COLONIALISM AND OBSTETRICS AND GYNAECOLOGY TRAINING IN THE UK

A Critical Discourse Analysis

Samuel Yosef

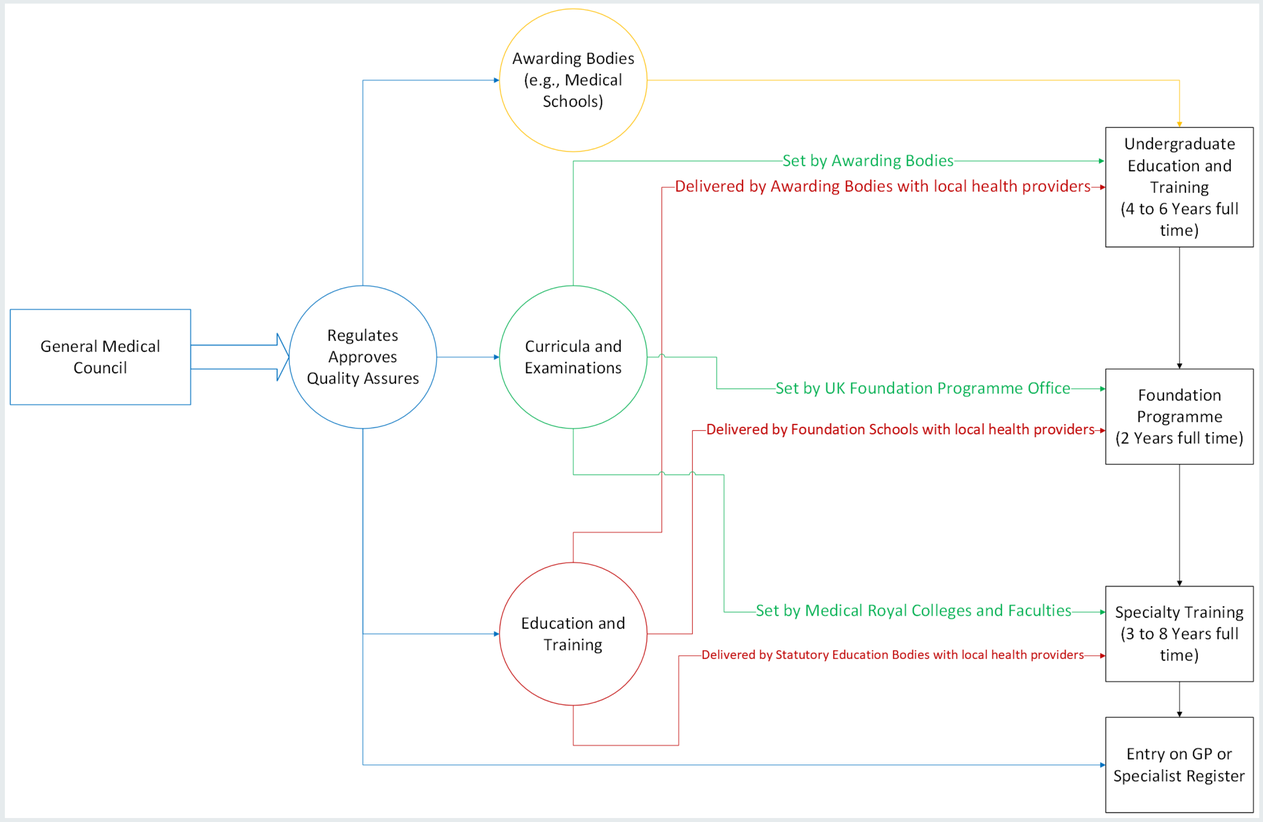
KING'S College LONDON

INTRODUCTION

In this research, I explore how power, hierarchy, and colonial influences manifest in the institutional texts governing Obstetrics and Gynaecology (O&G) postgraduate education in the UK. Using Critical Discourse Analysis (CDA), I analysed documents from the General Medical Council (GMC) and Royal College of Obstetricians and Gynaecologists (RCOG) including frameworks, standards, curriculum, syllabus and guidelines, uncovering the embedded systems of authority and their implications for various stakeholders.

GOALS

- To **analyse** how power is structured and enacted in O&G training texts.
- To **understand** how people and their voices are constructed within the text
- To **explore** how the discourses identified, related to colonial influences.



METHOD

1. **Critical Discourse Analysis: I used Fairclough's Dialectical-Relational CDA framework (Fairclough 2013). 6 Key texts: GMC's Excellence by Design, Promoting Excellence and Generic Professional Capabilities Framework; RCOG's Core Curriculum 2024, Essential Guidance and MRCOG Syllabus. Examined language use, interdiscursivity, and identity construction to uncover power dynamics.**
2. **Analytical Framework: Based on Raven's bases of power: legitimate, expert, reward, coercive, referent, and informational (Raven 2008).Focus on identities of stakeholders (organisations, doctors in training, educators, patients) and who has what power over whom and how is this enacted.**
3. **Reflexive Positionality: Researcher's insider-outsider perspective acknowledged to mitigate potential biases**

RESULTS

Hierarchical Power Dynamics
A clear hierarchy exists, with the GMC at the top, delegating responsibilities to Medical Royal Colleges and Faculties (MRCFs) like the RCOG. While MRCFs have autonomy in developing specialty curricula, final approval by the GMC maintains the hierarchy. Doctors in training are positioned as recipients of education and supervision rather than active contributors, further embedding this structure

Centralisation and Standardisation
The GMC exerts significant centralised control over medical education through its standards and frameworks. These standards aim to ensure uniformity across curricula, exemplified by the RCOG's alignment of its curricula with GMC requirements. The use of nominalisation in GMC texts (e.g., "requirements") frames standards as impartial and objective, reinforcing adherence and minimising resistance

Surveillance and Compliance
Surveillance mechanisms, including assessments, supervision, and quality assurance processes, are pervasive. These ensure compliance with standards but also reinforce the hierarchical dynamic. The programme of assessment serves as a tool of surveillance, with high-stakes assessments like the MRCOG examinations enforcing progression. Self-assessment processes further integrate surveillance into professional identity formation.

Patient Safety as Justification
Patient safety is consistently cited as the rationale for centralisation, standardisation, and surveillance. The GMC and RCOG argue that uniform standards safeguard patients by ensuring consistent competencies among doctors in training. However, patients' direct involvement in shaping these standards is minimal, raising questions about representation.

Marginalisation of Stakeholders
Patients and doctors in training are constructed as objects rather than active participants in the design of medical education. Non-discriminatory practice is mentioned, but practical engagement in areas like trans and non-binary healthcare is limited, reflecting marginalisation within training priorities.

DISCUSSION

The findings of the analysis demonstrate how the discourse that is connected to O&G postgraduate training in the UK is closely related to colonial discourse. In particular, the focus on standardisation and centralisations reflects a colonial discourse in which binaries are established and promoted (Quijano 2000) and othering is used to promote only one form of doing and being (Ashcroft, Griffiths et al. 2008). Moreover, the centrality of institutions and standards and the erasure of marginalised identities that comes with this is directly linked to colonial structures and processes (Ashcroft et al., 2002)

CONCLUSIONS

This study highlights how institutional texts in O&G postgraduate training reinforce centralised authority and colonial legacies, perpetuating systemic inequities. The alignment of the RCOG with GMC standards enforces compliance and marginalises diverse identities. Reforms addressing these power dynamics are essential to create a more inclusive and equitable training system, ultimately improving outcomes for trainees and patients. I will build on this work by conducting interviews with stakeholders across the system to understand whether it is possible to surpass these structures and fully address the influence of colonialism on obstetrics and gynaecology training in the UK.

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CONTACT
Samuel Yosef
samuel.yosef@kcl.ac.uk
King's College London

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