range goals or plans of which he or she is consciously aware” (Benner, 1984, p. 25-26).</td>
</tr>
<tr>
<td>Proficient</td>
<td>The proficient practitioner “…perceives situations as a whole rather than in terms of aspects and performance is guided by maxims [long term goals]. Perception is a key word here” (Benner, 1984, p. 27).</td>
</tr>
<tr>
<td>Expert</td>
<td>An expert practitioner, “… no longer relies on an analytic principle (rule, guideline, maxim) to connect her or his understanding of the situation to an appropriate action” (Benner, 1984, p. 31). Expert nurses possess an enormous background of experience, as well as an intuitive grasp of each situation and the ability to focus on the accurate region of the problem (Benner, 1984, p. 38).</td>
</tr>
</tbody>
</table>
However, there has been no elaboration by Benner (1984) or by Benner et al. (1996) of the psychosocial ontology relating to personal ‘meaning making’ that professionals engage in for their learning and the translation of experiences into transformational action. Benner’s model does not help to understand or research the dynamic interface between personal intention and social reality. For instance, where some practitioners have had many years experience but are not considered by their peers as experts, while others who have only a few years experience may be considered to be experts. In this respect, Benner’s model is a static model rather than dynamic.

Figure 4 provides a schematic cycle of the personal and professional identity formation individuals engage in, beginning in the public realm and proceeding through the interactions represented between the ‘public’ and ‘private’ domains for reflective practice (van Langenhove & Harré, 1994). Principal elements within such interactions include, for example, private or personal reflection occurring within the individual, such as private thoughts. Public reflection is embedded within professional conversations with peers (singly or within a group), midwives or the midwife/preceptor, and occurs within the ‘collective’. These underpinning principles have drawn upon Vygotskian theories (Hanfmann & Vakar, 1962) where public (external) and private (internal) language may impact upon actions that individuals may take following discussion with others (public) or thinking (private) through a problem. Harré (1983) observed that “in the private-public dimension: language is understood as a common instrument of representation” (p. 45). Individuals as agents interpret and respond to the world in a subjective and social manner that is appropriate for them. Harré (1983) also argued that “… an individual’s linguistic capacities and knowledge of conventions ensures the presence of the many through the persistence of collective conventions and interpretations of what can be thought and planned” (p. 42).
In recent years, attempts have been made to articulate the agency of the learner within the culture of professional education. More precisely, professional agency is the intentional causal intervention in the practice world where reflexive monitoring of such interventions is undertaken by both learners (students) and their supervisors (midwives/preceptors). Students should be viewed as active agents in their learning culture in assuming responsibility for their psychosocial determinations within the cultural world of professional practice.

A purpose of Phillips’s doctoral research was to explore the theoretical platform for clinical and research in midwifery education to facilitate understanding of transformational behaviours. Social theorists of critical realist schools, such as the transformative model of social action, have sought to explicate the relationships between structures of agency in developing a transformational model of social action (Bhaskar, 1978; Giddens, 1979; Archer, 1988). They argued that the social structures function of our everyday actions results in the unconscious reproduction of culture.

Social and cultural organizations are, according to Archer (1995), analytically separate and once this is done “… it becomes possible to assert that discursive struggles are socially organized and that social struggles are culturally conditioned” (p. 324). An agent is an individual who possesses properties as agents to facilitate social identity.

In reference to agency, Bhaskar (1978) observed “… we are aware of ourselves as causal agents in a world of causal agents; and that unless we were so aware we could not act intentionally, or come to know ourselves as causal agents at all” (p. 215). This is understood to mean that agents coexist through awareness of each other’s intended actions. Archer (1995) pointed out that each individual is an ‘agent’ prior to becoming an ‘actor’ because the properties of an agent are acquired through collective memberships such as gender groups, indigenous, middle or working class groups, which are a system of social stratification. This entity, as described by Archer (1995) as agency, is an efficient mediating mechanism of elaboration of self-identity. Harré and van Langenhove (1999a) observed

There are kinds of identity which we attribute to people, and that we refer to by the use of the word ‘self’. There is the self of personal identity, which is experienced as the continuity of one’s point of view in the world of objects in space and time. This is usually coupled with one’s sense of personal agency, in that one takes oneself as acting from that very same point.

(Harré and van Langenhove, 1999a, p. 7)

Archer (1995) said structures referred to relational properties that include friendships and commitment, as well as the laws of society and forms of censorship, whereas Bhaskar (1978) stated that structures in a metaphorical sense “… place conditions on the inner workings of the world” (p. 110). Archer referred to structure and agency as being located in social theory,
while traditional theorists, such as Bhaskar, considered these entities to be quite distinct and irreducible to individuals and their interactions. This has been taken from an assumption of stratified ontology. Harré (1976) stated that social structures are immanent in conversations, while Archer (1995) advocated the interrelationship of cultural layers in stratified ontology.

**Morphogenesis and Transformation Theories**

As a process, morphogenesis refers to a complex interaction that results in change in a social system, structure or state, with the end product termed elaboration (any form of elaboration is concerned with culture, agency and structure) (Archer, 1988). Such actions are ceaseless and imperative to a stable continuation or further elaboration. When morphogenesis occurs, the subsequent interaction will be different to the earlier action because it has been conditioned by the elaborated consequences of that prior action. The morphogenetic perspective is concerned with structure and agency. It is not only dualistic but sequential as well because it encompasses three-part cycles that include structural conditioning, social interaction, and structural elaboration. Time is incorporated as a theoretical variable rather than as a medium in which events take place. The critical factor that makes the morphogenetic perspective unique is the notion that culture and agency operate over different time periods (Archer, 1988).

Figure 5 provides a summary of Archer’s morphogenesis of ontological strata from which new structural configurations emerge, as depicted in (a), and new cultural configurations in (b). Ontologically, this process is time dependent for the uniqueness of both structural and cultural transformations that each agent must pass through. The morphogenesis of agency in midwifery education requires a different ontological movement, as shown in (c), because agents act on the basis of their structural and cultural conditions and resources, as well as changes that may occur within group configurations. Such changes can lead to discursive or structural ramifications.

In this background to social theory, three intrinsic characteristics exist. Firstly, social sciences are inseparable from human components because of human activities; secondly, society is transformable in that there is no preferred state; and finally, individuals are not immutable as social agents as they are transformed by their social actions (Archer, 1995). It is from this backdrop that a ‘Transformational Model of Social Action’ (TMSA) is applied in this research. The individual narratives of the student participants in this research present in their dialogical accounts the transformation of their personal professional identity.

Each individual brings into situated learning his/her interpretations, new meanings of the social world in which he/she has entered, developed on the basis of social interaction. Each individual arrives at conclusions about his/her and ‘other’ moral agency or purposes within everyday conversations in, for example, areas of midwifery practice such as birthing rooms, in education. The compelling relationship of reflection within the realms of a social ontology is introduced as positioning theory, a tool for exploring reflective and social constructions in discursive practices.
**POSITIONING AND SOCIAL EPISODES**

Positioning theory is a recent development that initially emerged from the work of Hollway (van Langenhove & Harré, 1999a), who examined positions and gender differentiation, with underpinning theories from social constructionist psychology including Wittgenstein and Vygotsky, (Howie & Peters, 1996; Gillett & Harré, 1994; Davies & Harré, 1990). The relationship of positioning theory to midwifery education and practice is presented in consideration to the possible range of human behaviours within personal, societal and institutional contexts. van Langenhove and Harré (1999a) described positioning theory as a tool applied to the analysis of everyday conversations conducted in clinical settings in which
student midwives are engaged, whereby identities (individual and social), societal issues, and culture may be determined.

**POSITIONING THEORY DEFINED**

A ‘position’ is a metaphorical concept in which an individual ‘positions’ himself/herself within three social entities encompassing people, institutions, and societies, where discursive practices are conducted either privately or publicly. Moghaddam (1999) explained that the application of the word ‘position’ rather than ‘role’ is to bring to attention the “dynamic and negotiable aspects of interpersonal encounters” (p. 74). Harré and van Langenhove (1999c) support this claim stating that “adopting or being assigned a role fixes only a range of positions, positions compatible with that role” (p. 196). It is apparent that the notion of ‘position’ in an institution or society has a more fluid connotation in regard to participation in conversations (van Langenhove & Harré, 1999a; Tan & Moghaddam, 1995; Gillett & Harré, 1994; Davies & Harré, 1990). The word ‘position’, therefore, takes on a specific meaning in regard to standpoints, either on a personal level or as a group representative.

Davies and Harré (1999) explained that positioning “… is the discursive process whereby people are located in conversations as observably and subjectively coherent participants in jointly produced storylines. There can be interactive positioning in which what one person says positions another” (p. 37). The concept of position is manifested by a certain set of rights, duties and obligations as a speaker whereby each episode of everyday life can be seen as the development of a storyline (Gillett & Harré, 1994; van Langenhove & Harré, 1994). The literature more recently emphasized the importance of local moral orders or obligations that are implicit within social structures and interactions through conversations (Harré & van Langenhove, 1999a; van Langenhove & Harré, 1999b; Davies & Harré, 1999; Moghaddam, 1999; Gillett & Harré, 1994).

Moral orders are upheld within linguistic practices performed either privately or publicly (Tan & Moghaddam, 1995), frequently supported by the application of metaphors and images (Howie & Peters, 1996) to facilitate positioning within conversations. These inherent features exemplify the ontological model for positioning theory that comprises people, speech acts, rules, and storylines. Rules within this context are applied as descriptions to operationalise the range of possible responses that are unique to participating individuals within specific situations, language, and communication processes (Gillett & Harré, 1994). Howie (1999) emphasized the relationship between the moral capacity to position another individual and the skill applied to undertake this effectively with variables such as the individual concerned, situation, intended outcomes, and issues associated with power and parity, which were explained fully by Johnston and Kerper (1996).

Although it is acknowledged that interactive positioning can occur, generally positions are relational. For example, when one is positioned as powerful, others may be positioned to feel powerless. Conversely, one may feel confident simply because another individual has positioned himself/herself as confident. Davies and Harré (1999) warned that it would be a mistake to assume that positioning is intentional since “one lives one’s life in terms of the kind of person one takes oneself to be, whoever or whatever might be responsible for its
production” (p. 37). This is understood to mean that positioning theory is dynamic and dependent upon situations which individuals find themselves in and how they manage these situations. In the following, van Langenhove and Harré (1999a) explained:

Positioning is thus to be understood as a procedure of making determinate a psychological phenomenon for the purpose at hand. But positions can and do change. Fluid positionings, not fixed roles, are used by people to cope with the situation they usually find themselves in.

(van Langenhove and Harré, 1999a, p. 17)

Importantly, it is within discursive practices that the ‘social world’ is formed and, according to van Langenhove and Harré (1999a), it is “within conversations, [that] social acts and societal icons are generated and reproduced” (p. 15). This means that social actions can be recognized or ‘determined’ by others, whereas some actions may not be understood and are described within the literature as ‘indeterminate’. Obviously individuals choose whether or not they wish to respond to being positioned within institutional settings. Choices may not exist for individuals subjected to positioning by those who have, for example, a foremost function of authority within an organization. In essence, positioning theory employs the mutually determining triad of position, speech-act, and storyline (Harré & van Langenhove, 1991; van Langenhove & Harré, 1999a).

**SOCIOLGICAL, PSYCHOLOGICAL CONTEXTS AND POSITIONING**

The sociological and psychological background of the social world occurs when individuals are active in the production of social relations with events in which they are involved. The notion that the social world is a social construction was developed during the 1970s (Gillett & Harré, 1994; van Langenhove & Bertolink, 1999). Harré and van Langenhove (1999a) described how two basic principles underpin social constructionism with positioning. Firstly, what individuals do, publicly and privately, is intentional; and secondly, what individuals are to themselves and others is a result of interpersonal interactions developed over a lifetime. Davies and Harré (1999, p. 33) referred to the “immanentist stance” that makes acknowledgment of conversations conducted within social rules, whereas van Langenhove and Bertolink (1999) emphasized that individuals are responsible for the construction of their social reality.

Social constructionism, as argued by van Langenhove and Bertolink (1999), is crucial for social phenomena to be considered and generated in and through conversations and conversation-like activities. As such, discursive processes are considered to be the place where many, if not most psychosocial constructions are jointly created (Harré & van Langenhove, 1999a). Positioning theory focuses on understanding how psychological phenomena are produced in discourse. The constant flow of everyday life in which we all take part is fragmented through discourse into distinct episodes that constitute the basic elements of our biographies of the social world.

Harré and van Langenhove (1999a) viewed the social world comprising one basic realm: conversations and analogous patterns of interaction in which psychological and sociological
phenomena are generated within complex interpersonal relations and belief systems such as social class. A ‘social world’ is also understood to consist of a network of interactions framed within some relatively stable repertoire of rules and meanings. Within this context, Harré and van Langenhove (1999a) promoted positioning theory as a most valid analytical tool to facilitate understanding within many and varied institutional discursive processes. This can also be applied to the societal and cultural influences within midwifery education and practice.

**PERSONAL IDENTITY IN SOCIAL EPISODES**

According to Gillett and Harré (1994), Harré and van Langenhove (1999a), and Sabat and Harré (1999), personal identity is one’s sense of being located in a position and moral order and may be recognized in autobiographical stories. For example, when an individual assumes accountability for actions and this is evident in application of the first person indexicals such as ‘I’, ‘me’, ‘myself’, ‘my’ or ‘mine’. Personal identity, as explained by Harré and van Langenhove (1999b), is connected with personal agency and is related to the assumed responsibility for actions taken. The literature also refers to ‘selfhood’, ‘personhood’ and ‘self’ in which Gillett and Harré (1994) proposed that shared meanings and relationships are connected with personal identity, agency and autobiography. For most individuals, personal identity is related to many multifaceted factors such as culture and time, which are subjected to change, within the parameters of personal and social attributes of discourse in which there are many contradictions and paradoxes. Individuals position themselves by means of either oral discourse or written discourse. Personal identity can be expressed by representation of a biography to indicate the individual’s position at that particular moment in time (Harré & van Langenhove, 1999a; Harré & van Langenhove, 1999b). The necessity for individuals to have both a personal identity and social identity in order to be perceived as complete is emphasized by van Langenhove and Harré (1999a). Sabat and Harré (1999) clarified that social identity means the notion of ‘selves’ that are presented socially and publicly, but yet within this context, ‘self’ presents as a contradiction to collectivism practiced by non-western societies (Berman, 1999).

Autobiographical accounts produced in either public (speech-acts) or private (thoughts), enhances persona development upon which the cooperation of others in discursive practices is critical with many possible outcomes, either positive or negative (Gillett & Harré, 1994). Sabat and Harré (1999) explain that personas “... serve to create the public impression of a type, a persona or character, from a local repertoire” (p. 93), clearly demonstrating that personas are typically joint productions. Recognition of a persona may impose profound effects on society or individuals, whereby the persona and related behaviour is open to scrutiny and has the potential to attract appropriate or inappropriate responses or actions by participants. Harré and van Langenhove (1999a) emphasized that positioning theory is reliant upon the moral and personal attributes of participants to provide guidelines or rules for discursive practices.
LANGUAGE AND DISCURSIVE PRACTICES

Language, according to Davies and Harré (1990), is a public institution and, as a consequence, is the foundation upon which social structures and interactions are developed and generally referred to as either the social force, or illocutionary force. Gillett and Harré (1994) explained that discourses are constructed jointly by individuals within socio-cultural groups as important components of the framework for interpretation, whereby symbols, interactions, relationships, and rules are applied. The discursive act of positioning involves a reconstruction of the biographies related to the individual being positioned and the positions that may be subject to rhetorical re-descriptions. Individuals, therefore, construct stories about institutions or events that are intelligible and become, as pointed out by Harré and van Langenhove (1991), ‘societal icons’. Three methods assist in the expression of personal identity within discursive practice: (a) agency (assuming responsibility); (b) statement on the point of view; and (c) evaluation of a past event as a contribution to one’s biography (Harré & van Langenhove, 1999a; Howie & Peters, 1996).

Oral presentations may also be referred to as stories or autobiographies. Harré and van Langenhove (1999b) and Davies and Harré (1999) referred to stories as the result of interactions between the audience and the narrator who is compelled to speak in accordance with the demands of his/her audience. For this demand to be met adequately, the narrator requires an effective memory. When a story is written the reader can only grasp the meaning of the text whereas, in oral presentation, can “… intervene to change the text” (Harré & van Langenhove, 1999b, p. 67). Stories serve as a critical means by which individuals make themselves intelligible within a social world. Harré and van Langenhove (1999b) referred to the ‘discursive triad’ that incorporates storylines, the positioned speaker, and the social force of narration, as contributing to the construction of storylines. Clearly, written stories generate a great deal of information about the author concerned and, according to Moghaddam (1999), also reveal the speaker’s favoured forms of autobiographical presentation. Activities such as letters, memos, or research proposals can also be regarded as conversations because invariably decision-making processes occur in this way (van Langenhove & Bertolink, 1999).

Position, storylines, and relatively determinate speech acts are three key factors inherent within discursive practices or conversations, and play an influential part in human behaviour (Harré & van Langenhove, 1999a; van Langenhove & Harré 1999a). Discourse is considered as a central concept in the theoretical development for social constructions and, in particular, the relationship of discourse with powerful influences such as psychic and social phenomena. Harré and van Langenhove (1999a) explained that “… some basic issues from social constructionism and discourse analysis in order to frame positioning theory as one possible conceptual apparatus that allows for social constructionist theorizing based on a dynamic analysis of conversations and discourses” (p. 2). Other factors that should be considered when engaging in discursive constructions include history, culture, and social differences that are individually unique and require thoughtful, sensitive negotiation (Carbaugh, 1999; Berman, 1999; Moghaddam, 1999; Sabat & Harré, 1999; Tan & Moghaddam, 1999).

CULTURAL DIFFERENCES
Harré and van Langenhove (1999a) also promoted positioning theory as an analytical tool for societal issues on a cultural level. Moghaddam (1999) explained reflexive positioning applied to moral and personal attributes of the self to encompass culture, cultural ideals, and symbolic meanings. Culture, in this context is applied to environmental, social, political, and spiritual forces that act as direct influences within an individual’s culturally embedded narratives. Carbaugh (1999, p. 160) stated that every social interaction “invokes culture, intelligible forms of action and identity” and cautioned that conflicts and confusion may occur as a result of variation within cultural meaning systems specific for each cultural group. Although culture is intrinsic within all individuals, the positioning framework presents as an active and dynamic view of the self “… while being mindful that fundamental aspects of intrapersonal positioning practices may vary widely with culture” (Moghaddam, 1999, p. 75).

In the application of the term ‘intrapersonal positioning’, Moghaddam (1999) described this as an extension of positioning from ‘self’, (typical of western society), to encompass the ‘collective’, (typical of non-western society). This allows cultural differences to be accommodated and allow individuals to utilize, for example, moral orders, metaphors, and storylines within their narratives specific for them and their lived experiences. In reference to positioning in ‘intergroup relations’, Tan and Moghaddam (1999), explained that positioning is not exclusively for individuals and may be applied to members, representatives, and mediators of groups. In support for the acknowledgement of cultural differences and positioning, three examples developed by Moghaddam (1999), and presented in the following, provide explanation of how they can vary with:

1. Cultural ideals and the desire by a particular group of people to move toward through positioning;
2. Particular dimensions in which a group of people find relevant (sic) in positioning themselves and others in discourse;
3. Preferred forms of autobiographic telling, which may influence the types of stories people tell themselves about themselves in the process of positioning.

(Tan and Moghaddam, 1999, p. 80).

With the acknowledgement of cultural differences and the potential impact upon discourse and social interactions, the types of positioning presents as a critical component of this literature review.

**TYPES OF POSITIONING**

Several types of positioning have been identified by van Langenhove and Harré (1999a, pp. 20-23) who explained ‘modes of positioning theory’, which are summarized in the following:

1. First order positioning (refers to the way an individual locates herself or himself and others).
2. Second order positioning (occurs when the first order positioning is questioned and has to be negotiated) must be intentional.
3. Third order positioning (occurs when accountive positioning occurs outside the initial discussion) must be intentional.
4. Performative and accountive positioning (refers to one’s own or others conflation).
5. Moral and personal position (positioning with regard to the moral orders in which they perform social actions).
6. Self and other positioning (positioning constitutes the initiator and others in certain ways, and is also a resource through which all persons involved can negotiate new positions).
7. Tacit and intentional positioning (includes three typical kinds of positioning talk: (a) the first kind refers to the positioning assumed by individuals, how they position others and are positioned by others; (b) the second kind includes discursive practices in which acts of positioning where the first kind becomes a topic or target; and (c) the third kind refers to discursive practices in which the positioning-talk has as a topic first or second order positioning.

The modes of positioning theory are offered as discrete categories and concede certain flexibility. The categories raise questions in regard to possible constraints on spontaneous social acts that occur within conversations, devoid of motive or intention.

The application of intentions within positioning theory is subject to further examination when an individual decides to express personal identity, in a number of ways. For example, the individual may choose to apply any one of the four categories of positioning as outlined by van Langenhove and Harré (1999a), supported by elaborations to exemplify positioning within midwifery education and practice. Figure 6 provides a diagrammatical representation of the types of intentional positioning.

<table>
<thead>
<tr>
<th>Self-positioning</th>
<th>Deliberative positioning</th>
<th>Accountive positioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other-positioning</td>
<td>Performative self-positioning</td>
<td>Forced other positioning</td>
</tr>
<tr>
<td></td>
<td>Performative positioning of others</td>
<td>Forced positioning of others</td>
</tr>
</tbody>
</table>


Figure 6. Types of intentional positioning in midwifery practice.

Intentional positionings (van Langenhove & Harré, 1999a, pp 24-28) that can be assumed in midwifery practice have been summarized below:

1. **Situations of deliberative self-positioning**: Occurs when an individual wishes to express his/her personal identity and present a course of action. A student, for example, discusses with her preceptor/midwife, the care of a childbearing woman based on needs that have been identified by the student. The student recognizes her limitations within midwifery practice.
2. **Situations for forced self-positioning**: This is applied when the initiative lies with somebody else rather than the individual involved. For example, a student reporting all aspects of care to the preceptor/midwife, who is responsible for the delivery of safe midwifery practice.
3. **Situations of deliberative positioning of others**: Frequently this type of positioning occurs when a student positions a midwife who she/he holds in high esteem and tends to actively engage the attention of the midwife as often as possible and whenever possible, in order to learn about professional development.

4. **Situations of forced positioning of others**: This may be demonstrated within student groups when one group member is identified by his/her peers as the person who needs, for example, additional support and care. In regard to this final point, the social force of the speech-acts depends to some extent on the positions an individual being positioned decides to take, whereby the individual may reject all offers of assistance from peers.

**REFLEXIVE POSITIONING**

Davies and Harré (1999) referred to reflexive positioning as the process by which individuals choose to position themselves privately (thoughts) or through internal discourse that promotes both intentional and unintentional positioning with the production of storylines. It also influences an individual’s local moral capacity and personal attributes to influence speech acts (Harré & van Langenhove, 1999b; Tan & Moghaddam, 1995). According to Moghaddam (1999), reflexive positioning is a pragmatic practice because there are various mechanisms to produce one’s autobiography.

Moghaddam (1999) explained that an individual’s story might be retold as a new experience, thereby suggesting that autobiographies following a process of reflexive positioning may be altered to produce mutual storylines and meanings for particular occasions and participants. Harré and van Langenhove (1999b) supported this viewpoint when they observed that positioning theory embodies “… a reconstructive element: the biographies of the one being positioned and the positions may be subject to rhetorical redescriptions” (p. 62). This sets the scene, as Howie and Peters (1996) noted, for both positioning theory and reflection in which creative, dynamic, collaborative storylines, and meanings are developed. Within this, opportunities exist for the individual to reflect, position him or herself or others, to apply appropriate images, metaphors, and storylines for that particular social episode.

Positioning therefore, enables a study of relationships between participants as well as the rich detail that occur even with the most fleeting moment of interactions between individuals. Even in these brief episodes of interaction can provide invaluable opportunities for positioning (Winslade, 2005). This is the case of midwifery education where professional conversations are encouraged (Phillips & Hayes, 2006). Positioning is therefore an effective tool for analyzing the dynamics of conversations through the emerging patterns of speech acts and storylines (Harré, 2005).

**POSITIONING THEORY AND MIDWIFERY EDUCATION**

In positioning theory, speech patterns in everyday conversations in institutions indicate the local moral order, the local system of rights, and duties and obligations within which both public and private intentional acts are performed. While the meanings are clear to individuals
involved in conversation, the location of the individuals, using the variety of discursive positions available to them, may also be easily recognized within the social context. A typical example is when a new student positions herself (self-positioning) as a neophyte in midwifery practice. This neophyte status is easily identified by the midwife in conversation, even if the student was previously unknown to her. The student may be ‘positioned’ and identified in discursive practice (accountive positioning) as one who requires supervision and support in practice.

*Types of positioning:* One distinction in positioning refers to first and second order positioning applied to the discursive practices conducted between students and their preceptors in this study. The distinction refers to the manner in which individuals locate themselves and others. A characteristic example of first order positioning normally occurs when a preceptor, who has the moral capacity to position the student, requests in conversation that the student provide a component of midwifery care. The student accepts this, either consciously or unconsciously, by locating the preceptor/midwife as a trusted partner of care. Second order positioning occurs when the first order positioning is challenged and requires further negotiation. Third order positioning occurs when for example, “accountive positioning” (van Langenhove & Harré, 1999a, p. 21) takes place outside of the initial discussion.

**Indexical Use to Demonstrate Storylines in Positioning**

The concepts of ‘position’ and ‘positioning’ within conversations make “… a person’s actions intelligible and relatively determinate as social acts and within which the members of the conversation have specific locations” (van Langenhove & Harré, 1999a, p. 16). The application of ‘indexicals’ bring attention to the storyline and facilitate analysis of reflection and positioning theory within the psycho-sociological interactions that are typical of everyday professional conversations conducted in institutional settings.

Through the application of personal pronouns such as ‘I’, ‘we’, ‘me’, ‘my’ and ‘you’, speakers can demonstrate responsibility for their own actions (agency), a sense of personal identity, and commitment. In conversations when the first person is employed, the meaning applied is simply to claim a personal action or responsibility. Harré and van Langenhove (1999a) referred to these applications of ‘indexicals’ as ‘personas’, which all individuals at some point might choose to employ in the course of a conversation.

‘I’ is applied to express ‘personal identity’, while ‘we’ is expressed to create “… a double singularity of public personhood” (Harré, 2002; Harré & van Langenhove, 1999a, p. 7). Personhood or personal identity is demonstrated when an individual takes responsibility for an action (agency). The application of, ‘me’ and ‘my’ constantly draws attention to the constructionist accounts that may be used to disclose personal identity (Harré & van Langenhove, 1999a). The use of the pronoun ‘you’ is another frequently used expression that may be applied when an individual applies another persona within a particular context, for reasons that are known only to themselves (Harré & van Langenhove, 1999a). Within a culture of ‘caring’ in midwifery practice, ‘I’, ‘we’, and ‘you’ demonstrate attitudes and relationships that existed between students, midwives, childbearing women and their families. In regard to such relationships, the expression ‘you know’ was typically employed with the interviewer, thereby bringing the interviewer into the storyline. The pronoun ‘they’ can be
used in the context of “intergroup positioning” (Tan & Moghaddam, 1999, p. 183) and where responsibilities are shared.

**EVERYDAY MIDWIFERY CONVERSATIONS**

Everyday midwifery conversations presented as autobiographical dialogues are considered to represent personal experiences and meanings constructed by students and their respective preceptor/midwives using a case study approach. The overarching goal was to “…catch the complexity of a single case” (Stake, 1995, p. xi), where the ontological and phenomenological significance for the person presented in various social episodes and where each participant’s descriptions and interpretations of their accounts in conversations could be carefully studied. The presentation of specific storylines within everyday midwifery conversations is to depict the subjective meanings of experiences and their intentionality (Eberhart & Pieper, 1994), as well as transformational learning for the participants of conversations.

Within the culture of midwifery education and practice, use of indexicals such as ‘I’, ‘we’, ‘my’, ‘you’ and ‘they’, pertain to the relationships between midwives, students and their preceptor midwives, educators and consumers of care, women and their families. The conversations of students and their conversations partners were all women and this is acknowledged as not being unusual in midwifery education as it has been found that the number of men enrolling midwifery education tends to be exceptionally low. Examples of excerpts of professional conversations of three students from a cohort of ten were selected as they presented diverse professional and learning experiences and where understanding, according to Stake, (1995) is a critical component of case study design. The respective storylines of three students are presented in the following along with those of their preceptor/midwives, including a storyline analysis (Phillips, 2002). The indexicals of ‘I’, ‘we’, ‘my’, ‘you’ and ‘they’ have been underlined to highlight their application in storylines.

**Student One**

They let you do more things. For example, when I was on night duty a new lady came in [admitted], they’d say go and do baseline things [perform a maternal and fetal health assessment] and come back and tell me what you think. And so that’s what I did. [**Forced positioning by others**].

And yes, it was really good. They would only assess the woman when the doctor went in there to see her [woman] and they’d acknowledge what you know, what you thought. [**Self and other positioning**].

In that regard there are still other things. Like midwives showing you one delivery [assisting with birth]. Things like that and with my last delivery, “Oh you don’t do it like that!” Yes, I just think, “Oh my goodness!” [**Forced positioning by others**].
**Storyline Analysis – Student One**

The use of the third person ‘you’ indicates the student’s perception of herself as a subordinate member and the struggle for limited autonomy within the local moral order. In reference to the comment by the midwife, “Oh you don’t do it like that!” (third order positioning), the student in her response used the first person of ‘I’ to indicate how she felt about this statement. This is in contrast to the preceding texts where there is reference to ‘they’ and where it is implied that the midwives are responsible and accountable for care.

**Midwife One: (Preceptor/Midwife for Student One)**

_I_ guess in the last couple of weeks _we_ had talked a little bit as _we_ were on night shift. _We_ had quite a few hours to fill in. So _we_ had general discussions. _We_ had five midwives on night shift _so_ _we_ had quite a few discussions with people with different incidents that _they_ would talk about. She would listen. [**Deliberative self-positioning**].

_I_ was quite happy to let her conduct the cases [assist women during labour and birth] and _I_ was just there more as a sounding board. If she had anything that she was worried about or any concerns at all … [she could access the midwife]. But _I_ was quite happy letting her do the appropriate care and _I_ was just there to check _you_ know, nothing was going out of the ordinary, which _I_ didn’t think it would. Because as _I_ said, _I_ was quite confident she would run the case okay. [**Accountive other positioning**].

**Storyline Analysis – Midwife One**

Storylines within the selected excerpts with Midwife One placed emphasis upon the adaptation to discursive action in which social representation and institutional forces influenced professional appraisal of technical competence and decision-making related to safe practice. Use of ‘I’ and ‘we’ were used within these ‘performative’ and ‘accountive’ storylines as a consistent presentation of the student’s confident self and other positioning. Implicit in these texts was the midwife’s positioning as a competent preceptor of the student.

**Student Two**

_I’m_ still thinking about it [reflective practice] all the time, in a positive way. Not in a stressful manner. _I_ don’t feel stressed by what _you_ know. _I_ went through a period in the course where _I_ felt quite stressed by certain events that occurred. But certainly now, _I_ seem to cope, _you_ know. Sometimes it doesn’t always work out the way _you_ want it to and _I_ cope. _I_ think to myself and _I_ still think a lot and think about now, should have I done that or did I do the right thing and _you_ know, did so and do the right thing? _I_ still reflect a lot on best practice, _I_ guess. _You_ know, what is [the] best practice in certain situations. [**Deliberative self-positioning**].

**Storyline Analysis – Student Two**

The first person ‘_I_’ was predominately used by the student throughout this selected excerpt. The focus in this interview was the transformation in her reflective practice from simply ‘thinking’ to extending this process to encompass learning and developing a role as a future midwife by reference to best practice.
Student Two Continued
Yes, I think I always questioned my own ability I guess. But guess with midwifery the buck stops a lot more with the midwife. I found more in general nursing that there were times that you were following orders or you were always calling the doctor for an opinion. I was always calling the doctor for an opinion, I guess. And there was always somebody else that was checking up on you (the midwife with whom the student works with in a model of supervision). For instance, blood results. That type of thing. Whereas now, I feel I have the knowledge and the ability to take more responsibility for my own practice. I think not only as a midwife but also as a general nurse. [Deliberative forced positioning].

Storyline Analysis – Student Two
The reference point used as a measure for professional development was the comparison of her practice as a registered nurse in a rural setting and how her learning throughout the course had also strengthened her perceptions of her role as a nurse. The use of the second person ‘you’, indicates a detachment from the responsibility in the provision of care within institutional practices in which procedures and policies required a secure position in the local moral order for professional practice. Of particular note in this excerpt is the positioning assumed by the student in the dual role of both nurse and midwife.

Midwife Two
I couldn’t class her as an equal [partner of care] at this stage. Unfortunately because she doesn’t have, I suppose the clinical expertise that I need in my unit because it is so small. I need somebody perhaps who has a few years of experience behind them, to make her an equal partner [of care]. We’re talking partnership because there is only two [midwives] working in the area. However, she has such, such insight that she can manage as much and when she needs help she comes and gets it. So that she knows when is stepping over the mark at this stage. [Accountive other positioning].

Storyline Analysis – Midwife Two
In this text with Midwife Two, frequent use of the first person ‘I’ and ‘we’ demonstrated a concerned and caring practitioner but acknowledging the limitation of resources such as experienced midwives employed available at her small unit.

Student Three
I feel relieved. Like I feel a weight has been lifted off my shoulders because you know, I guess for me, academically things are finished [academic course requirements had been successfully completed at the time of this interview]. Excited. Because it is something that I wanted to pursue. I’m glad now to be moving into women’s health. You know, it would be nice to keep up my general [nursing] skills but I can really see my future, career wise, in women’s health. Each clinical day and work day, whatever, is constantly rewarding. So it is very fulfilling as well. Hard sometimes. Very emotional sometimes, but satisfying. [Deliberative positioning].
Storyline Analysis – Student Three

In this particular storyline, the student applied first order positioning, demonstrated by her use of the first person ‘I’ to express her relief that she had completed all of the academic work required for the course, the Graduate Diploma of Midwifery. The phrase ‘you know’ was applied, co-opting a casual but familiar approach to convince the interviewer in this storyline that her future is within women’s health.

Student Three Continued

A lot of my girlfriends at the moment are talking about getting pregnant and a couple of them have asked me for advice just about planning for their pregnancy and what not. And just the way that I talk to them you know, let them talk about their attitudes and it’s just like you would jump in and say blah, blah, blah. But this time I found myself sitting back and listening more to them and where they’re coming from and what is important to them and their partner and then I’ll give advice. [Deliberative self-positioning].

Storyline Analysis – Student Three

In this text there is an overt self-positioning presented as discursive acts of declarations in the storyline in which the student asserts herself as midwife in the use of ‘I’ and in giving advice to her friends.

Midwife Three

I think with a lot more experience she will be a very good midwife. Yes definitely. Especially with her fantastic communication skills! She is really good and I think that’s a lot and the key to it. I mean you hope to be able to communicate very well to be a good midwife. I mean, the clinical skills will come but she’s had limited exposure to all the clinical areas so far. [Deliberative positioning of others].

Storyline Analysis – Midwife Three

This midwife identified the student’s strengths of communication skills but at the same time made acknowledgement of the student’s limited experience in midwifery practice settings. Despite this limitation the midwife’s position was one of confidence in that the student would develop her practice as a very good midwife. In this the midwife positioned herself as a supportive and caring preceptor for the student.

These selected excerpts supported by the storyline analyses provide an example of the social episodes conducted in midwifery practice settings to influence professional identity formation and induction into professional practice.

DISCURSIVE ACCOUNTS OF EMOTIONS

A strong sense of emotion is offered in the discursive accounts of these interpersonal exchanges in which collegial relationships developed between the three student participants, their peers and midwives. Bateson (1989) stated, “We grow in dialogue, not only in the rare intensity of passionate collaboration, but through a multiplicity of forms of friendship and collegiality” (p. 94), to reflect the intensity of these relationships. This statement also draws
attention to the intimacy of conversational relations and powers revealed amongst students in
the program in which the three students were enrolled. The retrospective accounts were often
identified as ‘debriefing’ by the students and midwives, and were understood as a discussion
of social episodes in which their positioning in midwifery practice was reviewed. Typically,
debriefing was implemented to gain support in conversations from peers or other midwives,
(as well as myself as researcher/mentor), outside the initial episode for validation of their
social discursive acts or actions.

DEBRIEFING

Debriefing promoted discursive practices with others and ensured that through work
place conversations there was a mutual exchange of information, questions, and answers.
These episodes were encouraged to foster reflective practice. In a number of episodes, ‘oral’
constructions and ‘written’ reflexive practices were referred to as strategies by each of the
three students to create meanings from spontaneous or unpredicted events that developed into
challenging experiences (Yost et al., 2000). This is in opposition to problem-based learning
developed upon structured situations (Boud & Feletti, 1991; Ross, 1991) and where there is a
distance from discursive acts or activities in terms of time and space. Watson (1998) and
Heath (1998), however, argued for dialogical support.

Students claimed that dialogical support offered by preceptors/midwives was mainly
serendipitous, rather than being conscious and planned events. It seemed that personal
professional identity formation also depended upon forms of particular friendships and
collegiality, which preceptors/midwives often engaged in during frontline action or cultural
agency. In the debriefing conversations researched here, students were in the frontline action
and cultural agency. The restrictive availability of preceptors in maternity services meant that
the notion of ‘preceptorship’ tended to operate in the collective/accountive spaces rather than
individual/deliberative psychological spaces (figure 4) of students in their personal
professional identity formation. Students, therefore, occupied these psychological spaces in
debriefing conversations with significant others. Conversations are therefore imperative for
professional learning.

In reference to Gonzalez Rodriguez and Sjostrom (1998), it is argued that discursive
practices employed by the students were the types of reflective practices characteristic of
adult learners who utilized learning opportunities. This aspect of adult learning is interpreted
as a skill innate for discursive positioning in the deliberative and accountive locations of
oneself and others in conversations. Thompson and Rebeschi (1999) noted that adult learners
tend to be primarily concerned with their capacity and predisposition to apply critical analysis
and thinking in their professional practice.

Implicit in the positioning and repositioning adopted in the storylines of the three
students was their intentionality of practice development in the many spontaneous clinical
events cited by each of them. Although many examples have been presented in the narrative
chapters, perhaps the one that is most compelling is by Student One, in her account, was told
by her clinical educator to observe a birth in which intervention was required.

I was pushed into observing a birth and felt it was impersonal. [Forced self-
positioning] I felt that I was invading the woman’s privacy because she looked at
everyone present in the room. I felt unwanted in the room. She (woman) was also crying
and was very distressed by what was happening to her. There should not have been so many people and I felt powerless because I had to observe. If I had a choice, I would not have been in the room because of her (woman) distress. Urgent action was needed by the obstetrician, registrar, resident medical officer, two paediatricians, and a midwife to assist the paediatricians, the midwife to assist the lady, the doctor delivering the baby and two students. [Deliberative self-positioning]

This was a most disturbing incident for Student One to observe because she empathized with the woman’s distress and subsequently positioned herself as the ‘unwilling observer’. In this situation, the student positioned herself as being disempowered and unable to seek support from either the clinical teacher or midwives present in the birth room.

In another storyline, positive positioning occurred when a midwife complimented Student Two on how well she assisted a woman during birth.

One midwife said to me “Oh you can deliver my baby any day!” I took this as a compliment. She (midwife) also said “I would be very happy for you to look after me when in labour”. So, I thought that was good. So I thought that was good. I have had very positive feedback from the Unit Manager from the postnatal ward. This reinforces the fact that often clients have expressed to her (Unit manager) the support that I have given to them and enable them to move and improve the quality of care with their babies. [Deliberative positioning by self and others]

On the other hand, Student Three’s culturally sensitive positioning with women from other cultural groups is exemplified in the following selected text.

The woman was a multigravid who had a daughter of two and a half years of age in Bali before migrating to Australia. Her husband and daughter were present at the labour and delivery. I was present for some of her first stage of labour … I had the opportunity to build a rapport with the woman and her family and establish their cultural beliefs and traditions related to the birth and their birth plan. The family requested to keep the placenta and take it home. It was so interesting to hear about their customs related to the placenta and the blessing ceremony they will perform at home, to honour the birth of their child. I was able to ascertain their expectations of the birth and how it differed from their experience in Bali. The woman commented on how well she had been treated and that the staff had been sensitive to her needs and made her feel in control … [Accountive positioning]

The illocutionary force employed by each of the students in their psychological positioning has been demonstrated in their pronoun grammar. Their repositioning is demonstrated in the reconstruction of grammar, as well as in the reconstruction of meaning and understanding in their storylines. In the application of their tacit understanding, positioning skills, and personal professional identities, these students transformed their discursive actions in various social episodes throughout the year.

**Professional Conversations with Preceptors**

In their function as preceptors, midwives as employees of maternity services were obliged to supervise and appraise students in practice, while students were expected to
identify with the rules, regulations, and local moral order in which they continued to be positioned as the least effective members of the chain of authority. Students’ discussions of interactions and relationships with the preceptor/midwives were developed from the perspective of ‘other’ in this research. The relationship differences have been taken to be complimentary because particular interactions in a community of professional practice places emphasis upon a concrete (ethical) (Lineham & McCarthy, 2000) and caring participation, rather than collaboration and friendship as institutional norms or standards.

The impact of conversations broadly defined between preceptor/midwives, (including those midwives who were not preceptors), is an important consideration in professional education. The psychological mechanism argued is one that is conducted through institutionally embedded frontline conversations with midwives and debriefing with significant others, and where complex meanings were appropriated, internalized, published, and conventionalized over time. Within such culturally embedded practices, it is argued here that midwives, through their positioning acts or activities, projected the social force of their storylines. These storylines occupied multiple identity possibilities within the institutional moral order in which the students encountered other students, for example, medical students, undergraduate student nurses, and allied health workers. As part of their employment within maternity services, it is expected that midwives fulfill this obligation in the promotion of interdisciplinary relationships and teamwork.

The actual moral authority and power exercised by midwives in their function as preceptors have been acknowledged in the many recalled discursive episodes of the students who provided testimonies of both positive and negative positioning. In reference to forced positioning of students, many sources of power exist but the one that stands out most in this research is institutional authority which, according to these students, is not always used appropriately. In its association with organizational hierarchy, institutional authority is usually held by virtue of an institutional appointment to a role, which Hatch (1997) observed “… exists within the relationship between social actions [discursive practices] rather than residing within the actors [roles] themselves” (p. 282). By contrast, and in application of positioning theory, authority is assumed by discursive participants on the basis of their moral capacity on any level within an organization. This applied not only to midwives in their function as preceptors, but to students as well, because they were also employed by the same health care network within maternity services on a part-time basis throughout the duration of the course.

**Professional Identity Formation and Induction into Professional Practice**

Personal identity formation and induction into professional practice was supported by students’ experience in practice settings and where they were supported in a model of supervision called preceptorship. The social episodes occurred within the social structures of maternity services and recalled conversations were generally around the interactions between the students and their preceptors/midwives. Clinical learning was framed within the ‘private/public’ and ‘self/shared’ dimensions of acts and actions. These acts/actions were held
to both inform and maintain professional practice at a personal and social organizational level.

Figure 7 shows how conversation (social act) and quasi conversation (reflexive action) have been defined in this research to sustain the professional identity formation of students within institutional practices. This is characterized as four phases in a personal professional identity formation projection that include, appropriation, internalization, transformation, and conventionalization, as shown previously in figure 5.

It is assumed that the process of personal professional identity formation is a dynamic interaction or reconciliation between private and public thinking. In reference to van Langenhove and Harré (1994) however, they did not project this process as a linear method of individual socialization into a role. On the basis of their social constructivist interpretation, individuals may move back and forth between public and private speech acts in particular episodes, rather than being limited to one phase in the cycle.

<table>
<thead>
<tr>
<th>Midwifery setting (critical incidents)</th>
<th>Reflective practice (oral and written)</th>
<th>Phases in personal identity formation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PRIVATE</strong> (self)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>After participation in a clinical incident in which a student consults the preceptor/midwife or peers for advice.</td>
<td>Following a clinical incident, a student thinks about the events that had occurred. May be reflexive (internal reflection) or involve written reflection.</td>
<td>Appropriation of social understandings, grammar, institutional practices and societal rhetoric.</td>
</tr>
<tr>
<td>Participation in a clinical incident in which a student does not consult the preceptor/midwife or peers for advice.</td>
<td>Self-other positioning/repositioning in conversation initiated by the student concerned with a peer, preceptor/midwife and/or lecturer.</td>
<td>Internalization of professional expectations through conscious or unconscious reflexive positioning.</td>
</tr>
<tr>
<td><strong>PUBLIC</strong> (shared)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public presentation following a clinical incident: Documentation is made in a woman’s history. For example, the administration of medication in an emergency situation. Report time (handover), meal breaks, tea breaks or quiet times in a midwifery unit provide an ideal opportunity for midwives to tell their stories about midwifery related experiences. It is also an opportunity for assessments of students by preceptors to occur.</td>
<td>The performance/demonstration of the construction of professional identity with the student’s preceptor/midwife, lecturer, other midwives, peers, family, or significant other. Self-other positioning/repositioning in conversation initiated by the student concerned with a peer, preceptor/midwife and/or lecturer. Such opportunities facilitate discussion about care where students are expected to make</td>
<td>Transformation of professional practice following professional repositioning of the student concerned. Conventionalization of institutional midwifery culture and formation of a professional identity.</td>
</tr>
</tbody>
</table>
During clinical placements, the students were exposed to events that promoted explorations of their life space through both public and private speech acts/actions, which they sought engagement in to influence their personal professional identity formation.

As three agents, each student positioned themselves pertaining to their personal attributes such as their physical and dispositional skills and powers, as well as personality and temperament (Harré & van Langenhove, 1999c). In this context, the notion of agency has been designated to include the capacity of each individual to influence professional judgments in the domain of midwifery practice. In essence, the focus of the conversations was on the relationship between what these students believed they could perform and what they could not perform in midwifery practice under the supervision of their preceptor/midwives. Here, the sense of professional agency is formed and the social structure of midwifery practice is reconstructed.

Phillips’ research was also concerned with the analysis of the ontological levels of discursive acts that incorporated the meaning of actions and whether or not the participating students fully understood midwifery gestures and signs in social episodes. It drew attention to their claims that they could correctly identify and understand the meaning of symbols for safe midwifery practice and the application of such meanings in the correct context. What they were permitted to do on any occasion within midwifery practice was taken from a small but a rapidly expanding repertoire of categories and subcategories of actions, which were always subject to the discretion of the preceptor/midwife to whom they were each assigned. The moral dimension of personal professional identity formation has not been identified in terms of a set of moral principles or rules, but rather in terms of the moment-moment ‘oughtness’, in which each of the students responded in particular situations. The application of “oughtness” according to Lineham and McCarthy (2000, p. 452) means, “… selfhood emerges and is enacted in particular moments in a given community of practice”. Each student therefore, undertook certain actions based upon the belief that they possessed the right or the moral duty or responsibility to engage in. Such personal actions projected their selfhood and agency.

It was through discursive actions as social actors that for each of the three students, whose selected excerpts of their storylines from interviews, came to the realization they too embodied the rituals of safe midwifery practices that, over time, led to a wider understanding of institutional policies and procedures. The social discourses they engaged in with their preceptor/midwives, peers, and significant others were made determinate in the public reality and impacted on their public performance as a student (both academic and practice development). The social episodes that they selected in their everyday conversations with midwives and others were unfolded, analyzed, and synthesized through discursive psychology. It is within these accounts of social episodes that the flux of social life in midwifery education and practice was researched. It was here in the social episodes of midwifery practice settings that the local moral order and authority of maternity services, course requirements, and the local authority (NBV), were also determinate in the transformation of each student’s personal professional identity. This research has also
emphasized the necessity to demarcate and protect the ‘discursive space’ where the personal and social meanings are acquired, as well as interpretation of Benner’s stages of skill acquisition. In this commitment to a new ontology in midwifery research and practice based on discursive space, taking conversation as the starting point of social theorizing is important to attend to the particularities of intimacy. This claim is to maintain individual differences and nuances in the local expressive order related to the language systems of institutions such as maternity services.

**POSITIONING AND REPOSITIONING PROCESSES**

In positioning theory, ‘conversation’ is important for human behavior where individuals are active in the production of social interactions. The social world of midwifery practice embraces the ontological levels of semiotics, agency and cultural structures through professional conversations and where positioning and re-positioning occurs (Phillips, Fawns & Hayes, 2002). Further, human behavior and personality traits are taken to be inherent in power relationships amongst individuals (Bradley, 1999), to influence or even transform the cultural environment. As observed by Fahy (2002) and McKenzie and Carey (2002), this occurs in patriarchal settings of maternity services and presented in the social episodes of each of the three students.

Kanter (1981) noted that women in female groups tend to be more oriented toward immediate relationships than men in male groups. This was certainly an expectation of the three students (all women) who often sought closer working relationships with their nominated preceptor/midwives, all of whom were also women. Their early accounts were often interwoven with expressions of dissatisfaction with immediate relationships with their preceptor/midwives who positioned them as less supportive than expected. It was in conversations students assumed positions that were associated with their view of their professional life-world at that given time. It is argued here that the students’ positions in the social world were continually being constructed and reconstructed in conversations. This is consistent with the feminist post-structuralist stance and its relationship to positioning is explained by Davies and Harré (1990, p. 46) who stated

> Once having taken up a particular position as one’s own, a person inevitably sees the world from the vantage point of that position and in terms of the particular images, metaphors, storylines and concepts, which are made relevant within the particular discursive practice in which they are positioned.

Conversation relationships with midwives were and continue to be potent for students linked to the fascination of childbearing and the miracle of birth. At times, the tenuous links of life appear fragile and sometime death of either a woman or fetus/newborn can occur as a result of birth. These factors may impose incredible demands on midwives to deliver responsible, effective, and appropriate care that can be matched with the corresponding need to debrief with colleagues to verify and validate professional actions. The impact of the social setting in which the midwife is the significant other and through social interactions is pivotal in the personal professional practice identity formation of students.
PROFESSIONAL IDENTITY FORMATION

The application of positioning theory and discursive psychology together has afforded a better understanding of indeterminate interactions that present during induction into professional practice of midwifery. It does this through combining attention to midwifery practice as the social world in which the rapid dynamics of social interactions coexist with consideration of the personal rights and obligations in the local moral order of preceptor/midwives and students. Discursive positioning processes have been elaborated in the cognitive apprenticeships of the three students, identified through their experiences of professional practice in midwifery. Their storylines projected an understanding of selfhood developed from moment-by-moment interactions in practice.

Another powerful and yet paradoxical example of the influence of the workplace discourses with midwives is in the appropriation of ‘midwifery language’ and metaphors. In the curriculum for the Graduate Diploma of Midwifery, the word ‘birth’ is consistently applied because it reflects the language used by women and is consistently voiced through childbearing consumer groups. Academics use the word birth, and yet many midwives in practice continue to apply the word ‘delivery’ to mean birth. This application is also used by students thereby demonstrating the influence and authority of those engaged in professional practice.

This semiotic device continues to prevail within social institutions where midwives have a direct influence upon students. This continued use of the word ‘delivery’ by midwives within maternity services could be related to the traditional influence of medicine through ‘obstetric language’ applied to childbirth practices by obstetricians. Johansen, Newburn and Macfarlane (2002) stated that, from an international perspective, midwives have contributed to the medicalisation of childbirth and disempowerment of midwifery as a profession. Clearly, this has been achieved through semiotic devices such as the word delivery, which is at the expense of midwifery heritage and culture that identify it as a separate profession from that of medicine. Both Giddens (1984) and Bhaskar (1986) observed that social reproduction is an unintended consequence of social action and discursive action. It is central to the argument of this research that semiotic interactions can inform, in a powerful way, the understanding of cultural agency and transformational models of social action.

Many midwives have frequently stated that when they talk about aspects of care, it is typically presented in a broad context that is impersonal. Frequently these low-level insights, given to the childbearing woman and her family about midwifery care, can also be extended to students. Students continue to report that preceptors/midwives and non preceptors, usually exercise their authority over them in practice settings and in the delivery of care, but despite their shortcomings in student supervision, they were highly valued. The three students also reported on a number of occasions, that learning experiences were often left to chance and this continues to be the case. This outcome for students is often reflected in the episodic nature of frontline experiences, coupled with the inability to predict workloads. Most childbearing women are normally admitted to maternity units for their birthing experiences, that in terms of duration and time, are not always predictable.
The phenomenological and ontological framework for interpretation of social behaviour provides a heuristic structure for the description and interpretation of discourse in midwifery practice and research elaborated in the various psychological spaces. These are afforded by different situated learning opportunities operating in response to appropriate pedagogies in midwifery education, as depicted in figure 8. These pedagogies pertain to situated cognition in social episodes in professional identity projects with educators, preceptors/midwives, other midwives, and health professionals, as well as significant others (such as family members), in public debriefing conversations and maintaining written accounts in their clinical logs. In their role as preceptors, midwives were expected to both formally and informally encourage discourse by engaging in conversations related to frontline social episodes of professional practice. In all cases, the students and preceptor/midwives located each other in conversations as objectively and subjectively coherent participants in jointly produced storylines about midwifery where positioning theory is inherent.


Figure 8. The psychological spaces in discursive action in a cycle of professional identity formation.

Figure 9 relates positioning to learning settings through the cycle of professional identity formation. For example, Phase A (conventionalization) represents socialization of students through discursive actions during their clinical placements in maternity service settings, whereas in Phase B students move to appropriate their agency as emerging midwives during their induction into midwifery. This was achieved through positioning and repositioning themselves for best possible learning opportunities in practice. It can be seen, for instance, that writing in clinical logs needs improved scaffolding to be more effective in cognitive
transformation, rather than complete reliance upon descriptive accounts normally provided in professional education.

Positioning theory can be applied as an analytical tool in explaining cultural stereotyping of postgraduate students during their clinical placements. Its application in midwifery education emphasizes the significance of both cultural factors and symbols of professional practice through the formally sanctioned social dialogical practices conducted within institutional settings. Here they can seek to transform and maintain the local moral order through their committed actions. In their own way, each of the three students exhibited relational positions within social settings, significant for analysis and construction of meanings relevant for their personal professional identity formation and organizational transformation. Social positioning theory has been applied as a framework for explaining the manner in which the three students engaged in information seeking behaviours to influence their personal professional identity formation.

<table>
<thead>
<tr>
<th>Individual Action</th>
<th>Collective Action</th>
</tr>
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<tbody>
<tr>
<td><strong>Phase d</strong></td>
<td><strong>Phase a</strong></td>
</tr>
<tr>
<td>Contribution in the collective experience through the participation of care under the supervision of preceptors/midwives.</td>
<td>Participation in social/collective experiences through the delivery of care for childbearing women by, for example:</td>
</tr>
<tr>
<td>Application of self and other/forced and deliberative repositioning to obtain learning opportunities.</td>
<td>listening and using midwifery language, technology use in frontline care delivery conversations with midwives, women, and others related to care contribution to reports about the care of childbearing women.</td>
</tr>
<tr>
<td>Comparison and analysis of practices according to, for example, the policies and procedures of maternity services and requirements for endorsement as stated by the Nurses Board of Victoria.</td>
<td>Skills and knowledge accepted/rejected by preceptors/midwives.</td>
</tr>
<tr>
<td><strong>Phase c</strong></td>
<td><strong>Phase b</strong></td>
</tr>
<tr>
<td>Comparison, analysis and evaluation of practice development through private thoughts and/or clinical logs. Identification of personal goals for personal professional identity formation. Implementation of actions to achieve learning goals.</td>
<td>Engagement in second and third order positioning, reflecting upon discursive acts or actions with preceptors/midwives related to social episodes in midwifery practice. Review of own actions in midwifery practice and the practice of others. Reference to preceptors/midwives for expert knowledge and debriefing. Engagement in debriefing with peers or significant others.</td>
</tr>
</tbody>
</table>

Figure 9. Codification of repositioning operations conducted by students.

**A Transformational Model of Social Action**

Midwives, as cultural agents in maternity services, enact and embody cultural ideological resources and institutional rules and regulations to uphold safe practices. This research has
framed professional education as a social behaviour that affords interactions at various ontological and phenomenological levels in workplace semiotics. Bhaskar (1989) conceded that humans are the only moving force in history because events occur through their own actions. He argued that the choices for actions are usually based on pre-existing structures but does not, however, acknowledge the causal effects of social actions. Explicit in Archer’s dynamic elaboration of Bhaskar’s transformational model of social action (TMSA), is the social and cultural transformation undertaken by agents (Archer, 1995). The responsibility of a systematic transformation of social and cultural agency lies with each agent. The accounts of the three students illustrated that this has been the case and anchors morphogenesis of agency. The data from this research along with Archer’s morphogenetic TMSA have provided the analytic tools to begin to explain the complex agential interchanges between the macro and micro ontological levels which elaborate change in a system’s structural form or state.

When agential morphogenesis occurs, interactions will be different from earlier actions because of the impact of elaborated consequences of prior action. This claim has been supported by the many examples presented in the accounts of the three students, and especially those of their respective preceptors/midwives related to the students’ professional identity formation. Inherent in these accounts are the reflective practices and positioning in which all students engaged. The morphogenetic perspective is not only dualistic but is also sequential, dealing in endless three-part cycles: structural conditioning, social interaction, and structural elaboration (Archer, 1988). Throughout their various clinical placements during the course, the three students engaged in this transformational cycle, which required analysis at both macro and micro levels. Implicit in the transformation process were the reflective practices (both public and private expressions), and positioning accounts of all participating students (and their preceptors/midwives), which demonstrated the trajectories of their social expectations and intersected into transformational action.

**DISCURSIVE AND CULTURAL VIEWS OF AGENCY IN MIDWIFERY EDUCATION**

Through the discursive accounts of students the concepts of structure and culture are intrinsic within institutions, but they are contingent upon social agents and their interactions to influence different generations of people (Harré, 1983; Archer, 1988; 1995). In the transformational journey of the three students as active participants in their professional education, the culture of midwifery practice was also revealed. Within this culture, each student actively researched their positioning, and the positioning of others, in their discursive acts in midwifery practice to advance their personal professional identity formation as a midwife. During clinical placements, each student’s agency was conducted as a “… causal intervening in the world, subject to continuing possibility of reflexive self-awareness only analytically separable into episodes” (Bhaskar, 1989, p. 82). As agents, these students positioned and repositioned themselves, as well as others, to meet specific needs throughout their induction into midwifery practice. It became clear that they responded to these needs by negotiating their professional lifestyle through various interpersonal dialogues and, at times, they constructed their psychological ‘life spaces’ through intrapersonal dialogues.
The notion of cultural agency in professional discourse related to social conditions encompassed factors such as power, technology, physical environment, and institutional bureaucracy. These factors were considered by preceptors/midwives to be part of the ‘routine’ of maternity services within the institutional practices of the health care service are also explicitly acknowledged by each of the three student participants as important influences during their induction into midwifery practice. It is argued that the case for agency operates inside society where linguistic entities create institutions through structures. Structures include institutional behaviours and dynamics that influence the structure of students’ psychology through rules, policies, and procedures, and predispose their personal professional identity formation. A function of professional education is to influence personal change, but usually the concept of social psychology is overlooked because it is here that personal change is effected through organized cultural processes. If change is difficult to effect amidst broader social constraints in a community of practice, individual change is even more difficult to achieve in isolation. This means that to effect substantial psychological change, major alteration is required in the formative social relations, conditions, and institutions. The linguistic sociability of the midwives in this research project contributed to a defined culture that was generated and reproduced within the institutional setting of maternity services where specific rules, policies, and procedures are applied.

Institutional practices, societal rhetoric, and discursive positioning also facilitated a dynamic social ‘structuration’ achieved through language, rules, and signs that all contributed to a reproduction of culture. Each of the three students and their preceptors/midwives frequently stated that they found these factors to be often unpredictable and inexplicable. The students presented many structural and cultural entities in their selected accounts of the conversations with their preceptors/midwives and others. In these conversations they also provided social representations of their meanings and interpretations of these entities. This was the process in which cultural psychologists, such as Ratner (2000), see all individuals subjugating their conscious or unconscious individuality to the group or work unit and act as cultural agents through their expressions of significant opinions and viewpoints. The students frequently indicated strong concerns in their accounts about denied recognition, appreciation, and inclusion by midwives in workplace discourse. These accounts, and those of their preceptors/midwives, have together demonstrated a professional culture rich in discursive practices and relationships.

While this cultural aspect of personal agency within professional practice is shared, questions remain. These relate to inherent cultural factors of individual professional practitioners and social constructions, ethnicity, and family values that influence social actions. In addition to class and gender, Bradley (1999, p. 21) argued that concepts such as ethnicity and age, assist individuals “… to make sense of the way in which members of societies differ from each other” and where identity is influenced by ancestry, culture, language, or religion. In this instance, reference is made to Student Three’s vibrant accounts of her need for symbolic interchange with her peers, midwives, family members, and significant others for her personal professional identity formation.

Conversely, both Student One and Two, on the other hand, presented more familiarly stoical accounts that were concentrated on care and any technical issues in which they participated. They described their management of clinical learning opportunities as part of course requirements, with a view to their future practice as midwives within their respective communities. It could be argued that as more technically minded individuals, these two
students reduced components of the course to essential elements to conceptualize insights into their practice development. Over the duration of the course, all three students built on their prior knowledge, experiences, and dispositions to connect episodes together into a biography, supported by situated learning with midwives, other health care professionals (obstetricians and general medical practitioners) and significant others.

The manner in which the three students conducted their social lives through their discursive practices and rhetorical skills, led them to particular locations to enforce meanings and narratives antecedent social structures. Antecedent social structures in this context constituted the control in which discursive interactions took place. What is required is a more elaborate social framework in which clinical educators and academics can give adequate weight to social structures and the value of discourse or professional conversations. Midwives, clinical educators and academics as social agents need to acknowledge the influence and impact of social structures through conversations. It is through conversations that social structures and human agency are not only presupposed by they are also revealed. In the interviews with each of the three students and their respective preceptors/midwives, their accounts were filled with social episodes in which structures and human agency were innate.

Harré (1983) espoused different causal influences over the course of social episodes in ‘macro’ social structures the impact upon individuals. In the case of students who have particular needs such as the completion of practice requirements, a powerful macro-social structure within maternity services was economic pressures that often limited opportunities for students to engage in particular social episodes with their preceptors/midwives who frequently had other concurrent responsibilities. These issues were expressed in the accounts of the three students and their respective preceptors/midwives.

**A Transformational Model of Social Action in Midwifery Education**

Practice and research in professional education often lacks a transformational model of social action to embrace the social ontological levels of cultural purposes or semiotics, agency, possibilities or structure. This is specifically in reference to the location of agency in the social world and the way social structures are reproduced and transformed. In midwifery education, clinical educators and academics have generally overlooked the organized social life of professional practice where the moment-to-moments interactions are both intentional and interpersonal. These interactions are those conducted in the provision of care. Instead, educators and academics have promoted the more restrictive reflective narrative approaches founded on individualistic conceptions of cultural agency in professional education. An individualistic view of agency and culture in professional education in universities is a form of scholasticism, but ignores the demands and constraints with professional practice.

A transformational model of midwifery education developed from discursive practices can fill many gaps in the theory of reflective practice by adopting an understanding of the clinical learning context where internal or private purposes and public or social activities intersect. This model will also offer a more dynamic theory of socially situated learning in codifying the ontology of experiences and concepts because it fosters production of meaning...
in the non-rational and non-cognitive aspects of tacit learning. In doing so, it offers a more coherent analysis of relationships between interactions that occur through a public semiotic system of practices, gestures, and both private and public speech. Features of a transformational model of midwifery education and research (Phillips, 2002) are summarized in the following:

- Preceptors/midwives, educators in practice settings as well as academics need to invite students into situated learning experiences that are understood as personal professional identity projects for learning.
- Preceptors/midwives, educators in practice settings as well as academics through their mutual and open discursive practices support student discussions related to specific public responsibilities and duties within the local moral order of the institutional framework of maternity services for safe practice.
- Student placements in maternity need to be developed in systematic approach to provide diversity of experiences of pertaining to technical procedures, cultural settings and support debriefing discussions between students and preceptors/midwives.
- Reflective practices conducted through debriefing activities in a one-to-one activity or in a group and or a private journal are generally considered by academics, professional organizations such as the ANMC Australian Nursing and Midwifery Council (2006) and the literature, contribute to the cycles of personal professional identity formation in different ways and at various stages. In practice settings there are abundant learning opportunities that should promote dynamic interactions between public (conversations) and private (thinking) reflections.
- Students needs to be seen as active participants of their learning and should be encouraged to participate and present in various collegial settings for the purpose of assessing their own emerging perceptions, positioning and repositioning skills in conversations with others in practice settings.
- The transformation of a student’s cultural agency can be self-monitored through their reflective practices encouraged in courses such as the Graduate Diploma of Midwifery. Through entries in each student’s private space using online modalities, or even written entries, each student is well placed to chart their professional learning. Regular conversations between preceptors/midwives, educators, academics and students can be used to judge formative and summative competence in technical and cultural practice.

Professional conversations clearly contribute to the personal professional identity formation of students through the social structures of maternity services. Educators need to move from didactic approaches in midwifery education and fully embrace the tacit potency of moment-by-moment frontline conversations into their strategic planning processes of teaching and debriefing activities.

CONCLUSION
As social cultural agents in various practice settings of maternity services where there are defined structures such as rules and regulations are upheld for safe practices, midwives also provide supervised support and care of students. It is within these settings that the actions and conversations of midwives influence students in their professional identity formation as future midwives by learning about the delivery of care on a one-to-one basis. This is achieved through the work related conversations that are both intentional and interpersonal, often resulting in reflective practices that are promoted in academic programs.

It is generally claimed that reflection serves as a mechanism for individuals to identify, problem solve, and transform their learning through processes that could be seen as psychological or sociological entities, but rarely both. Positioning theory is a psycho-sociological ontology in which individuals metaphorically position themselves within three entities: people, institutions, and societies, where discursive practices are conducted either privately, as thinking, or publicly expressed through conversations. Three principal concepts in positioning theory include position, speech-act, and storyline developed from conversations where meanings are constructed and impact upon the social world. In the complex but dynamic social world of professional practice, positioning can be applied in midwifery practice settings as an analytical tool to disentangle and understand the conversations related to the delivery of care. In applying this, students can reflect upon their identified learning need in practice settings and position themselves to fill their knowledge gap by engagement in deliberate conversations with their midwife. Academics need to acknowledge the potential of conversational interactions between students and midwives in practice settings and embrace them in their teaching and learning activities. Reflective positioning is therefore, the way forward in promoting active student learning in preparation for professional practice development in the social and cultural environment of midwifery practice settings.

REFERENCES


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