

AN ILLUMINATIVE EVALUATION OF A PROSTHODONTIC CURRICULUM

A research report submitted to the Wits School of Education, Faculty of Humanities of the University of the Witwatersrand, Johannesburg, in partial fulfillment of the requirements for the degree of Master of Education by combination of coursework and research

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Signed on this day of in the year In Johannesburg

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Pusetso Dineo Moipolai

ABSTRACT

An illuminative evaluation of the final year prosthodontic component of the Oral Health Science curriculum (OHSC 501 Component 1) at the University of the Witwatersrand, Johannesburg, South Africa was conducted. This evaluation method was employed to illustrate how an evaluation strategy was used to assess classroom practices following institutional curriculum reform. The aim was to use a qualitative evaluation process to assess the impact of the curriculum change at classroom level and to evaluate how a department had reformed its' teaching and learning strategies within the hybrid problem based learning curriculum that had been implemented. Additionally, it was to evaluate how this curriculum operated in its own terms. From July through October 2007 small group teaching involving problem based learning, led by two faculty from the department of prosthodontics were observed. Six two hour long small group sessions (equivalent to twelve forty minute lessons), were observed and they revealed a variety of pedagogic strategies utilised. The plan, as outlined in the instructional system was held up against the reality through observations of what happened in the classroom. By and large the findings illustrate that much of what was planned was realised, with the more experienced staff member teaching more or less to the plan. However, from the themes that were inductively derived from analysis of the data, it was clear that integration of content knowledge and critical thinking necessary to assist in the comprehensive management of dental patients was not as robust as would be expected from the students at this level during their training. This finding illustrates the importance of using qualitative evaluation approaches as a mechanism to assess curriculum change efforts as this conceptual framework afforded the opportunity to both look at what actually happened in the classroom and describe what happens in its own terms .

Keywords: Illuminative evaluation, educational evaluation, instructional system, learning milieu, prosthodontics, oral health education, health education, problem based learning, small group teaching.

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LIST OF ACRONYMS

ADA	American Dental Association
AERA	American Educational Research Association
BDS	Bachelor of Dental Surgery
BGDC	British General Dental Council
DLP	Dental Learning Package
EDUCOM	Education Committee
HoS	Head of School
HPCSA	Health Professions Council of South Africa
ILS	Integrated Learning Session
MEd	Master of Education
MFOS	Maxillo Facial and Oral Surgery
OHSC	Oral Health Sciences
PBL	Problem Based Learning
SOHS	School of Oral Health Science

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CHAPTER 1: INTRODUCTION

Evaluation of curriculum reform is necessary at all stages of curriculum innovation. It can be undertaken at the beginning and the end of a curriculum in order to determine whether goals are being achieved and that a programme remains relevant and does what it set itself to do. A study was undertaken in the early 1990s in the School of Oral Health Sciences (SOHS), University of the Witwatersrand, to review the then curriculum with the view of reforming it. This decision was “forced” by both the British General Dental Council (BGDC) and the then Medical and Dental Council [currently known as the Health Professions Council of South Africa – HPCSA] (BGDC, 1997). A decision was taken to reform the curriculum and implement a hybrid problem based learning (PBL) curriculum. This study, undertaken following the implementation of the curriculum innovation, evaluated an aspect of part of the overall curriculum and looked at whether what was planned in the discipline of prosthodontics was been realised in line with the objectives of the hybrid problem based learning curriculum.

Evaluation ... has to do with adjudications of worth, in curriculum ... (Worthen and Sanders, 1987: 3), how adjudications are arrived at, where professional judgments are made by evaluators about the worth of programmes and whether such live up to expectations or are doing what they set out to do (Hamilton, 1976; Stenhouse, 1976). Broadly speaking, there are two paradigms that inform evaluative studies: quantitative and qualitative approaches. Within the qualitative paradigm is illuminative evaluation which informed the present study. The decision to undertake the study using illuminative evaluation principles as the conceptual framework was based on the finding that there was an absence of literature in the oral health education field informed by qualitative evaluative paradigm. Much of the evaluative literature in dental education is underpinned by a quantitative paradigm. Illuminative evaluation was also chosen as the evaluation method to describe the prosthodontic programme in its own terms and to provide a description of how the curriculum was being realised through observing classroom

practices and recording the ‘voices’ of the stakeholders, i.e., the students and teachers of the programme.

Illuminative evaluation, using anthropological tools seeks to ... “describe, interpret and takes account of the contexts in which educational innovation must function” ... (Parlett and Hamilton, 1976: 89). It focuses attention on the importance of classroom practice (learning milieu) and its description by looking for ‘matches’ and ‘mismatches’ between the learning milieu and the planned curriculum (i.e., the instructional system, comprising all that is planned and written down as curriculum). The planned curriculum is essentially a set of documents that delineate the programme’s ... “aims and objectives, content, teacher pedagogy and assessment practices” ... (SAIDE, 1999: 10). As such, the evaluative process seeks not only to look for relationships between phenomena. It asks the question ‘why’ these relationships exist. This is important for programme modification due to the increased responsibilities and resources that are now allocated to education and all its related activities. Evaluation thus, is used for accountability.

Before implementation of the hybrid problem based learning curriculum, the School of Oral Health Sciences had a traditional, content driven, lecturer centred and lecture based pedagogy. The curriculum was neither contextualised in nor responsive to the South African context. It consisted of separate subjects which were stratified into an initial block of four years of basic and medical sciences, followed by another two and a half years of clinical dentistry. Assessment consisted of midyear and end of year examinations, with use of a limited variety of assessment tools.

A hybrid problem based learning curriculum fashioned against the Adelaide model was introduced to the SOHS in 2001, in every department (Townsend, Winning, Wetherell, and Mullins, 1997). Inherent within this was the transformation of teaching and learning strategies wherein integrated, interactive learning was to take place in small, student

centred problem based learning groups and integrated learning sessions and assessment was to be continuous, utilising a variety of assessment tools. The change from traditional curricular globally was prompted by several changes that the profession was undergoing worldwide driven primarily by reform in medical education (ADA, 1994; DePaola and Slavkin, 2004; Kersten, Vervoorn, Zijlstra, Snyders Blok and van Eijden, 2007; Aldred, Aldred, Walsh and Dick, 1998).

The aim of this study was to adjudicate the worth of this innovation in as much as it related to the prosthodontic programme at the SOHS using illuminative evaluation as the conceptual framework. The study was to evaluate how the prosthodontic department had managed to move from a traditional, teacher centred, lecture based pedagogy towards more interactive, student centred, small group focused and contextualised learning and teaching strategies and if it had been able to equip dental students adequately in the field of prosthodontics. It sought to reveal how the programme operated in its own terms, and how well it lived up to its intentions and whether these intentions were realised. Additionally, the study was cognisant of any ‘emergent’ issues that arose during the undertaking of the study. Unfortunately most of these issues could not be progressively focused upon due to limitations and challenges of time and resources. However, these issues were made available for discussion by the department to assist in its teaching and learning activities in order to better understand, develop and refine the programme under review (Parlett and Hamilton, 1976).

Naturalistic observations of the “learning milieu” (a description of what actually happens in classrooms) was undertaken, followed by in - depth follow up interviews which probed and helped clarify issues that arose from the observations, in order to describe and interpret what was being observed (Spradley, 1979, Parlett and Hamilton, 1976). These were matched against the instructional system (i.e., the programme documents) to check for any ‘matches’ and ‘mismatches’ between the learning milieu and the instructional system (Parlett and Hamilton, 1976). The data collection was undertaken over a five

month period, whereby a purposive sample of students undertaking small group problem based learning and integrated learning activities in the prosthodontic programme together with their facilitators were observed and recorded.

The study asked the following questions:

- i) In what ways were the intentions of the prosthodontic programme within the hybrid problem based learning curriculum being realised (or not)?

The aim being to establish whether what was planned was actually happening and to establish whether there were any “matches” and “mismatches” between what the curriculum documents stipulated and what was in reality actually being practiced.

- ii) What, if any, issues emerged during the observation phase?

Some of these were focused on and inquired into further for the purpose of advancing the refining of the programme. As stated earlier it was not possible to focus on all the emergent issues. These issues were foreshadowed in the programme. To a certain extent, these issues, in addition to strengthening the prosthodontic programme, some were found to weaken it to some degree.

This report consists of seven chapters, a list of references and a number of appendices. The topics discussed in each chapter are briefly outlined below.

Chapter 1

Introduces the reasons why the topic was chosen for study (as part of the requirements for completing the degree of Master of Education in the field of curriculum studies, in the University of the Witwatersrand). It also gives a brief overview of the study.

Chapter 2

Literature reviewed here relates to the nature and use of illuminative evaluation and studies in oral health education. It also highlighted the lack of qualitative evaluation studies in the field of oral health science (dentistry) and helped argue for the case of using illuminative evaluation as the conceptual framework to underpin the present study.

Chapter 3

Outlines the research design of the study and discusses the research problem and research questions that are critical to the focus of the study.

Chapter 4

Describes the methodology used and the data sources employed. Following Parlett and Hamilton (1976), methods used in this study included selecting a purposive sample of participants to ensure a sample that was most likely to yield fruitful data in order to allow for an indepth study the problem. Naturalistic observations and with follow-up interviews to describe what actually happened in the classroom were done. The plan, which was derived from document analysis was held up against the reality of what actually happened to establish if there were any matches and mismatches between the two. This assisted in arriving at an adjudication of the curriculum.

Chapter 5

Provides a description of the instructional system, and from document analysis, principles that are key to the curriculum innovation are discussed. Primarily principles underpinning pedagogy inherent in hybrid problem based learning and integrated curriculum are argued.

Chapter 6

Explores the findings derived from observation of the learning milieu and provides a description and evaluation of the prosthodontic programme. It also highlights the recommendations that were brought to bear and given as feedback to the relevant department.

Chapter 7

This chapter presents a discussion of the findings, recommendations and conclusions drawn from the outcomes of data analysis.

CHAPTER 2: LITERATURE REVIEW

The literature was reviewed under two sections:

A. Literature informing evaluation

B. Literature on studies in prosthodontics

It focused on literature arguing the adjudications of worth and evaluation approaches. It also relates to prosthodontics and oral health curricula focusing on literature debating the need for curricula innovation in oral health education.

Evaluation Literature

Curriculum evaluation has grown as a formalised field of disciplined inquiry addressing educational reform, characterised by its own set of international journals documenting various studies, aspects and approaches (amongst other issues) to undertaking curriculum evaluation (Worthen and Sanders, 1987; Weiss, 1997; Jacobs, 2000). Primarily, there are two paradigms to curriculum evaluation - quantitative and qualitative – which look at adjudications of worth of curriculum. The former are more concerned with measurement and assumptions underpinning scientific research (agricultural – botany approach) and are often criticised for not bringing in the “human face” to evaluation (Parlett and Hamilton, 1976). This is in contrast to qualitative approaches to evaluation which evaluate programmes in their own terms.

Qualitative evaluation approaches derive from social anthropology, psychiatry and participation observation research in sociology utilising anthropological tools in the data collection and analysis (Parlett and Hamilton, 1976; Wolcott, 1988; Wandersmann, Snell-Johns, Fetterman, Keener, Livet, Imm and Flaspohler, 2005; Fetterman, 2001). They seek through observation to describe and interpret what happens in a social setting in order to add to information to better understand innovations and assist in the decision making process. Evaluators seek to broker multiple views and are usually not authoritative nor

the lone voice, but play the honest broker role between multiple voices in the adjudicatory process (SAIDE, 1999; Basson, 1997).

The challenge to the validity of qualitative approaches to evaluation is to investigate the issues in depth and present a detailed penetration or description of issues where the strength of the argument is explicit in the rigor with which the argument is presented and is not dependent on numbers. For example, Basson and Nonyongo (1997) in the DUSSPRO study evaluated, amongst other issues, the reduction of “transactional distance” through the provision of face to face tutorials, where the finding was that the uptake of face to face tutorials did not necessarily reduce “transactional distance” for a whole variety of reasons.

The shift towards qualitative approaches means that the evaluations need not control for all variables and need not be numerically objective, as is required in scientific inquiry, but have to ensure that a variety of techniques in the data collection phase are utilised and that the data has “trustworthiness” by using triangulation of data, interpreting such data based on sound understanding of educational theory, methodology, principles etc. This was evident in the study that evaluated the Scottish Integrate Science (Hamilton, 1975; 1976) where observation of what happened was matched with what was supposed to happen as stipulated in the curriculum documents and several mismatches between the intention and the reality were recorded.

As evaluations are also concerned with utility to impact problems, the utilisation focused approach as described by Patton (1997) ... brings closer together evaluations and their utilisation to impact practical action in sensible and tangible ways... (SAIDE, 1999) This is true in the Boitekong study where the community was able to define for themselves what was important and act upon their findings to effect change resulting in utility (Basson, 1998). “Utility” was brought into the evaluation fray as oftentimes findings from evaluations were never implemented and are said to have tended to gather dust in closets once the evaluation had been completed. Here, findings are thus used to address

the need. Utilisation – focused evaluations are thus ... done for and with specific, intended primary users for specific intended uses... (Patton, 1997: 23).

In order to “put back into the driving seat, those who know the programme best”, programme developers act as evaluators of the programmes themselves in empowerment evaluation and this is never a sole person as it is the collective that informs the adjudication (Fetterman, 1996). It could be said that curricula in health education where there is more of a student centered focus and a more participatory approach in the teaching and learning strategies, has an element of empowerment to it as the students’ voices are often solicited and taken cognisance of during the evaluation process.

In as much as evaluation studies report the failures in order to correct them, connoisseurship and criticism as a qualitative evaluation approach focuses on reporting ‘good practice’ (Eisner, 1985; Barone, 1985) and works off the prior adjudication of good. Connoisseurship evaluation thus seeks to disclose and celebrate good practice. Utilising this evaluative approach necessitates the evaluator to have refined sensibilities about the programme under review in order to effectively ... describe the programme, its organising principles, practitioners, practices, accomplishments, its exceptionalism ... to capture the ineffable qualities of the programme (Eisner, 1985; M^cGreary and Michaels, 1998). Oftentimes, good practice is not celebrated nor recorded for posterity, especially good practice coming out of Africa. An example of such is the Boitekong squatter camp where the community was able to build itself five face – brick schools and a community college without much fanfare and the usual associations of large budget government and NGO intervention (Basson, 1998).

Oral Health Education Literature

There is a worldwide renewed interest in dental curricula and how students become dentists (American Dental Association, 1994; DePaola and Slavkin, 2004; Kersten,

Vervoorn, Zijlstra, Snyders Blok and van Eijden, 2007; Aldred, Aldred, Walsh and Dick, 1998) driven primarily by reform in medical education that started decades before that in dental education (Neufeld, Woodward and MacLeod, 1989; Bnurs, Smith, Masterson and Lask, 1995; Love and Russon, 2004). This has led to a strong need to evaluate dental education reform. As it is widely acknowledged, curricula are not made for eternity and therefore there is always a need for change to try and align what is taught with what is needed. In most health communities, there is a real need to rationalise the curricula in light of current disease prevalence and patient demand for treatment. Traditionally content has always driven curricula. However, contemporary education has realised the need for reformed learning and teaching strategies. The movement towards curriculum reform in dental education aims at producing dental graduates who are not only able to provide comprehensive patient care that is scientifically based and technologically appropriate but also able to appreciate, understand and actively seek solutions to current intellectual, social, behavioural, and philosophical problems in dentistry (DePaola and Slavkin, 2004; Grant and Gale, 1989) and become 'oral physicians'.

Traditionally, preclinical and clinical dental education did not keep pace with nor was it responsive enough to the shifting patient demographics and patient / population desires and expectations, changing health systems expectations, evolving interdisciplinary expertise, and integration of emerging technologies (Kassebaum, Hendrickson, Taft and Haden, 2004), due maybe in part to the presence of educational silos. The notion of educational silos stems in part from academic fragmentation or compartmentalisation that characterised most dental faculties. This led to students developing tunnel vision, and the inability to make connections between say anatomy and physiology; endodontics and periodontology. The realisation of the above then led a drive towards integration of dental education through utilisation of different vehicles such as problem based learning and case methods, heuristic strategies, reflective paradigm, journals, reflective story - telling, performance based assessment methods etc. (Barrows, 1996; Whipp, Ferguson, Wells and Iacopino, 2000).

Much of the oral health literature has investigated particular aspects of the philosophies underpinning PBL / hybrid - PBL curricula employing (quantitative) classical agricultural – botany methodologies and there is a scarcity of literature looking at these curricula from a straight “evaluation” perspective as described in educational literature. This would involve adjudications of worth regarding the implemented innovations utilising any one of the several approaches in the qualitative paradigm to evaluate educational reform as the conceptual frame informing the study. There is a paucity of qualitative studies investigating curriculum reform in dental education. One study did look at classroom instructional practices in dental education using a (qualitative) formative evaluation methodology utilising the principles of illuminative evaluation (Behar-Horenstein, Mitchell and Dolan, 2005).

Several studies have reported on the broad perceptions of PBL from both students’ and faculty perspectives from a purely quantitative approach (Aldred, Aldred, Walsh and Dick, 1998; Barrows, 1998; Greenwood, Mullins, Townsend, Wetherell and Winning, 1999; Lim and Chen, 1999; Greenwood, Townsend, Joseph and Wetherell, 1999; Farmer, 2004; Dodds, Osmond and Elliott, 2001; Snyman and Kroon, 2005; Haghparast, Sedhizadeh, Shuler, Ferati and Christersson, 2007). Additionally, the majority of studies have tended to investigate PBL from a pedagogic and curriculum design perspective using the agricultural – botany approach mainly looking at the ... effectiveness of an innovation by examining whether or not it has reached required standards on pre – specified criteria ... (Parlett and Hamilton, 1976; Dederich, Lloyd, Dixon, Farmer, Geurink, Nadershahi, Robinson and Scannapeico, 2004).

Prosthodontic training and education has not been passed by these challenges that informed the need for educational reform in oral health. There has been a massive shift in prosthodontic education influenced by educators’ understanding of learning and the evolution of the profession. The emphasis shifted from prosthodontic curricular emphasising content driven by respected ‘expert’ opinion towards understanding the learning process and that which it hopes to achieve (Chaytor, 2005; Brunton, Morrow, Hoad-Reddick, McCord and Wilson, 2000). The ‘situated learning’ theory advanced by

Lave and Wenger (1996) perceives learning as a function of the activity, context and culture in which it occurs and oral health education is a prime exemplar of this. Even with this acknowledged change in the way prosthodontics is taught and the adoption of such teaching and learning strategies, there has been minimal evaluation of such reform in the qualitative paradigm.

Teaching and learning activities in prosthodontics present a complex educational phenomenon as they are largely experientially based. Any study looking at ‘researching’ such a learning milieu would therefore need to investigate qualitatively and not utilise the quantitative research paradigm that relies heavily on large sample sizes; randomised controlled sampling, utilising pre-ordained pre and post tests and working to either refute or validate a preset hypothesis. The research methodology employed in such instances need to provide the necessary information and ...take into account the complexity of the context – dependent situations involved... (van Rensburg, 2007; AERA, 2006). The qualitative paradigm adds to the body of information that seeks to provide an in-depth description and interpretation of what happens in the ‘classroom’. This would further provide information needed by the stakeholders and decision makers, in this instance the teachers (Faculty) within the department to enable them to modify and innovate further the programme at hand.

The aim of this study was to evaluate how the prosthodontic programme at the SOHS was working out, in its own terms. This study used an illuminative evaluation approach, which Parlett and Hamilton (1976) report was developed in order to address the dissatisfaction inherent with the traditional approach to evaluate innovations which primarily focused on “measurement”. Illuminative evaluation also takes account of wider contexts in which educational innovations function. Its primary concern is with description and interpretation rather than measurement and prediction. The aim of illuminative evaluation is to study the innovatory project. It seeks to address and illuminate a complex array of questions.

Challenges inherent with PBL curricula

Curriculum reform is not without its challenges and often barriers are created and encountered during the process. PBL curricula are therefore not exempt from the above and several reactions to it include: doubts about its educational benefits; anxiety that its outcomes may not be tangible; the challenge to faculty to change their teaching strategies and hence come out of their comfort zones and the general fear of anything new (Hung, Bailey and Jonassen, 2003; Azer, 2001; Abrahamson, 1998; Barrows and Tamblyn, 1980). These challenges therefore make it imperative to evaluate curriculum reform.

There are several reported issues implicit in resistance to curricula change or reform. These include amongst a host of factors, but not limited to, personal factors, organisational issues, educational views, individual faculty's interest in, beliefs and attitudes toward education, approaches to learning and views of teaching, educational and academic background and personal and career ambitions greatly influence ones openness to change (Peirce, 1877; Fullan, 1991 cited in Azer, 2001; Kelly, Shanley, McCartan, Toner and McCreary, 1997). With respect to organisational culture, the nature of the enterprise, the explicit and implicit distribution of power and influence, the degree of political control and influence driving the national imperative and the outlook of the professionals involved all greatly influence the outcome or organisational culture and may interact and limit the styles and types of change that is possible (Livet and Wandersman, 2005). Organisational resistance to the introduction of PBL curricula is widely reported (Ryan and Little, 1991; Ostwald and Chen, 1995; Ostwald, 1994).

Resource and time intensive nature of PBL curricula

Amongst the many challenges that have been reported is the issue of resource and time intensive nature of any PBL based curriculum impacting on the actual 'cost' of the innovation. There are many factors to be considered when assessing cost to time commitments of faculty and students, requirements for support personnel, cost of instructional materials, necessary infrastructural support etc. (Azer, 2001; Barrows, 1994;

Haug, Brown, Goodacre and Cerimele, 1993). Attention needs to be paid to these issues as they could impede student learning and improved professionalism.

PBL programmes are resource intensive and also require much liaison which is time consuming. An increased number of staff is required when teaching small groups compared to when delivery is to a large student group. This also implies that there is a large investment of staff time with PBL based programmes. Additionally, the sustained attention to teaching required by PBL curricula may create barriers to the delivery of teaching. One question that has to be asked before implementing any new innovation is whether the cost of change and its maintenance is justified in terms of learning effectiveness and efficiency. This is addressed with utilisation – focused evaluation strategies (Patton, 1997). With PBL curricula, it is well established that effective case planning and development is time consuming and planning the detailed content of each semester does occupy an inordinate amount of time (Benbow, Rutishauser, Stoddart, Andrew and Freemont, 1996; Hung, 2009).

Content Integration

Vertical integration in the context of dental curricula can be defined as the integration of basic science knowledge (e.g. biology) in the clinical context. Horizontal integration can be defined as the integration of knowledge and skills between the clinical subjects that relates to comprehensive and holistic patient management.

Critics have raised concerns that the introduction of PBL may detract students from the traditional rigor associated with the basic sciences and hence question the efficacy of PBL formats in facilitating knowledge acquisition. PBL is reported to enhance depth of knowledge and not breadth with an increased number of studies reporting student discomfort regarding the ‘looseness’ of PBL curricula in terms of requiring students to have the ability to identify knowledge deficiencies, search for and learn new knowledge effectively. Students have reported discomfort associated with the lack of definition of core material as well as clarity of the objectives of PBL (Boshuizen, Van der Vleuten,

Schmidt, Machiels – Bongaerts, 1997; personal discussions with SOHS students and faculty – see transcripts of student interviews: Appendix 4.4).

One of the major aims of PBL curricula is integration of knowledge. As reported, and noted during this study, integration is not an easy task. It takes time for behavioural and basic science knowledge integration to be realised and seen to prove its relevance in clinical settings even within PBL curricula. However, several studies are reported to demonstrate a counter view wherein PBL curricula encouraging critical thinking with students demonstrating improved attitudes to learning (Birgegard and Lindquist, 1998). It has also been reported that long term retention of information was no different between PBL students and traditional curricula students, suggesting that the advantages arising from lecture – style preparation are comparative with learning from PBL curricula, with however, reported greater retention of knowledge via the PBL mode of learning (Eisenstaedt, Barry and Glanz, 1990).

Staff expertise

Wilkerson, Hafler and Lin (1991) report that content expert tutors in a PBL setting have a more directive role and suggest that this may endanger one of the most important aspects of small group work: where students are expected to determine their own learning objectives and access appropriate literature resources. Other authors have found the converse. Schwartz, Burgett, Blue, Donnelly and Sloan (1991) have reported that tutoring skills are more important in facilitating student learning than the staff's experience in the content of the problems. The evidence relating to this aspect of PBL is equivocal with certain groups touting tutor expertise as paramount and others proclaiming that a tutor who has good facilitation skills without content knowledge of the cases under review, is required. Maybe the middle of the road view that tutors have to possess both content and small group facilitation skills is the way to go. For small groups to function effectively, the facilitator must be familiar with teaching techniques of facilitating small groups (Barrows and Tamblyn, 1988). Similarly it is also important for tutors to be well informed about a problem and about related learning issues (Eagle, Harasym and Mandin,

1992). Good group guidance by the facilitator has been correlated with effective group discussion in PBL programmes (Dolmans, Wolfhagen, Schmidt and van der Vlieten, 1994). It is argued that content expert facilitators tend to talk too often and too long and also provide direct answers to student questions and suggested more topics for discussion within the group instead of letting the students derive such concepts for themselves organically.

Importance of group dynamic to the success of PBL

There are essentially three factors responsible for group dynamic and hence the success or failure of a PBL session:

1. Facilitator associated issues
2. Student associated factors and
3. PBL case design

Facilitator associated factors include aspects such as lack of adequate preparation for PBL sessions, tutorial dominance, tutorial bias towards those students who dominate the discussion and inexperienced facilitators or those having lack of proper knowledge regarding the PBL process. All these can lead to a dysfunctional group dynamic which may not bode well for effective teaching and learning and may actually tip students towards disinterest in the PBL session.

With regard to students, if there is a negative attitude towards one another within the group, poor communication skills, lack of appreciation and support for each member of the small group, distraction / stress amongst the students, unresolved personal issues and laxity in getting assigned tasks completed group work will suffer. It is important that there is equitable participation from each group member for effective group dynamic. Another contentious issue is the notion that students from a PBL curricula may become dependent on the group environment and may not be effective in situations requiring them to function independently.

Case development and or selection can also make or break the PBL session. Issues such as inadequate design of PBL problems and lack of information in the student pack (the trigger), the facilitator guide, discrepancy between facilitator and students objectives may all contribute towards a dysfunctional group or PBL process. Failure to address these challenges appropriately may affect the learning process of the students in the PBL programme.

Conclusion

Illuminative evaluation was used to get beyond using the agricultural – botany paradigm in evaluating the worth of the prosthodontic curriculum within the innovation at the SOHS. It also linked classroom based observations in order to adjudicate if the PBL innovation within the discipline of prosthodontics as intended was operationalised. It looked at the intentions of the PBL philosophy and concepts within the prosthodontic curriculum, i.e., student centered teaching and learning, integration of knowledge, small group work, student - directed learning, amongst others. Essentially, the study evaluated how the prosthodontic department operationalised the intentions of the innovation and was cognisant of any emergent factors. These issues (i.e, the emergent ones) were made available to the department through discussions with faculty within the department and at departmental meetings.

CHAPTER 3: RESEARCH DESIGN

This chapter will focus on describing the research design, unpacking the principles that inform the research approach or conceptual framework. The unique features that are inherent in the specific methodology will be elucidated and finally the data collection tools and analytical methods employed will also be discussed.

The Research Paradigm

The study is evaluative in nature and is situated in the qualitative research paradigm. This is contrasted from the conventional quantitative or agricultural – botany (classical) paradigm which fundamentally deals with pre-ordinate (pre and post - tests) experimental designs and relies on the replicability of the ‘tests’ involving deductive methods and quantitative data (Worthen and Sanders, 1987: 17). The classical (scientific) view of evaluation practices is that, evaluations need to be objective and describe in quantitative, empirical terms whether or not the goals of a curriculum are being achieved. This approach proved to be limiting and hence the development of the qualitative (ideographic) approaches to educational evaluation. The agricultural – botany approach cannot capture the individuality and unique characteristics of particular educational situations as it treats all situations as “nomothetic activity” (Eisner, 1985: 138). The study does not talk to curriculum design and development, nor is it about curriculum planning and development. It focuses on adjudicating the ‘worth’ of the curriculum innovation.

Illuminative evaluation, using anthropological tools seeks to ... describe, interpret and take(s) account of the contexts in which educational innovation must function ... (Parlett and Hamilton, 1976: 86). It focuses attention on the importance of classroom practice (learning milieu) by describing what actually happens in the classrooms. It looks for

‘matches’ and ‘mismatches’ between the learning milieu and the planned curriculum (i.e., the instructional system, comprising all that is planned and written down as curriculum). The planned curriculum is essentially a set of documents that delineate the programme’s ... aims and objectives, content, teacher pedagogy and assessment practices ... (SAIDE, 1999: 10). As such, the evaluative process seeks not only to look for relationships between phenomena. It asks the question ‘why’ these relationships exist. This evaluation is thus important for programme modification due to the increased responsibilities and resources that are now allocated to education and all its related activities. Evaluation thus, is used for accountability.

Illuminative evaluation, as with all evaluation approaches, aims to arrive at adjudications concerned with the efficiency and effectiveness of programs. Any program or process should be effected in a way that it is not wasteful of resources. It should also utilise such resources effectively and efficiently to avoid wastage and primarily, it should set out to perform or do what it is intended to (Farrant, 1964, Worthen and Sanders, 1987, SAIDE, 1999). Curricular evaluations look at adjudications of worth, to evaluate or assess whether the curriculum is being implemented as intended; if comparative, to check the relative worth of curriculum; and test out “the goodness of fit between statements of content to be learnt and its actual accomplishment” (Tyler, 1949 cited in SAIDE, 1999: 12). Illuminative evaluation draws extensively from anthropology and focuses attention on describing what happens in the classroom (Parlett and Hamilton, 1976). From its descriptive approach, it aims to ask the question “why” there exist relationships between phenomena.

As a qualitative paradigm, it reports the emic perspective to curriculum evaluation and is not overly dependent on reference to measurement and assumptions underpinning scientific research / evaluation, where there is emphasis on large sample sizes, randomisation of sample subjects, validity and reliability of the data, numerical confidence in the data etc. and the rigor with which these measurements ascribe to. It also

... restores the “human face” to evaluations ... (and) the evaluator’s voice is one amongst many ... (Parlett and Hamilton, 1976: 86). The challenge to its validity is to investigate the issues in depth and present an in-depth penetration or description of issues where the strength of the argument is explicit in the rigor with which the argument is presented and is not dependent on the numbers. This is achieved through the utilisation of all research tools, including ethnographic and scientific research tools / techniques. The triangulation of data sought also adds to the validity and rigor of the analysis and findings of the study (Crowley and Vulliamy, 1984; Cohen and Manion, 1994).

As it brings the emic perspective to the research study, the researcher does not approach the project with preordained hypotheses that need to either be validated or refuted by the research findings. Illuminative evaluation recognises that curricular innovations cannot be separated from their associated learning milieu. The ‘context’ of the learning becomes an important aspect of the evaluation process.

Illuminative evaluation contextualises educational innovations. It leads to understanding and increased knowledge of a program or innovation in its own terms or context. By recording, describing and interpreting what actually happens in the classrooms and taking into account the contexts in which the innovation occurs given the instructional system (curriculum documents, learning sheets, educational catalogues, reports), the illumination is unearthed and any matches and mismatches are exposed between the intended and the actuality. With illuminative evaluation, emergent issues which would ordinarily be ignored (for example, in the agricultural – botany approach) may be focused on and may influence the direction of the study (SAIDE, 1999). As such, these emergent issues can be progressively focused on and may open up possibilities which would otherwise not be considered. It thus seeks to address a complex array of questions (Parlett and Hamilton, 1976). Additionally, the evaluator’s voice is one amongst the many voices, whereby a collegial adjudication is arrived at. The evaluator is never the authoritative and only voice and needs to be seen as an honest broker during the process.

Research Problem

A problem based learning hybrid curriculum fashioned against the Adelaide model was introduced to the SOHS in 2001, in every department (Townsend, Winning, Wetherell, and Mullins, 1997). Inherent within this was the transformation of teaching and learning strategies where integrated, interactive learning was to take place in small, student centered problem based learning groups and integrated learning sessions. Furthermore, assessment was to be continuous, utilising a variety of assessment tools and methods. The change from traditional curricular worldwide was prompted by several changes that the profession was undergoing worldwide driven primarily by reform in medical education (ADA, 1994; DePaola and Slavkin, 2004; Kersten, Vervoorn, Zijlstra, Snyders Blok and van Eijden, 2007; Aldred, Aldred, Walsh and Dick, 1998).

The reasons for undertaking such a study were informed by the fact that little had been done to evaluate the hybrid PBL curriculum within the discipline of prosthodontics. With any innovation, it is imperative to have it evaluated some time following the implementation of the change, after the innovation has been in place for a while. The evaluation is also needed to assess whether what was intended is being realised. Additionally the evaluation gives the stakeholders an opportunity to objectively review whether the innovation is effective, efficient and utilitarian. No extensive, formal evaluation of the teaching and learning activities in prosthodontics within the SOHS had been undertaken. There is generally, therefore, an absence of a systematic documentation of issues that relate to the prosthodontics curriculum and its effectiveness in achieving its intended aims as informed by the hybrid – PBL curriculum principles. The absence of this makes it very difficult to make any judgments about the strengths and challenges or possible shortcomings that the programme may have. Any judgment made would therefore be anecdotal and be devoid of any evidence that is the cornerstone of ‘evidence – based’ practice informing teaching and learning practices.

The main focus of the study was to evaluate whether and how a department had managed to move from a traditional, teacher centered, lecture - based pedagogy towards more interactive, student centered, small group focused and contextualised learning and teaching strategies and if it has been able to equip dental students adequately in the field of prosthodontics. It sought to reveal how the programme operated in its own terms, and how well it lived up to its intentions and whether these intentions were being realised. Therefore the study was to adjudicate if prosthodontics was being taught as intended in the hybrid – PBL curriculum, or if it remained much as before as a content focused discipline without having adopted the innovations' principles.

The study addressed the following research questions:

- i) In what ways are the intentions of the prosthodontics programme within the hybrid PBL curriculum being realised, or not?
- ii) What, if any, issues emerge during the observation phase?

In response to the first question, the study sought to establish how contemporary pedagogy informing PBL practice was been utilised within the discipline of prosthodontics to teach the subject (i.e. prosthodontics). It sought to establish how prosthodontics as part of a hybrid PBL curriculum was being taught. This was principally to ascertain how the principles informing problem based learning philosophy were being used in teaching prosthodontics; namely: problem solving, critical clinical reasoning, activation of prior knowledge, integration of knowledge, group dynamic, student centeredness.

With respect to the second question, any issues that emerged were to be taken cognisance of and if upon further probing, were seen as important to the programme, these were made available to the rest of the department through discussions with the staff members

and at meetings within the department that discussed educational matters, specifically, the undergraduate prosthodontics programme.

The study thus has the potential to add the following benefits (if taken up):

- a) Assist in refining the prosthodontic programme by identifying gaps in the pedagogy adopted or inherent in the hybrid PBL curriculum.
- b) Provide evidence based baseline data that may assist the department to justify or inform their teaching practices.
- c) Add some degree of improvement of educational practice to the prosthodontic programme at the SOHS (McMillan and Schumacher, 2006).
- d) Assist other departments within the SOHS with their programmes to better fine tune these. It is important to note that, whilst the findings will not be generalisable to the other programmes in the SOHS, it may nevertheless be of benefit to these disciplines by providing insights about issues and methodologies for investigating and evaluating such learning and teaching strategies in such curricular.

Therefore, the study may potentially add value to the whole SOHS hybrid PBL curriculum and not only be of benefit to the discipline under investigation. What is evident is the value it may inherently contribute to the discipline under review as it could assist in the ‘fine tuning’ of the programme.

Conclusion

The decision to use qualitative research methodology was made as there had been no studies done to evaluate how the curriculum innovation in and within the school was being realised. Instead there had been some studies which used quantitative methods to

investigate certain aspects of this innovation. Additionally, the rigid quantitative scientific method of controlled experimentation may not possibly be considered completely valid in an environment where there are 'contexts' that are multi – faceted and complex, therefore elude the 'tight control' that is expected of the quantitative research paradigm.

CHAPTER 4: THE RESEARCH METHOD

This chapter will focus on describing how the study was performed, the instruments used; how data sets were obtained and analysed. It will also give an explanation of the ethical considerations and limitations brought to bear during the study.

The study was conducted at the School of Oral Health Sciences, University of the Witwatersrand using participants in the Department of Prosthodontics, i.e., final year undergraduate dental students (BDS 5) and faculty. Following Parlett and Hamilton (1976), methods employed during the undertaking of the project included selecting samples purposively (McMillan and Schumacher, 2006) to ensure that there was good reason for using the sample to establish worth; ethnographic research methodologies including naturalistic observations and probing follow – up interviews (Spradley, 1979, 1980) to describe what actually happened during the lessons, were used.

Documents which were utilised included: the Prosthodontic curriculum, notes from departmental meetings and workshops and information provided to the students via the yearbooks about the programme were also used to inform the instructional system. What was planned for Prosthodontics was established through analysis of these documents. There were no specific ‘curriculum’ documents that mapped out the pedagogical methodologies and philosophies to be used for the delivery of the course, however documentation from the SOHS Teaching and Learning Committee were used for this part of the instructional system.

From July through October of 2007 two staff members / Faculty in the School of Oral Health Sciences who taught in the final year prosthodontics programme were observed during the small group case based problem based learning sessions. Each lesson was scheduled to last two hours and each case was completed over three meetings, therefore, in total twelve hours of lessons equating to eighteen conventional teaching lessons, were observed and recorded. The case based problem based learning sessions running as two hour sessions equate to three 40 minute classroom teaching sessions. Initially there were three such cases planned for observation, however, the

third case based problem based learning session was cancelled by the relevant department (Appendix 1 – notice re cancellation).

The observations sought to record descriptive details about who, where, how and why an activity or social scene occurred. Extended observations of participants in the various contexts, afforded the researcher to elicit data that are almost impossible to obtain with other approaches. These unstructured observations were used to document the staff members teaching behaviours. The purpose of the observations was to describe the activities or behaviours that took place in the setting. It is argued that this would allow the researcher to be open, discovery oriented and inductive because the researcher would be less likely to rely on prior conceptualisations of lesson teaching. It would also allow the researcher the opportunity to discover things that no one else may have really paid attention to and a chance to learn things that people would be unwilling to discuss in an interview (Patton, 2002).

Following the lesson observations, probing follow – up interviews were conducted with both faculty and student participants to delve deeper into the observed phenomena in order to seek clarity on what transpired during the lessons. These also assisted in unpacking any emergent issues which needed to be looked into in detail.

One of the strategies employed during the student participant interviews was to approach the student participants with broad questions regarding several aspects of the prosthodontic programme (McMillan and Schumacher, 2006). This enabled the researcher to obtain the participants perceptions of the programme expressed as tacit and non-tacit feedback - feelings, thoughts, beliefs etc.

The core of seeking and corroborating different perceptions lies in obtaining data from multiple data sources – different persons in different contexts at various times. Trustworthiness of the data was achieved through verification procedures such as using different ethnographic tools such as naturalistic observations of the lessons (Spradley, 1980), prolonged engagement in the field and triangulation of data. All this

was to enrich the argument and build confidence in the findings of the study. In this study, lesson observations, follow – up probing interviews of participants, documents where comparisons were made between what was planned and what actually happened in order to evaluate the course ‘in its own terms’ so as to record the emic perspective and give it voice to add to the worth of the course were the research tools used.

Permission was sought and obtained from the Head of the School / Dean (Appendix 2 – letter of approval from the Dean) to conduct the study. Additional permission was sought from the head of department prior to conducting the study and observing the lessons. Student participants were also informed of the study and permission was obtained from all participating students for consent to be observed and interviewed. All participants were assured on the maintenance of anonymity and their right to withdraw their participation at any point during the study, fortunately none chose to withdraw consent. Participants who were observed signed a letter of informed consent and the nature and reasons for the study was explained to them (Appendix 8 & 9). Ethical clearance (Letter of approval dated: September 27, 2007: PROTOCOL 2007ECE81) was obtained from the relevant ethics committee of the Faculty of Humanities (Appendix 7).

Sampling

Purposive sampling was utilised whereby due to the researcher’s intimate knowledge of the department of prosthodontics in the School of Oral Health Sciences, DLPs (Dental Learning Packages) which had a lot of prosthodontic content were selected. Additionally, staff members who were deemed to have the ability to provide the best information to address the purpose of the study were selected and observed during the lessons. This was done in order to provide ‘information rich’ data. The final (fifth) year prosthodontics course was also chosen for evaluation as it was deemed to be

sufficiently integrated as per the underlying principle of the curriculum innovation being studied. Purposive sampling is done to increase the utility of information obtained from small samples (Schumacher & MacMillan, 2006). The power and logic of purposive sampling is that a small sample / number of cases studied in depth would yield many insights about the topic. In this particular study, two groups of up to twelve students were selected for observation during the execution of the small group problem based lessons for DLPs which had a high prosthodontic content, even though they (the DLPs) were not 'prosthodontics – specific'. The cases were discussed over three contact sessions which were each intended to last for two hours. The lessons were scheduled such that groups met every alternate week, resulting in the lessons occurring over a six week period for each DLP.

Purposive sampling was utilised wherein final year undergraduate dental students and specific faculty were chosen as participants for the study – twenty four dental students and three faculty were observed and two were interviewed. Participation in the study was voluntary. The lessons observed were small group lessons comprising on average eight students facilitated by one faculty. All faculty involved in the study were senior members of the department with extensive subject content and teaching experience. Additionally there were specialists in the field of Prosthodontics especially the branch of Removable Prosthodontics. They had been extensively involved in the planning of the curriculum innovation that informed the hybrid – PBL curriculum in place at the School. All the faculty had at one time or another been part of the educational committee (EDUCOM or latterly known as the Teaching and Learning Committee) for the School.

The decision to use a purposive sample was so that a potentially information rich data source was selected in order to have a sample that was most likely to yield fruitful data in order to allow for an in depth study of the phenomenon. Particular faculty from the Department of Prosthodontics who were informative about the innovation were selected. This was enabled by the researcher's knowledge of the population and judgement as to which staff to select in order to have the best information to address

the purpose of the study. The cases studied were selected similarly whereby, only those with an increased degree of prosthodontic management were selected for the study. The decision to observe the final year student group during the case based integrated lessons was also informed by the notion that, as final year students they were better positioned knowledge wise to integrate information derived from various disciplines of dentistry in order to manage the learning required of them during the lessons.

The lessons observed were small group lessons comprising on average eight students facilitated by one faculty. In order to enhance the validity of the study, several strategies were employed, amongst which included:

- a) The use of multi method strategies to allow for triangulation of the data during collection and analysis
- b) Recording participants verbatim accounts of the learning milieu to capture their 'voices'
- c) Employing low – inference descriptors to enable the recording of precise, almost literal and detailed descriptions of the people and situations
- d) Utilising audio recording equipment to assist in capturing the participants voices / accounts
- e) Using actual accounts of what happened in order to assist with corroborating the findings
- f) And last but not least, using some of my colleagues to act as 'devils advocates' during the analysis of the data in order to check informally on my interpretation of the findings.

Research Instruments

Ethnographic tools used included naturalistic observations, probing interviews and document analysis. In order to validate the data collected, the different research tools were triangulated to increase the 'trustworthiness' of the data. The core of seeking and corroborating different perceptions lay in obtaining data from multiple data sources.

Naturalistic Observations

Extended observations of the participants during the lessons, afforded the researcher the opportunity to elicit data that are almost impossible to obtain with other approaches. Field notes were taken during the lesson. Much of the field notes noted how the group interacted, including how the facilitator managed the dynamics in the group and some of what was discussed. The responses were recorded against time. Participants' sat down around rectangular tables for the duration of the lessons, barring the student who acted as the 'scribe' for each particular lesson. This student stood by the whiteboard in order to record on the whiteboard what was being discussed. The seating arrangements were recorded for the small group discussions. The scribe spent most of the lesson at the whiteboard recording points from the discussion. A diagrammatic illustration of where each participant sat was drawn - up (Appendix 3 - seating arrangement at each small group lesson). The observations sought to record descriptive details about what happened during the lessons.

Unstructured observations were used to record the group (participants) members teaching and learning behaviours during the lesson. As stated earlier, the purpose of the observations was to enable the researcher to describe the activities or behaviours that took place in the setting. This was to allow the researcher to be open, discovery oriented and inductive as the researcher would be less likely to come with preconceived notions of how the lessons needed to be conducted. It would also allow the researcher the opportunity to uncover aspects of the teaching and learning

practices that may not have been overt from discussions during the department's meetings and workshops (Patton, 2002). It was hoped that this would provide an extensive description of the learning milieu and help unearth any emergent issues that needed to be followed up on during the interviews, as prescribed by the illuminative evaluation methodology.

Self - monitoring by the researcher for bias is an important element in qualitative research. This is essential for objective reporting of data, as being the primary research tool it poses certain limitations of the researcher as the instrument. The researcher's degree of sophistication in data collection and aspects of personal biography might contribute to bias - be it positively or negatively. This aspect of the research method was an issue that the researcher was cognisant of throughout the study, and will be expanded on further later in this chapter.

Probing Interviews

Follow – up interviews were also conducted, with both staff and students, and these were audio – recorded and transcribed. It was difficult to conduct the follow – up interviews immediately following the lessons due to the participating staff members' prior commitments. The students were also scheduled to different activities following the problem based learning sessions, therefore it was also impossible to interview them immediately following the conclusion of these lessons. Interviews were conducted at a later time, however every endeavour was undertaken to conduct the interviews not long after the observed lessons. This was to mitigate against participants forgetting what transpired during the lessons, so that a more fresh recollection could still be obtained (Appendix 4 – Student and Faculty Interviews).

Discursive, unstructured interviews (McMillan and Schumacher, 2006; Spradley and McCurdy, 1988) was one of the strategies employed during the student participant interviews whereby the student participants were approached with broad questions regarding several aspects of the prosthodontic programme. These provided participant

insights into the course. This also enabled the researcher to obtain the participants' perceptions of the programme expressed in their own voices and feelings. It is argued that this allowed the participants to not feel restricted as they may possibly have had they needed to answer a structured interview schedule with predetermined questions.

Documents Analysed

Documents from the Department of Prosthodontics outlining the programme and the School Teaching and Learning Committee (formerly EDUCOM) minutes were studied in order to explore how they guided the teaching and learning strategies in the said department. Dental Learning Packages were utilised for the study. DLPs are paper – based clinical cases. The format of how the problem based learning sessions run utilised the method as suggested by Schmidt and commonly known as the “Seven Jump” strategy (Schmidt, 1983 cited in Moust, van Berkel and Schmidt, 2005) and formed part of the instructional system. One of the chosen DLPs discussed treatment planning for different socioeconomic scenarios and the other DLP observed involved treatment planning a case for a ‘special – needs’ patient. Both these DLPs had a strong component of prosthodontics consideration. Together, these documents made up the instructional system which was used for the study (Appendix 5 & 6 - IS & DLPs documents).

Documents that were studied included material with information on the aims; intentions; content and context; competencies expected of the dental students in the discipline of Prosthodontics and the actual ‘paper cases’ that formed the DLPs. These documents, therefore, had the potential to act as an information source on the instructional system. These documents were scrutinised and analysed, using a selection of techniques for qualitative content analysis (McMillan and Schumacher, 2010) including:

- i) Locating the documents and sourcing them from the various offices such as the Department of Prosthodontics administrative office and The SOHS Teaching and Learning committee chairperson.
- ii) Identifying the relevant sections within the sourced documents that relate to the study and provide a source of information to assist with understanding the instructional system.
- iii) Critically analysing these identified documents to best serve the purpose of the study.

In instances where clarity was needed relating to any aspect of the documentation, faculty within the department availed themselves to informal discussions to assist in obtaining a better or increased understanding of the documentation. Faculty were also used to play the ‘devil’s advocate’ role and to assist in self – monitoring for bias in order to ensure objective reporting of data (Mason, 1996 cited in Behar – Horenstein, Mitchell and Dolan, 2005).

Part of the aim of this study was to add some degree of improvement of educational practice to the Prosthodontic programme at the SOHS (McMillan and Schumacher, 2006).

Ethical Considerations

Written formal permission was sought from the Head of the School of Oral Health Sciences to conduct the study. Verbal permission was obtained from the Head of the Department of Prosthodontics and informed consent was solicited from all the study participants – students as well as staff members who facilitated the lessons.

Participation in the study by all was voluntary and it was explained that participation could be cancelled at any point during the study. Participants were assured that their anonymity would be maintained and particular care was noted regarding the power

relations between the student participants and the researcher due to the fact that the latter was part of the teaching staff in the department where the study was being conducted. All names used in the study are fictitious (in both the lesson observations and interviews) and the researcher assured the participants that the data would be kept confidential, used only for academic purposes. The raw data was only available to the researcher. After completion of the degree and following publication in an academic journal, all data will be destroyed.

Analysis of Data

In order to make sense of the observational data and the interview transcripts obtained from the participants during the study, data was broken down into themes / codes during analysis and categorised, thereafter relationships between these categories were sought and acknowledged and themes identified. This will be discussed in chapter 6. Themes were inductively generated during data analysis, although I had started with a limited number of predetermined descriptive categories in order to facilitate the data analysis stage, following Miles and Huberman (1984).

Analysis of the interviews consisted of thematic analysis which was inductively generated during the data analysis (Miles, 1981). Interpretation of the themes and coding data was a collaborative effort between the researcher and faculty within the department who had extensive experience in prosthodontics and educational experience. Collaborating on identification of the themes was done using that suggested by Denzin and Lincoln (2005) so as to eliminate bias or assumptions that may arise when data is reviewed. The technique used for thematic representation and data coding used some aspects of those suggested by Taylor and Bogdan (1998). This protocol included:

1. Looking for words and phrases that capture the meaning of what is said

2. As a theme is identified, comparing statements with other subjects and seeing if there is a concept that unites them and
3. As different themes are identified, looking for similarities between them.

Limitations of the Study

Several factors raised limitations with the study. Included amongst these was the difficulty in having the opportunity to observe all the different contexts for teaching and learning opportunities in the department. There were several different teaching and learning opportunities available such as clinical sessions; tutorial sessions and integrated learning sessions / platforms. In the clinical sessions students are involved in the actual clinical treatment / management of 'real life' patients and are responsible to render all the clinical requirements for patients. This is instituted under supervision by qualified dentists and specialist prosthodontists. The tutorial sessions concern themselves with delivery of the majority of the didactic programme where the theory which informs clinical management is taught. The integrated learning sessions / platforms bring together several disciplines for the discussion of multidisciplinary clinical cases. This involves the discussion of management / treatment strategies for paper cases where the required treatment is not confined to one discipline only.

As mentioned earlier another limitation was due to the scheduling constraints which did not allow for immediately interviewing participants following the lessons. This may have resulted in some participants forgetting details of what had transpired during the observed lesson. Additionally, cancellation of one DLP later in the programme reduced the number of possible observations. More lesson observation may have enriched the data source.

The absence of a prosthodontic specific DLP was a major limitation as one could not specifically look at the content given during the lessons against what was planned. As

the DLPs were multidisciplinary cases, the prosthodontic content had to be looked for amidst the rest of other discipline content. However to minimise this limitation, DLPs with a high prosthodontic content were selected for observation.

The fact that the curriculum was a hybrid – PBL curriculum, and not totally PBL based, meant that the clinical disciplines teaching was mainly traditional (conventional) based, i.e., lecture based and ‘teacher – centred’. However, the department used in the study had undertaken to shift and align their teaching and learning strategies with the principles informing the innovation. The hybrid nature of the curriculum provided its own challenges in that delivery of content from different courses may not be aligned with each other to ensure temporal delivery of content between different departments.

As the researcher was a principal member of the department and was the person conducting the interviews, this may have had some degree of influence on data collection whereby the students may not have felt free to express their views openly. This was countered by actively reassuring students that their comments would never be used against them, and instead were to be used for the purpose of the research study and providing feedback to the department to modify and enrich the course. This could impact via uptake of the positive aspects of the programme that the students identified and curtailing those aspects of the programme that were deemed negative on the learning process wherever possible.

Other issues that needed to be considered with the employment of ‘researcher as instrument’ included the researcher’s degree of sophistication in data collection and aspects of personal biography that might have contributed to bias (Locke, Spirduso and Silverman 1993 cited in Behar-Horenstein, Mitchell and Dolan, 2005).

A challenge experienced was the missed opportunity to observe every aspect of the different components of the prosthodontics programme. The observational opportunity derived only extended to the small group problem based learning teaching

sessions / lessons. This was basically due to personnel challenges in the department as the researcher was also an active member of the teaching staff and could not be released from some of the department duties. However, being a member of the department that was being employed for the study, invaluable experience pertaining to the programme was had.

Furthermore, the follow up probing questions could not be scheduled immediately following the lesson observations as both students and faculty in most instances had other commitments following the lessons. The interviews were thus scheduled some time after the lessons. However, an attempt was made to schedule these not too long after the lessons were observed, i.e., within a couple of days following the lesson observations. With some of the student interviews, it was possible to follow up a few hours after the lesson observations.

Documents outlining the instructional system were also not readily available, and a lot of reliance was placed on discussions between the researcher and professorial faculty within the department especially when analysing the philosophies underpinning the pedagogy used. This was also assisted by the fact that the researcher had been an integral part of the problem based learning component for the school curriculum and therefore had an insider view of what was expected.

Conclusion

As explained in this chapter, the study used the illuminative evaluation methodology, within the qualitative research paradigm. The phenomenon under observation did not rely on studying preordained theory or criteria. This served as a basis for the eventual research findings. Due to the descriptive and interpretative nature of the study, there would be a degree of subjectivity with the study findings, however, because an increased effort went into injecting ‘trustworthiness’ into the research methodology and interpretation of the findings, it is suggested that the research design described above resulted in findings to which a high degree of validity can be ascribed.

The study focused on observing a single educational phenomenon within the prosthodontic department, its findings can therefore not be ascribed to the whole curriculum encompassing all the disciplines within the SOHS, nor to every aspect of the prosthodontic curriculum. Nevertheless, the study does provide insights into how the department had aligned its teaching and learning practices with the principles underpinning the curriculum innovation within the school. It is hoped that the findings may be used with findings from other research studies on similar curricula and be taken up at the observed school by the different disciplines to align and refine their programmes positively. It is also hoped that other institutions elsewhere with similar curricula can use these findings comparatively to enable generalisations to be drawn and thus enrich the teaching and learning in dentistry.

CHAPTER 5: THE PROSTHODONTIC PLAN

In response to the research question:

In what ways are the intentions of the prosthodontics programme within the hybrid – PBL curriculum being realised, or not?

data from documents such as:

1. notes from departmental meetings and the Teaching and Learning Committee of the SOHS
2. programme / course documents including lecture notes
3. programme / course documents that were issued to students
4. the DLP cases that were to be discussed

were used to draw up the instructional system. These were used to establish if the teaching had shifted to adopt the intentions of the innovation pertaining to the prosthodontic programme.

THE PROSTHODONTIC COURSE

The curriculum under consideration was formally identified as:

OHSC 501 2007: Component 1: Fixed & Removable Prosthodontics and formed part of the Bachelor of Dental Surgery. It was scheduled to run a full academic year from January until November 2007 (Appendix 5).

Aims of the Prosthodontic Programme

As reflected in its name, the course comprised both removable and fixed denture therapy, where the latter dealt with management of dental disease via the provision of fixed dentures in the form of cast restorations such as crowns, bridges and implants. The removable prosthodontic component dealt with the provision of removable dentures either as complete or partial dentures, for the management of tooth loss. The overall aims of the course may be summarised under the different components as follows:

Removable Prosthodontics - Complete Dentures

1. To appreciate the changes in the form and function of the mouth and jaws, brought about by the total loss of teeth and the possible social and behavioural consequences of tooth loss.
2. To be able to critically evaluate the influence of complete dentures on the remaining soft tissues and the underlying bony structures.
3. To help in understanding the scope and limitations of complete dentures together with the bio-compatibility and physical properties of the materials used in their construction.
4. To understand the socio – economic consequences of tooth loss and replacement and the role of a complete dentures service for communities served and in relation to a national oral health policy within a national health service.

Removable Partial Dentures

1. To gain an understanding of the changes in the form and function of the mouth and jaws brought about by the loss of some teeth and the possible social and behavioural consequences of partial tooth loss.

2. To be able to critically evaluate the influence of partial dentures on the remaining teeth and soft tissues.
3. To understand the scope and limitations of partial dentures together with the bio – compatibility and physical properties of the materials used in their construction.
4. To understand the socio – economic consequences of partial tooth loss and replacement and the role of a comprehensive denture service within a national health system.
5. To know the biological and functional principles to be followed in designing appropriate removable partial dentures.

During the discussion of the first DLP case, it was evident that students did demonstrate some degree of understanding of the above outcomes when they discussed the impact of the socio-economic consequences of dental intervention (Appendix 3), especially in relating this to the type of management strategies that they proposed for the case. Factors that were considered during the students' deliberation of the case brought out a number of factors including the relevance of age, social status, biological influences on denture design, amongst the issues discussed.

Fixed Prosthodontics

1. To understand the development of the masticatory system and the natural dentition from a bio - functional perspective.
2. To understand the consequences of alterations of the form of the external contours and surfaces of teeth on the stomatognathic system.
3. To be able to evaluate the need for fixed prosthodontic intervention and the long term consequences of the technologies used.

4. To be able to evaluate the alternative procedures available for the replacement of missing teeth and to assess the viability of a fixed, as opposed to removable, prosthodontic solution.

The discussions that were had by the students, when they first encountered the DLP cases, demonstrated that students had some understanding of the issues that were pertinent to the management of the cases (Appendix 3). Most of the outcomes for both the removable and fixed prosthodontics programme were touched upon, albeit not to an increased level of discussion. The discussions tended to be on the superficial level.

The prosthodontic course was structured such that there were pre - clinical / techniques courses given to the students prior to the students being introduced to the clinical aspects of dental care delivery on patients, in order to prepare the students for the clinical practice of whatever component of prosthodontics the patients who attend for dental treatment at the Dental Hospital may require. Students acquired procedural skills in the skills development laboratory (Techniques Laboratory) before starting clinical treatment of patients.

The pre – clinical technical courses ran in the second and fourth year of study with the removable prosthodontics techniques aspect being delivered in the second year and the fixed prosthodontics techniques aspect delivered in second term of the fourth year. The pre – clinical courses focused on the technical aspects of the procedures that are used in removable and fixed prosthodontics. For instance, with removable prosthodontics, the techniques course equipped the students with the cognitive and technical skills required for the provisioning of complete dentures. Students were taught how to fabricate different classes / types of complete dentures; how to set up the teeth using anatomical tooth forms for the different classes / types of jaw relationships; how to do the final waxing up of trial dentures, their flasking, packing, curing, deflasking, remounting and finishing. They were

also taught how to repair simple common denture faults such as a mid – line fracture, replacement of a missing tooth and the addition of a flange to a denture.

The cognitive skills emphasised included understanding the form of the dental arch and the edentulous ridge arch form; the skeletal relationships and incisal relationships according to Angle's classification; the use of simple average value articulators and the recognition of common faults in the technical aspects of complete denture construction and their correction.

With respect to removable partial dentures, there was no dedicated pre – clinical techniques course due to the infra – structural limitations of the laboratory space. Instead all the teaching was delivered via actual patient treatment and tutorials which emphasised the theory required and hence gave the students the requisite cognitive knowledge.

The fixed prosthodontics pre – clinical techniques course focused on teaching the students the actual technical skills required in preparing teeth for the various restorations informing fixed prosthodontics and how to use the required relevant tools and diagnostic aids during the provisioning and / or fabrication of such restorations. Students were taught how to use a more complex articulator requiring a face bow- transfer, custom incisal guide table, and the recording of various inter – occlusal records to enable the programming of such articulators. These were utilised during the occlusion course to facilitate the understanding of how the stomatognathic system works in relation to dental therapy. In addition they were taught to make the appropriate provisional restorations which are needed as part of the procedure.

The pre-clinical programme is meant to equip the students with the necessary psychomotor, as well as cognitive skill sets, to enable them to undertake clinical patient

management. Emphasis on the required diagnostic skill set is done during the provision of dental care to patients where more contextualised clinical training happens. However, diagnostic methodologies were taught in the didactic part of the programme as well, during tutorials, integrated learning sessions (case based PBLs) and in the PBL programme.

Integration of the pre-clinical and clinical curriculum is paramount to the success of the undergraduate dental student. In the fixed prosthodontics techniques course basic prosthodontic principles were taught to enable the student to accomplish various clinical procedures necessary in fixed prosthodontic. Emphasis was placed on treatment planning and management of the prosthodontic patient.

The pre – clinical course consisted of tutorial and laboratory / techniques sessions sequenced to provide maximum integration between understanding the principles of diagnosis and management of the prosthodontic patient with the technical skills required to perform fixed prosthodontic procedures. The tutorials also introduced and reinforced the fundamental principles associated with the related laboratory exercises. At the introduction of each new procedure, a demonstration / tutorial was given to outline the specific exercises that needed to be performed during that and subsequent sessions.

OHSC 501 Removable and Fixed Prosthodontics presumes a conceptual understanding of prosthodontics as competencies and the various skills sets relating to previous years of study are reviewed and greater depths of understanding pursued. It builds upon the conceptual foundations laid in the pre – clinical, clinical and didactic parts of the course from the first year of study. It also assumes that students have acquired certain knowledge in the medical and basic sciences which will be built on during the course such as in anatomy, physiology, pathology, pharmacology, oral biology, physics, chemistry and biology. The prosthodontics programme focuses on creating opportunities

for students to develop certain competencies throughout their training. Therefore the emphasis is not on achieving various 'objectives'.

Students are expected to develop different skill - sets pertaining to:

1. Cognitive
2. Psychomotor
3. Technical
4. Clinical
5. Diagnostic and
6. Interpersonal skills.

These inform how students are expected to view patient management – as an holistic and comprehensive approach – and not only focusing on the individual treatment procedures that they are required to master in order to obtain the requisite skills before moving on to the different levels of clinical competence.

The interpersonal skills that have to be developed focus on the ability of the student to motivate the patient to the degree of behaviour modification required for the establishment, and maintenance of the level of oral health required for the successful longevity and wearing of the dentures or restorations provided, be they removable or fixed prosthodontics. Additionally, students are encouraged to develop a realistic perception of their own limitations and potential in carrying out clinical procedures and arriving at appropriate diagnoses. As prosthodontic treatment involves working with other personnel in the dental team, emphasis is also placed on students developing recognition of the importance of working and communicating effectively with other members of the dental team.

Within the Department of Prosthodontics, all this is facilitated via the utilisation of varied teaching and learning strategies such as:

1. The traditional lecture
2. Interactive tutorials
3. Clinical sessions
4. PBL lessons and
5. The multidisciplinary teaching platform of integrated learning PBL sessions as well as alignment of the assessment philosophies to encapture the principle of continuous assessment.

As stated in the previous chapter, classroom observation only involved the PBL lessons and none of the other teaching and learning opportunities. During these observations, intentions of the prosthodontic plan were looked for to check if these were actually occurred and realised. Through these, realisation of the PBL process was looked for and matched against what was planned and what actually transpired. Below is a discussion on the PBL process as it was planned for the School, and to which the small groups observed would have followed.

Principles of PBL Instructional Methods and Techniques and Description of their Intended Learning Processes

With respect to the teaching strategies employed in the prosthodontic department, Faculty in the discipline were expected to teach according to the principles informing the curriculum innovation. A lot of emphasis was therefore made by the department, through regular departmental workshops and meetings, to instill and clarify any issues explaining PBL philosophy and contemporary pedagogy to enable Faculty to utilise the latter teaching methods even when teaching within the core discipline.

Problem – based learning is designed to address three critical educational objectives:

- the acquisition of deeply understood knowledge that is integrated from a wide variety of disciplines and required to analyse and solve patient problems
- the development of effective clinical problem solving, self - directed learning and team and interpersonal skills
- the development of curiosity and the desire to continue learning (Behar-Horenstein, Mitchell and Dolan, 2005).

These principles are reflected in the educational philosophy which was adopted for the institution's curriculum innovation and which the prosthodontic department supported. These included striving for academic excellence in order to graduate competent dental professionals; creating a humanistic educational environment which was cognisant of the broad public health issues; inculcate a values system that embodies integrity, fairness and cooperation as well as having Faculty who integrate and facilitate effective and active learning in order to produce graduates who possess and demonstrate knowledge and skills in cognitive, psychomotor and affective domains. Additionally, the assessment policies were to offer both formative and summative assessments and provide continuous, timely and constructive feedback. Assessments were also to be structured in a way that they assessed increasing levels of complexity with emphasis in the senior year towards clinically applied integrated and comprehensive problems. Problem – based learning is grounded in the literature of cognitive psychology particularly through its emphasis on learning in context, activation of prior learning and elaboration of learning (Schmidt, 1983).

The actual problem – based learning DLP cases that were observed had objectives that were in line with general aims of the programme. With regard to case A, the DLP was designed to allow students to consider treatment alternatives using an actual patient who had been treated by Faculty in the Dental Hospital clinics and case B was planned so that it could start broadening the students concepts governing patient treatment and assist

them on how their approach to patient management to suit different kinds of patients with special needs. The case was also structured such that knowledge gained from discussions during the lessons would form a basis for detailed studies in different core components / subjects (Appendix 6).

Critical thinking and reasoning skills are imperative in the area of treatment planning, as required in one of the DLP cases observed (Case A). Here, context - based information must be horizontally integrated and multidisciplinary based information needs to be vertically integrated in order to design strategies for comprehensive patient care (i.e. treatment / management plans). Traditional curricula, where students typically receive information in a non – interactive teacher – driven lecture format and where clinical teaching is typically organised in a discipline based structure, makes the development of such skills particularly challenging in dental students. Seemingly, problem - based learning curricula has been shown to enhance development of such skills (Schmidt, 1983; Walton, Clark and Glick, 1996; Greenwood, Mullins, Townsend, Wetherell and Winning, 1999).

Students are expected to attend consecutive sessions and meet about 3 or 4 times, depending on the length of the DLP. During these sessions subject – matter and skills are integrated around a central theme. Most of the themes or cases are multidisciplinary in nature. At the start of each DLP, students are offered a specially prepared paper case, which provides them with information about scheduled activities or when they are expected to meet in order to discuss the case and come up with relevant requirements informing the particular DLP. This includes attendance with the faculty as a facilitator of the DLP and group process. Included in the DLP is an explanation on the way the process is to run, what the learning objectives are, a vignette of the case to be discussed with a list of references and other learning resources to facilitate the learning process. The main educational vehicle is the tutorial group, which consists of about ten to twelve students. In their tutorial group, students meet each other for two hours once a week. During this time, students discuss theoretical problems designed by faculty. Some of the cases are

sourced from real patients treated by post graduate students and faculty in the school. Since the problem offered is the starting point of the students' learning process, they are expected to analyse the problem initially based on their prior knowledge from the preceding years of study and other sources. During this phase, students then hypothesise about possible underlying principles, mechanisms and processes that may explain the phenomena described in the problem. They may also be expected to attempt to come up with procedures that could be used to assist in addressing or solving the problem at hand (Schmidt, 1983; Rohlin, Petersson and Svensater, 1998); Seymour and Walsh, 2001). It is through this process that it is expected that a degree of knowledge integration occurs. Additionally cognitive elaboration of the knowledge is expected. As students may run into challenges during this phase, the facilitator is then expected to assist the students either as content expert or process facilitator (Bochner, Badoniva, Howell and Karimbux, 2002). Trained staff / Faculty therefore assume the role of facilitators and are guardians of the group process rather than content specialists. However with the specific small group lesson observed during the study, the staff members served the dual role of process facilitators as well as content specialists.

The prosthodontics programme is thus structured on the basis of early introduction to clinical dentistry and is based on the fundamental philosophies of horizontal and vertical integration; outcomes based education; continuous assessment; student centred approach and problem based learning, with a mixture of the tradition concepts such as teacher centred lecture based. Furthermore, the curriculum is based on three main domains of human biology, health sciences and clinical dentistry which are interplayed appropriately throughout the training whereby in the early years the emphasis is more on the first two which gradually decrease later on; whereas the clinical dentistry component does the opposite, starting as a small component and increasing with each successive year. This is meant to ensure vertical continuity as the two components are meant to align with and support clinical dentistry. The assessment philosophy is meant to provide timely constructive feedback especially in assessing both clinical work and theoretical knowledge informing the clinical aspects.

In summary, the instructional system is the teaching plan (curriculum) that aimed to help students learn in a manner reflected in the broad aims and objectives of the institution's curriculum and needs to be read with the description of the lessons (Appendix 3). What was looked for in the prosthodontic plan included how students and staff used the PBL principles to facilitate their clinical reasoning skills and demonstrate evidence of integration of prosthodontics knowledge in addressing the cases that they discussed during the small group lessons. The findings are reported in the next chapter.

CHAPTER 6: RESEARCH FINDINGS

This chapter will focus on the research findings drawing from the instructional system and the observations of the lessons, including information from the interviews that were conducted with both Faculty and students. These discussions focus on how, using the principles of illuminative evaluation, the prosthodontic – content – rich DLPs were used to adjudicate whether the curriculum innovation was internalised in the prosthodontics curriculum. It therefore seeks to look for matches and mismatches between what was ‘intended’ and what was ‘realised’.

The study has these questions:

- i) In what ways are the intentions of the prosthodontic programme within the hybrid – PBL curriculum being realised (or not)?
- ii) What, if any, issues emerge during the observation phase?

Content analysis of the various documents, as outlined in the previous chapter, together with the lesson observations (see Appendix 3), assisted in generating a description of what was operationalised. Through information derived from observation of the lessons as well as via the interviews, themes were identified.

Themes were derived inductively and categorised as:

- i) The teaching process and processing of the information by the students in the small group contact lessons
- ii) Use of lesson time
- iii) The group dynamic
- iv) Application of the learning experience
- v) Emphasis on integration of the information or content knowledge.

The first three apprise the first research question and the latter inform the second question.

The Teaching Process

In as much as there were no specific documents prescribing the ‘how to teach’, information pertaining to this aspect of the study was derived from document analysis from the various structures such as the Curriculum Task Force later known as, EDUCOM, and currently called the Teaching and Learning Committee; the Prosthodontic Department workshops, documents informing the teaching and learning practices specific to the department (for example, The Year Book) and departmental meetings. What also helped the process was the fact that the researcher had been intimately involved in the development and coordination of the PBL aspect of the hybrid – PBL curriculum and had intimate knowledge of the process as it unfolded in the early stages of the curriculum innovation, as well as being a staff member of the prosthodontic department.

As illustrated in the earlier chapters, in the hybrid – PBL curriculum (Chapter 5), students are taught in small groups of about eight to twelve students. The group meets with its appointed facilitator, who is a member of staff in the school, for two hours once a week for about three to four weeks, depending on the length of the case to be discussed. In each of these cases, the subject matter (discipline / subject) content and skills are integrated around a central theme and these are multidisciplinary in nature. At the start of the DLP, the students are given the paper case, with any other resources as prescribed. The DLP provides them with information about the schedule of meetings, an introduction of the case with the broad aims outlined, and a vignette of the case to be discussed. The main educational vehicle is the tutorial group under guidance of the facilitator who invariably was the content specialist for the cases under discussion. During the two – hour meeting, the students discuss the theory informing the case; they have to analyse the case, initially based on their prior knowledge. During the initial analysis, the students hypothesise about possible underlying principles, mechanisms and processes that may explain the phenomena under discussion and described in the DLP guided by the objectives set for each case. They may attempt to formulate learning issues or concepts that could assist in addressing the case under discussion in order to solve the problem.

At the start of the DLP with the two groups observed, there was some attempt to follow the prescribed PBL methodology. However, the method was not followed as per prescription (see Appendix 6 – in the Facilitator guides where the process is outlined).

With the first group (Group A) the facilitator did not introduce, nor allow the students to introduce themselves. This is reflected in the DLP process wherein the expectation is that as final year students, this aspect of the process need not be performed (see DLP addendum). Instead, he started reading through the DLP and followed that immediately with asking if the students knew about ‘clearing’. Students were not given an opportunity to follow the prescribed pattern of how to conduct the lesson. The explanation given by the facilitator was that:

this group of students have been together for the last five years
and by this time they know one another well enough as they
have been doing DLPs for the last five years

He further went on to argue that

as I was one of the core group of staff involved in the
facilitation of student groups, I have come to know the students
well and felt no need to follow the prescribed process to the letter.
It does not allow creativity with how the process unfolds

This deviation from the process may interfere with the learning process and group dynamic (Moust, van Berkel and Schmidt, 2005; Bhattacharya, Gupta, Jewitt, Newfield, Reed and Stein, 2007). What was glaringly obvious was the fact that the group did not set any ground rules to inform how the process was to pan out. It can be argued that this did not allow the participants to be open about how they wanted to run the process and none of them brought this omission to the attention of the other members. It therefore meant that there were no explicit expectations set that informed how the group was going to conduct the lessons. This may also have had some impact on the group dynamic and may therefore interfere with the learning process wherein

there may be limited or no contribution from students who may be overlooked or feel overlooked, or those who feel that as no ground rules had been agreed on at the start, that they have the opportunity to then not participate.

The second observed group (Group B) did not fare any better. However, in this particular group, the facilitator, even though introductions were not conducted, allowed students to choose the officials right at the onset. Similarly, as observed with Group A, no ground rules were set and the lesson started immediately with the student who had volunteered to chair the session reading aloud the DLP to the rest of the group. However, with this particular group, it was the student chairperson who, after one of the group members suggests setting ground rules, deemed it not necessary.

Fatima tells the group that they need to come up with ground rules for their group, however Verushka says that there is no need for the rules. No one in the group counters this viewpoint, they let it stand without any comment.

(see Appendix 3.4B: Group B)

The next stage of the process – the clearing - was also not followed through efficiently. Only one Group (A) undertook the clearing process. The other (Group B) did not even venture into this aspect. This may not have allowed participants to ‘clear the air’ as intended by the process. It has been hypothesised, within the school, that by clearing, it enables participants to understand where each one of them are emotionally at that given point in time and may assist with attainment of an effective and efficient group dynamic. Even though Group A did have a clearing phase, the way it was conducted left certain students out, who had to then ‘find their voice’ and become part of the process. One of the students in Group A did not participate in the clearing process at all, and neither the chairperson, nor the facilitator seemed to notice this omission or oversight.

Instructions given in the facilitator guide for the DLPs stress the necessity of undertaking the ‘clearing’ process

Clearing

At the beginning of any and each small group session, go round the group, and each person (including the facilitator), should tell the group what is presently occupying their head space. Only after unloading current preoccupations, can a group member truly focus on the task of the group.

(see Appendix 6: Facilitator Guide)

The clearing process was therefore only performed in one lesson at the beginning of the face – to face contact opportunity. It was not done at all the small group lesson times as intended. This may have implications on the emotional space that each participant was in and may have impacted on the unfolding of the lesson as participants were not given an opportunity to ‘share’ before the start of each lesson.

The facilitator was directive in Group B, as he directed the students on how to approach the case under discussion

... we’ve got to do mind maps

(see Appendix 3.4B: Group B)

He did not allow the students the creativity to decide for themselves how to conduct the lesson. On follow-up interview he stated that

I like to tackle the case as a mind – map, as it allows the students to think broadly around the central issue or theme and I find that students have taken to the concept of mind – maps quite enthusiastically

This approach seemingly has an element of a ‘non student – centred’ approach, wherein the opposite – a teacher centred directive approach is evident. One of the principles that underpin PBL curricula is the student centred learning approach that characterises this pedagogy as it is intended to allow for ownership of the learning issues by the students (Schmidt, 1983).

Another explanation may be that these subtle deviations from the prescribed format on how the process needed to unfold may have serious negative effects on the learning process. Whether students knowingly or not, deviate from the prescribed

protocol these changes can affect the outcome. If the facilitators then do not curb or manage these changes in order to reverse the negative impact, the learning process may be compromised (Moust, van Berkel and Schmidt, 2005).

Both observed groups did not clarify any words or concepts that they may not have understood pertaining to the case and both facilitators did not explicitly ask this from the students. Groups instead delved straight into the brainstorming and elaboration phase as the whole group. They also did not break up into buzz groups. This phenomenon was also reported by Moust, van Berkel and Schimidt (2005) where they found in their study that students tend to skip certain steps such as the brainstorming and elaboration phases of the PBL process. They argue that students may deem that they do not have the necessary knowledge or skills to effectively engage in these steps and thence jump to those steps that they feel most comfortable with and omit those they deem to not have sufficient knowledge of. Additionally, students may feel that, at that point in their training – as final year students – they do not need to go through each step as detailed out in the DLP as they have knowledge on how the PBL process needs to run. From the students' interviews, this viewpoint came out strongly, wherein students reflected that they had been doing DLPs since their first year and could therefore omit some steps and, in their opinion, not compromise the quality of the learning.

well coming from first year, PBL now for me is a more constructive exercise than it was earlier. I know that that the full point of PBL is to stimulate your learning and to make you find out about things that you've never heard about before but personally I feel I can enjoy PBL more now that I have more knowledge

(see Appendix 4.3: Student Interview)

In these observations, students attempted to define the problem or issues inherent in the case in an endeavour to construct a detailed coherent theory of the concepts and processes underpinning the cases under discussion. As intended, this aspect of the lesson did take up most of the lesson time, with students throwing ideas around and attempting to understand the phenomena better. Both groups relied a lot on activation of prior knowledge to understand the case under discussion. Bransford, Brown and

Cockling (1999) cited in Moust, van Berkel and Schmidt (2005), offer a contrary finding and argument drawing from their research. They contend that students may share the misconception that they do not possess any relevant prior knowledge to effectively engage and discuss the issues inherent in the PBL cases without the facilitator directing the discussion. This, it is reported, makes the acquisition of new knowledge less efficient. In this study however, both groups of students, though especially Group B, do demonstrate an increased understanding of the issues and concepts, drawing from their prior knowledge.

The group A facilitator is more adept at guiding the students through this mine field, and at the same time allowing the students to take ownership of the learning process. However the group B facilitator seemed to follow the facilitator guide more closely during the first lesson. He even told students that

I've got 5 big headings and we've got...; let me see if I can
give you a clue ... we've got... and I'm going to give it to you on
a plate

I'm almost ready to show the mind map

shows them the Facilitator mind map and assures them that theirs is better
(see Appendix 3.4B)

Use of lesson time

Utilisation of allocated time

The allocated classroom time was not always used to its full extent. Some classes started late, some ended early – all resulting in the utilisation of less time in comparison to the allocated two (2) hours per lesson.

Group A lasted approximately one hour thirty seven minutes at the first lesson (1417Hrs – 1550Hrs), one hour thirty five minutes during the second meeting

(1401Hrs – 1536Hrs) and one hour sixteen minutes at the plenary (1407Hrs – 1523Hrs).

Group B ran for approximately forty three minutes at the initial small group meeting; from 1414Hrs until 1457Hrs, one hour and thirty two minutes during the second meeting (from 1402Hrs until 1534Hrs) and the plenary session ran for one hour fifty minutes (1407Hrs until 1558Hrs). This was less the stipulated scheduled two hours per meeting. The first meeting, which is meant to occupy much of the time, was surprisingly the shortest of all the lessons. The first lesson is meant to last long as issues raised through activation of prior knowledge need to be debated by the students.

It is clear that both groups did not utilise all the allocated time for the lessons, instead they fall short. Possible explanations may be that students rushed through the process in order to finish quickly. Facilitators may also have hastened the process. There may also have been constructive engagement with the learning issues resulting in effective use of the allocated time. It may additionally mean that students had not prepared adequately for the lessons and therefore ran out of matters to discuss. This phenomenon was reported by Moust, van Berkel and Schmidt (2005). The implication for this may be that deep engagement of the learning issues as well as self - study time are compromised and therefore ownership of the learning process by the students may be negatively affected.

During the follow – up interview with Dave, he reported that he was satisfied with the group's engagement with the issues. He reiterated the assertion that

as long as the students are able to come up with most of the learning issues during the first session, I am not fussy with whether they spend the allocated two hours or not

This phenomenon is reported by Moust, van Berkel and Schmidt (2005) and they contend that this may lead to 'watering down of the processes' which may impact negatively on the small group learning value for the students through the tutorial

group not achieving its 'surplus value' for the learning processes. This may not be the case in the groups under observation in this study, as reported by Prof. Tamlin, wherein the priority with the facilitator is the group deriving the prescribed learning objectives and the non – reliance on staying the prescribed length of time for each classroom session.

Another argument that may be raised from this observation is with respect to the self – study time students undertook. Although students were not asked explicitly during the follow – up interviews, they did offer an explanation that

... with Pros for example if like as we said if you have positive feedback it builds your interest and next time you'll want to show that you've got it and have learnt the work. But you know uh if whereas if the lecturer or supervisor was negative about it you gonna be as quiet as you can in that session.

You're not gonna ask questions

Yeah, you're just gonna like you know uh do what you need to do, but you'll be as quiet as possible, you won't ask any questions and you'll just want to make sure that your work, hoping that they're gonna say: OK it's fine, you know and get finished as quick as possible. Whereas with the positive feedback even if it's wrong, they'll tell you that you need to correct this and you'll be like: Ok you go back, go correct it and then you take it back to them, and when it's correct at the end of the session right you'll still discuss it with them. Think OK yeah, that was more, this is what I did right, why didn't it work, whereas if they're negative about it, the minute they say it's right: that's it; you pack up, dismiss the patient and gone!

You learn more in the other way

You're more interested

You're not so scared you're gonna stuff up

And everything works better

I find if I'm relaxed and if the supervisor is relaxed then I'm not saying that they must become you know easy on you and let standards drop, but it's just the way in which we interact. Because students in themselves probably have a, you know they don't think they're doing well and just that bit of motivation will improve their work

(see Appendix 4.5)

Students reported that their learning styles or motivation is greatly influenced by the teacher's interest in their work (Parker and Deacon, 2006; Victoroff and Hogan, 2006). As evident in the above excerpt of their interviews, it is clear that they report that they are keen to show knowledge with Faculty who are supportive and encouraging whereas, they use as little time as possible with those Faculty who do not demonstrate a keen interest in their learning. This is also borne out in several studies (Henzi, Davis, Jasinevicius and Hendricson, 2006; 2007; Henzi, Davis, Jasinevicius, Cintron and Isaacs, 2005). This may therefore impact on how they utilise their time during the actual lessons. One can proffer that maybe by using as little time as possible during the lessons under observation, they were not motivated by the facilitator(s)?

This reported perception by the students is supported by Prosser (2004: 56), who argues that

it is not the way that we design our courses and programmes of study in higher education that relates to the quality of student learning, but how our students experience and understand that design

He goes on further to report that students adopt qualitatively different approaches to their studies, depending on their prior experiences as well as the particular context in which they find themselves. From the student interviews, it was verified that how they learn is influenced by how they perceive their own learning. Therefore it is not the course design per se that automatically impacts on student learning, rather how students locate themselves within this community of practice. Students are also reported to vary their approaches to study within and between courses. They therefore do not adopt one approach to all programmes or to one programme all the time. This finding therefore makes it imperative for programme teachers to be sensitive to this and maintain relevance in their teaching styles and approaches. It also calls upon teachers to provide students with substantially more support in developing their own understanding of what problem – based learning is about (Prosser, 2004). Students therefore need to be constantly and early on in their studies, enabled to develop sophisticated understanding of their learning

outcomes in order to support and enhance the learning process (Kieser, Herbison, Waddle, Kardos and Innes, 2006).

Facilitation Style

Evident during the classroom observations of the second lesson was the observation that with Group A, within thirty minutes of the lesson commencing, the facilitator dictated the process by taking up much of the discussion and giving what came across as ‘a mini – lecture’. This part of the lesson took a considerable amount of the lesson – forty two minutes. On reflection, this was prompted by the observation wherein the discussion reached a point where it seemed to lack integration and contextualisation of information. The students were observed to report on the ‘bare’ facts and did not attempt to relate these to the actual case under discussion

The discussion seems to lack integration and contextualisation of information gathered. Students report on the ‘bare’ facts and do not attempt to relate them to the actual case under discussion; discussions are too global.

There also seems to be a lack of direction on how to run the lessons. This is evidenced by the fact that, a good twenty (20) minutes into the lesson, a student suggests how the lesson should be conducted. They may have been thrown out by the presence of a different facilitator in the middle of the case, even though they had been forewarned about this eventuality at the beginning of the case. The Facilitator then takes over the lesson and gives a ‘mini lecture explaining the important features and issues with respect to the case under discussion. She explains what issues to look out for in such cases. She also explains how radiographic evidence or aides enhance the diagnostic process. Other points she raises are with regard to the use of removable appliances and the different designs with the associated components

(see Appendix 3.2A: 2nd lesson observation at around 1428Hrs)

As reported by Moust, van Berkel and Schmidt (2005), Dr Boitumelo seemed focused on ‘covering the content’. Instead of allowing the students to become more self – directed and self – responsible learners, the facilitator took over the lesson, turning it into a ‘mini lecture’. The lesson at that point was not process driven, instead it focused on the ‘content’. This could be contrasted from Prof Tamblin’s facilitation style, wherein,

instead of 'taking over' the learning, he asked 'facilitative' questions to prompt students whenever he felt the discussions were losing direction or lacked focus.

There also seemed to be lack of direction on how to conduct the lessons, from the students' side. This was borne out by a suggestion from one of the students a considerable period into the start of the lesson, on how to conduct the lesson. It is hypothesised that they may have been thrown out by the presence of a different facilitator in the middle of the case, even though they had been forewarned about this eventuality at the beginning of the case.

As evidenced during the second lesson (the report back session), the nature of the lesson demonstrated a subtle change, where with Group A the facilitator took up much of the lesson to make it more lecturer - centred than student - centred. However, during the earlier aspect of the lesson when the students reported back on the variously researched learning areas, they each utilised the time well and offered well researched topics on the learning areas that had been identified., albeit failing to relate the specifics of the extra information to the case under discussion and keeping the reporting 'global'.

Delivery of content information was partially contextualised, in both groups, to the case under discussion in each groups' report back sessions. However, this was assisted by the facilitators in an attempt to integrate the information that students brought back to the lesson. The students' reporting back of the issues, though attempting to integrate and contextualise the information, resulted in more of a stilted reporting manner. Students were observed to be less adept at integrating and contextualising the information to the case under discussion.

On the manner in which the lessons were to be conducted, Group B clearly defined how it would run the lesson at the start of the lesson. The student who chaired the lesson obtained affirmation from the rest of the group at the beginning of the lesson,

before any discussion ensued regarding issues that students researched on. Group A on the other hand, started off with an attempt by the facilitator to slowly 'ease' the students into the discussion by asking them outright

... did you enjoy the case?...
(see Appendix 3.2A)

There was no demonstrable introduction at the start of the lesson instead the facilitator asked the question above. This is contrasted in Group B wherein the students assigned to chair the lesson clearly defined how the lesson was to run.

1402
Dave walks in and jokingly says: 'Sorry I'm early guys' and with that he hands over the process to Verushka to start the report back session. Verushka then proceeds to explain how the session will be conducted and gets affirmation from the rest of the group about the process to they will follow.
(see Appendix 3.5B)

This introduction by the chair followed the facilitator's apology with regard to his tardiness right at the beginning of the lesson. This is normal accepted professional behaviour. The facilitator also, early on in the discussion, contextualised the learning process and brought in an element of autobiography in this regard, to explain phenomena that were discussed.

1404
When Sue finishes off her presentation, Dave requests to ask a question, asking for clarity on a point raised during the presentation. Sue answers the question. Following this Dave uses this opportunity to introduce the concept of APPROPRIOTECH to the discussion to contextualise what has just been presented. He goes further to explain what he is involved in regarding the Delphi Questionnaire and brings the relevance of this to the learning issue just discussed. He emphasises the need for the students to keep the learning real and always bearing in mind the circumstances that they work in.
(see Appendix 3.5B)

The student chair of Group A, also explained what the agreement was following the initial discussions on how the process was to be run and he then took ownership of the

process by directing which student would present on the relevant topics. All this happened eight (8) minutes within the official beginning of the lesson. Contrast this with Group B's process where with the latter group, the discussion and ownership of the process / lesson commenced three (3) minutes following the official start of the lesson. In this regard, it can therefore be argued that the latter group demonstrated more effective utilisation of the lesson time at the commencement of the lesson, compared with Group A.

Both groups demonstrated a mix regarding the style of reporting – with some reading off prepared scripts, others using the notes as prompters and some actually explaining (without reference to any notes) the phenomenon or issues that they had researched further, demonstrating some heightened degree of understanding of the issues being reported on.

Ten minutes into the students' report back, Group A's discussions demonstrated a lack of focus and some degree of confusion crept into the discussion, to an extent that one of the students (Graham) asked for clarity on how the discussion was meant to ensue. It also came across as if there was a lack of integration of the issues under discussion and lack of relevant contextualisation of such issues. There was a perceivable element of lack of direction offered by the facilitator in directing the discussions and offering support to the students' discussion. This may have 'thrown off' the students and left them 'rudderless'. This was in contrast to the first lesson where the facilitator was 'facilitative' and supported the students' discussions without being directive. The facilitator during the first lesson demonstrated a 'guiding approach' especially during instances when it seemed as if the students were losing track and may have been veering off course with the discussion. It became quite clear, twenty minutes from the start of the student discussion during the second lesson, that the group discussion had lost focus, when the facilitator asked them if they knew why a certain diagnostic tool had been provided or requested in the clinical management of the case. This was discernable in the direct answer given by the students and the nervous laughter that accompanied the response.

1424 - 1437

Dr Boitumelo interjects and asks the group why they think the Lateral Cephalograph was provided in this case.

The students collectively answer that 'we don't know' and follow this with what sounds like embarrassed laughter

Dr Boitumelo then gives an explanation of the important features and issues with respect to the case under discussion. This turns into a mini-lecture on what issues to look out for in such cases.

(see Appendix 3.2A)

There is a mix of facilitation style used throughout both groups. As noted in the earlier sections, facilitators moved between a student - centred approach to a lecturer driven lesson mode quite seamlessly. The lecturer driven approach was adopted mainly by the facilitator in Group A during the report back session in an attempt to integrate the information and reinforce the objectives of the case under discussion.

The facilitator in the second group demonstrated the adoption of a lecturer centred approach and also tended to be more directive. He informed the students early on that he would give them the facilitator mind map. This act may be construed as counter - productive to student exploration of issues and may have discouraged the students to put a lot of effort in the research aspect of the case as they knew that they would get a copy of the facilitator guide, which contained all content knowledge inherent to the case. This undertaking therefore may also be counter – productive to the principle of student driven information gathering and synthesis as it does not encourage students to take ownership of the lesson process, instead focuses them to be reliant on information that facilitators give to direct the learning.

The facilitator in Group B had the ability to effectively direct the students on non-core issues such as language use which was gender sensitive. He did this mid – sentence whilst the student was presenting. He did not wait for the student to finish that aspect of the presentation before interrupting and drawing the group's attention to the fact. This feedback was effectively internalised by the student who then became more gender sensitive with respect to the language used.

Group Dynamic

The following characteristics were sought during the observations of the lessons, as reflected in the PBL principles (see Chapter 5)

- i) learner centeredness
- ii) participation and ownership
- iii) efficacy of the facilitation

in order to adjudicate how effective the uptake of the PBL philosophy was operationalised during the small group lessons by both groups of students and the assigned facilitators (Rudduck, 1978). Below is further analysis of what transpired in addressing the questions raised for the study.

The Group A student chairperson reinforced the principles of the PBL philosophy at the start of the process. The way in which the lessons were to unfold was clearly explained. Students were given an element of ownership of the process in a way that was not directive, but facilitative. The first facilitator (Prof Tamblin) guided the discussion effectively especially during the lulls in the student discussions and did not take ownership of the lesson. There was an attempt to ‘encode for specificity’ through the facilitator continually reinforcing the fact that the case under discussion had been treated by a staff member that the participants had known as one of their teachers (Tulving and Thompson, 1973).

In lessons that Group B held, though seeming chaotic throughout, on closer analysis conform to the format of the PBL process more closely and most of the decision making was driven by the students. The Facilitator (Dave) demonstrated a facilitative language – both through his verbal and non-verbal actions. Even though at certain instances as observed during the lessons, he seemed not engaged with the discussions, he interjected constructively and did not offer comments that did not add value to the

discussion. He actively drew all student participants to participate in discussions. Contrast this from Group A wherein a student was left out during the ‘clearing’ process and none of the students, nor the facilitator seemed aware of this omission.

The alternate facilitator’s (Dr Boitumelo) style traversed both paradigms where, when a lull occurred during the discussion, she took over and drove the discussion in a ‘lecture’ type, teacher directed mode. However, when discussion flowed, driven by the students, she let the process run and did not take over the discussions then.

The chairperson in Group B was observed to be a bit authoritarian as at times, she did not allow for engagement with issues or concerns raised by the other participants. Those raising issues were usually not given an opportunity to have these addressed. The Chair instead carried on with the process as if no issues or concern had been raised on several occasions, especially during the first meeting.

1429

Having exhausted the discussion on AGE, the group takes up Fatima’s suggestion of FINANCIALS and suggests that they break this up into several aspects. This suggestion is dismissed outright by Verushka without offering any reasons for doing so, and no one in the group asks her for an explanation for her outright refusal towards Fatima’s suggestion.

Nicky reminds them that UNEMPLOYMENT will affect a person’s FINANCIAL status, and Priscilla adds that what one’s OCCUPATION is will also impact on all these aspects.

Verushka asks them:

‘are you happy with SOCIOECONOMIC?’

and even though Nicky answers to the negative, Verushka does not take her concern up and offer (or at least ask any other member of the group) clarity to help Nicky understand it better.

(see Appendix 3.4B)

This may not bode well for group dynamic and may cause resentment amongst the participants. Another observation was that, even though participants in Group B came

out with topics / issues to discuss, this did not happen to a great extent, points were raised and not debated, instead the group was urged to move on by the chair following minimal or no discussion of the point(s) raised. This forms a clear indication of the complexity involved with small groups and small group teaching (Mennin, 2007; Mennin and Kaufman, 1989).

With Group A on the other hand, the chairperson of the group had a participatory outlook, where he was aware of which student had not contributed and attempted to bring them into the discussions by directly asking for their inputs and taking note of those inputs once given.

At this point Stavros asks Patrice (who has not contributed much to the discussion so far)
What do you think?

(see Appendix 3.1A)

Both groups did have elements of a student - centred approach wherein the students, on the main, drove the discussions and brought out the major issues and concepts to be considered. As stated earlier both facilitators brought different elements of facilitation styles to the PBL session depending on the flow and quality of the discussions. At times, both facilitators were directive, and at other times facilitative.

Research into facilitator skills has shown that a facilitator with good facilitation skills is perceived to contribute more positively to the discussions; to stimulate elaboration and knowledge integration and effectively direct the learning process and promote interaction and individual accountability from and by the students (De Grave, Dolmans and Van der Vleuten, 1998; Bochner, Badovina, Howell and Karimbux, 2002).

Both groups seemed to own the process and took ownership of the learning process effectively, even though at times gaps in the knowledge base did become apparent, especially pertaining to the ability to critically reason some of the clinical concepts.

Understanding that one of the assumed principles in a PBL influenced curriculum is discussions that ensue during the case discussion and problem solving tasks, discussion in the small group lessons therefore play a central role in stimulating student learning. It can further be assumed that the quality of the discussion influences student learning (Nieminen, Sauri and Lonka, 2006). Studies have demonstrated that well - functioning groups increase students' commitment to learning and this may enhance group attendance and study process. It has also been argued that it may influence students to invest more time and resources on independent study (van Berkel and Schimdt, 2000). To a large extent, therefore, the students' contribution to the success of the tutorial group is important.

All in all, the PBL principles were realised during the small group lessons with both facilitators and students adhering to some degree to how the PBL process should run. The facilitators brought different styles to the lessons and the more experienced facilitator adhered more closely to the process when compared to the less experienced facilitators.

In responding to the second research question

What, if any, issues emerge during the observation phase

emphasis was placed on how students responded to the learning experience and whether there was evidence of knowledge synthesis and integration by the students.

The prosthodontic plan was matched against the lesson observations and information / data obtained from both students and staff interviews.

Application of the learning experience

Following on studies that have reported on conditions that foster human learning, the aspects below were focused on during the study:

i) Relevance and contextualisation of the learning experience

Activation of prior knowledge by the students was evident, especially during the first lessons of each DLP. Students drew on their knowledge from the previous years of study as well as from all relevant disciplines to try and solve the problem at hand. They did not rely on knowledge from one discipline. Discussions around issues from oral biology, orthodontics, maxillo facial and oral surgery, pathology, prosthodontics, restorative dentistry, to name a few, were used to inform the discussion in helping formulate the learning objectives that had to be looked into further.

As final year dental students, it was also clear that they showed more informed knowledge as they possessed more prior knowledge to enable them to process new information more easily (Schmidt, 1983; Mertens, 2005). PBL pedagogy, as an instructional method, has been reported to foster better and appropriate activation of relevant prior knowledge and thereby assist students in activating relevant knowledge that would facilitate the processing of new information.

The concept of ‘encoding for specificity’ was evident, especially with Group A wherein the facilitator prompted students by giving them retrieval cues that went some way in assisting students to reactivate information that they may have had by informing them on the specificity of the case under discussion

This is an interesting case, which was treated by Dr Patel. Do you all remember her – she was a registrar in the department?

(see Appendix 3.1A)

This information may have prompted the students to think along the lines of the speciality that Dr. Patel was pursuing (prosthodontics) and therefore helped inform the discussion that ensued. Furthermore, students were given the opportunity to elaborate on their knowledge. Most of the time spent during the first lesson was on this specific aspect of the learning process. This was done by students discussing the subject matter to be learnt with other students in the group (Anderson and Biddle, 1975 cited in Schmidt, 1983). Elaboration of information was also conducted via several ways, such as answering questions posed by the facilitators during the lessons and taking notes during the discussions, to name a couple of examples. It is reported that

...when students try to explain problems (under discussion) by hypothesising possible processes responsible for the phenomenon observed, they are not merely reproducing knowledge acquired at some point in the past. They are using this knowledge as “stuff for thinking”. In doing so, previously unrelated concepts become connected in memory, newly produced insights change the structure of their cognition, and information supplied by peers is added...
(see Schmidt, 1983: 14)

All the above concepts attempt to optimise the learning by assisting students to activate relevant prior knowledge, providing context(s) that resemble the real life situation as closely as possible and stimulate students to elaborate on their knowledge (Murphy, Gray, Straja and Bogert, 2004). The DLP case attempted to address all these aspects by using a real case that was managed by faculty and the problems that students had to address were related to real life situations wherein they had to formulate treatment plans that addressed situations that they found themselves working under where patients from different socio-economic situations sought dental intervention as well as, following completion of the course, they would find themselves working under.

ii) Wait time

Especially evident with Group B, wait time between the asking of a question and the provision of an answer was an issue. In most instances, the student chairing the lesson did not allow for sufficient time for this process. Questions were left unanswered following being asked by other students. Concepts were not probed deeply enough. As noted at the end of observing the first lesson of Group B:

... Not a particularly enjoyable session to observe – issues were not thoroughly debated; instead just came out with issues and moved to next heading...

(see Appendix 3.4B)

However, the students did bring out the main headings for discussion even though there was no extensive elaboration of the issues as the researcher may have liked.

As reported by Behar-Horenstein, Mitchell and Dolan (2005), facilitators tend to deliver content – based information without pause. A brief description of this is evidenced during discussion with Group A below:

Dr Boitumelo explains and alerts the group to the issue of orthodontic treatment (and specifically mentions that it is stated in this scenario). She leads them to start thinking about involving orthodontic specialists and the value of teamwork (including other specialists) especially regarding the timing of treatment and different procedures. She explains the reasons for the need for teamwork.

She asks the group why they thought that implant supported prostheses were the best option (as stated by Stavros earlier) and passed a joke about 'titanium deficiency'. ...she queries the biological price inherent with the desired option. She has to explain and give answers to her questions.

(see Appendix 3.2A)

There was minimal observed evidence of an attempt to consider ways of promoting students' ability to come up with this information by themselves at this stage. Behar-Horenstein, Mitchell and Dolan (2005) suggest that 'the one minute paper' strategy could be utilised to assist this process. This involves the teacher asking students to provide a written summary of the main points that have been discussed to that point; respond to a question and wait for it to be answered (by the students); or apply a

concept that they have learnt during the lesson. During the observed lessons, even though questions were asked, especially during the report back sessions, they were not answered effectively, hence leading the facilitator to give the answers themselves or delve into a 'lecture' mode in order to deliver the 'content'.

iii) Use of media

PowerPoint presentation was the preferred mode of media used during the class presentations by the students. Key points were outlined on the slides and students also used prepared notes to augment their reports. Media was used in a non - dynamic manner making the presentations somewhat dull. However, most of the content was covered on the slides and during the verbal presentations.

Extrapolating from literature espousing characteristics of effective classroom teachers, presenters who are seen to be energetic and interact directly with the audience are perceived to create a better environment for the retention of knowledge than those presenters who are not (Jahangiri and Mucciolo, 2007). A few students during the plenary sessions did attempt to draw the other students into the presentation by asking questions and using examples that they had encountered during their clinical training

Maria then starts giving real examples using her own clinical experience to explain points and explains how she handled such patients in terms of calming the patients to enable her to carry out the proposed dental treatment: 'I talked using a soft, reassuring and calming voice'.

(see Appendix 3.6B)

Xavier, standing by the podium, then introduces the topic he will present on: SOCIOECONOMIC.... Xavier asks the class: 'what would you guys say with regards to who sees dentists more?'

(see Appendix 3.6B)

Curricular innovation that is reported to be extensively incorporated into oral health teaching is the increased use of computer technology (Kassebaum, Hendricson, Taft and Haden, 2004). This is in line with keeping abreast of technological innovation and its application in the classroom. The facilitators did stipulate that electronic / digital media was to be employed during the plenary session where the small groups were to present the learning issues researched and answer the questions raised by the DLPs.

1448

Beverley's group then presents and Prof Andressen informs the class that the presentation will be a power point one.

(see Appendix 3.3A)

This was one aspect of curricular innovation which had been keenly taken up by the prosthodontic department. The department, during the year of the study, introduced electronic books (i-books) to augment the teaching methods. This emerged as an issue during the student interviews, where students reported that, in as much as this was meant to facilitate their learning, it did not live up to expectation as most of the students did not have the necessary software on their private computers to enable easy accessing of the learning material. It therefore meant that they could only access the learning material when on site, using the institution's computerware.

And the i-book, the provision of the i-book, did that help?

That had lots of pictures and stuff

But in terms of doing it on your own weren't those helpful or did you ever refer to them when you were doing it alone, for the pictures?

We don't have the computers programme, like you can't get the pictures out in your room

But those pictures really helped us in the lessons though

If you probably know that OK tomorrow I'm going to do this, you might go through it to see exactly how the procedure is being done and in that way it helps you the following day if you have any hiccups or whatever

Ok and in in terms of the lack of computers or the provision of computers to view the modules, did it ever occur to any of you to maybe talk with the course coordinator to provide a departmental or school computer?

Well, like we thought they will put it on the disk for people who asked, but I think it was forgotten

If the class had more like, more visual access to the computers programme

If you have a computer next to you like this, it is fantastic

(see Appendix 4.5 – Student Interviews)

Even though the use of media within the prosthodontic curriculum was not explicitly stated in the prosthodontic plan, during department workshops, meetings and discussions, this was one of the key innovations that the Department of Prosthodontics introduced in its curriculum in the use of e-learning through i-books. These were used during the preclinical techniques courses, especially with the Fixed Prosthodontics part of the curriculum. There was extensive encouragement from the Head of the Department for staff within the department to actively use media when developing teaching aids and with the delivery of lessons.

Emphasis on integration of the information or content knowledge

Synthesis and integration

It was reported in the earlier part of this chapter that observational data reflected a ‘patchy’ mode of information integration demonstrated by the students, leading the facilitators in both groups to adopt a directive teacher - centred approach during certain aspects of the discussions. Students demonstrated an ability to find the facts on the learning issues that had been identified during the first lesson, however, they lacked the ability to effectively integrate the facts to the specific case under discussion and therefore could not contextualise the content detail.

Discussion of issues not integrated and following a question and answer mode with the staff present dominating most of the talking and taking over certain points and making them into mini lectures. Not allowing students to develop their reasoning / justification

of issues they raise.

Prof Tamblin only facilitator seeming to facilitate discussion from the class and pointing them to issues that they seem to miss out and trying to provide an integrating thread to the student discussion – otherwise Profs Lizzard and Andressen ‘giving’ students the information and not letting students bring out the issues themselves.

(see Appendix 3.3A)

Critical reasoning and problem solving ability is mandatory to all health care clinicians and students. Critical thinking, as defined by the American Philosophical Association Delphi Report (1990) cited by Facione and Facione (2008: 128) is

...the process of purposeful, self – regulatory judgment. The process giving reasoned consideration to evidence, contexts, conceptualisations, methods and criteria

Critical thinking, is an educational outcome that has become pervasive in educational mandates both from the training institutions and professional councils regulating health care professionals or their associated credentialing bodies (HPCSA, 2006). These institutions require all healthcare professionals to have critical clinical reasoning skills to enable excellence in professional judgment ability. This was one of the critical issues informing the curriculum innovation implemented at the institution that this study was undertaken. The lesson observations looked for the students’ ability to link discussions to concepts and the case under discussion, as well as how they developed the rationale underpinning the discussions. This would therefore demonstrate the students’ ability to critically reason the clinical cases drawing on the available evidence, literature, contexts and objectives set for each case. As Facione and Facione (2008: 130) aptly put it

...critical thinking is (a) process we use to make a judgment about what to believe and what to do about the symptoms (evidence) our patients present for diagnosis and treatment.

They argue that in order to arrive at a judgement of what to believe and what to do we need to consider the unique character of the evidence (symptoms) in view of the context (patient’s current health and life circumstances) using the

...knowledge and skills acquired over the course of our health sciences training and practice (methods, conceptualisations)...

and anticipate the likely effects of the outcome (consideration of evidence and criteria) and finally monitor the progress of care delivered (evidence and criteria).

This process thus needs adequate time to think and some degree of expert knowledge in the field under discussion or observation. It was previously thought that students would somehow naturally advance in their clinical reasoning as they were introduced to clinical case scenarios. However, there is a body of literature to suggest that this is not so (Facione and Facione, 2008; Patel, Arocha, Chanhari, Karlin and Briedis, 2005) and that there need be well structured formal programmes and teaching and learning activities that foster clinical reasoning and critical thinking. Modern pedagogical approaches such as problem based learning have to a degree demonstrated that these skills can be taught and learnt. It is also imperative that clinical teachers, facilitators and mentors can facilitate reflective problem solving by prompting meta analysis and evaluation of clinical reasoning through how they teach and assess the learning and teaching practices. Pedagogical approaches that look at effectively inculcating and improving critical reasoning skills in students and clinicians alike have evidence supporting them (Facione and Facione, 2008).

From the lessons observations, it is clear that the students possess limited ability to critically reason and evaluate information that they are given. Most of the discussions raised by the students were 'global' (Moust, van Berkel and Schmidt, 2005). Questions raised were not answered, the process of brainstorming and elaboration were undertaken in less the stipulated and allocated time, resulting in what came across as 'patchy' discussions lacking substance and relevance to the cases that were under discussion.

Students reported that they appreciated the relevance of the PBL cases in the final year of study as they 'encoded for specificity' and therefore could make sense of the

knowledge gained from the discipline. They also reported that most of what they were learning made sense as applied via the PBL cases

...coming from first year, PBL now for me is a more constructive exercise than it was earlier. I know that the full point of PBL is to stimulate your learning and to make you find out about things that you've never heard about before but personally I feel I can enjoy PBL more now that I have more knowledge

(see Appendix 4.3 – Student Interviews)

Emergent Issues

In the discussion to follow, focus will be placed on issues that emerged during the interview phase of the data collection. In as much as some of the issues were external to the programme being evaluated, they were deemed to have an impact on the prosthodontic course. These issues were brought to the department's notice during reflection of the study findings at various platforms including, but not limited to departmental meetings, workshops, informal discussions with staff members, report – back to the head of department with regard to the progress of the study.

During student interviews several issues emerged which had not been apparent during the lesson observations. Chief amongst these were:

- Increased stress levels due to the perceived intensity of the prosthodontic programme
- Lack of resources to support students during both the clinical and didactic aspect of the course
- Assessment fatigue and its impact on other aspects of the course – students choosing to prioritise what subjects to study in order to not fail the major courses
- Facilitator expertise with regard to supporting student learning

- The fact that certain departments did not have detailed assessment schedules and therefore decided without consulting students when to give tests. These were reported to have been given without much notice and usually during the latter part of the year, hence stressing students who would have been preparing for their final examinations.
- Another issue that students reported was departments missing their own stipulated assessment dates as outlined in the year book
- Remedial assessments had to be offered to students in the prosthodontic course, which were not stipulated and scheduled in the year book. This was a glaring mismatch between the instructional system and what was realised.
- Students reported that they felt that their issues were not listened to in formalised structures such as EDUCOM and therefore ended up not attending the meetings. A critical point that was raised was with regard to clinical issues. They reported that EDUCOM advised them the structure only dealt with curriculum issues and could not assist them with any clinical problems. This left students feeling confused. It was also contrary to data obtained from staff who reported that the structure was effective in addressing student concerns. The feeling, from staff interviewed, was that EDUCOM was the only structure which allowed students space to air their issues in a safe space without letting students feel disempowered.
- One critical issue that came out was the feeling of victimisation reported by some students. They felt that they were not empowered enough to create their own spaces within the programme in order to have a voice, as underpinned by the tenets of problem based learning. It therefore becomes imperative for teachers to be highly cognisant of such feelings and attempt to dispel such notions by reassuring students and building learning communities which could assist in this regard.

It was reported from interviews with students that the Prosthodontic programme was well structured and organised. At the start of the programme students were each given a copy of the programme for the year outlining in detail all they needed to know with

regard to the course – how they were going to be assessed; what the tutorial and didactic programme was going to discuss; what the clinical requirements for the year were etc. The various detail regarding when assessments were to be held and what type of assessment they would undertake were clearly defined in the document that was handed out to students and they reported a degree of lessened stress because of this information. However, other factors outside of the prosthodontic programme imposed stresses on the whole – for instance the total number of assessments that students had to sit for during the year and the intensity of the whole dental programme was deemed to negatively affect the students in terms of their enjoyment of the course and how they therefore approached their learning overall.

...I've got to say that uh the Prosthodontic Course is most definitely the most challenging course that I've ever done. I think it's almost a credit to the way that it is run uh in that it is so thorough. They make sure that every student gets a uh everything thoroughly, completed and all the requirements are clearly outlined in the Year Book...
(see Appendix 4.6 – Student Interviews)

RECOMMENDATIONS

The above issues were brought to the attention of the department and the programme was refined, resources permitting, to address the issues. Some of the ways in which the department refined the prosthodontic plan are outlined below:

- The pedagogy adopted and reinforced for the teaching practices were to be more aligned to contemporary methodology – PBL – with emphasis on explicitly reinforcing problem solving skills and encouraging critical reasoning.
- The number of assessments that the department scheduled were reduced without necessarily negatively impacting on the desired assessment outcome. The department's assessment policy was modified to address the reported 'assessment fatigue'. A critical analysis of how the department was assessing

students was undertaken and more creative assessment tools were implemented of prosthodontics, a written sit-down test was set where students were informed beforehand on what they were to be assessed on. This was also informed by the observation that the report method resulted in a high degree of 'cut and paste' reports without a demonstrable understanding of the concepts been assessed

- The practical assessments were modified and made clinically relevant. Previously, students had to undertake these under clinical simulated scenarios. Students had to undertake these assessments on real patients, during their scheduled clinical lessons. Both students and staff reported a decreased sense of stress with the newer method and found this method more relevant and contextualised to the real world.
- The department decided to formalise the remedial assessments and include them in the instructional system. This decision was taken following feedback from students during the interviews with regard to the degree of confusion that tests that were not scheduled brought to bear. Even though this practice (remedial testing) was deemed to be to the benefit of students it transpired that its non - explicit inclusion in the prosthodontic assessment guidelines caused distress to students.
- Staff in the department were encouraged to support students in order to facilitate the learning. One method was to allow students to use departmental resources such as photocopying in order to reduce the financial cost to students, bearing in mind that students paid for notes in their tuition fees.

Shades of 'utilisation focused evaluation' (Patton, 2002) were evident within this study as most of the findings were brought to the attention of the department and issues that were deemed critical enough were taken up in order to refine and modify the programme accordingly. Students' voices, through the interviews, were brought to the fray as part of the adjudication process and the evaluator's voice was not the lone voice during this study. At the time of submission of this report therefore, any recommendations would be belated and hence do not form part of the report, suffice

to note the comment above clarifying how findings from the study were fed into the programme under evaluation.

In summary, the prosthodontic plan was realised to a certain degree and what was intended within the plan was realised in terms of the teaching process and meeting the outcomes of the plan as outlined in the curriculum. Additionally, the feedback obtained during interviews with the students was taken heed of and part of it was used to refine the programme. The lesson observations demonstrated that facilitators used various teaching styles during a lesson and did not stick to one style only in order to reinforce learning and ensure knowledge integration. Students, as well, on the other hand demonstrated activation of prior knowledge and the ability to seek out relevant information to enable derivation of the required learning objectives in order to meet the learning objectives set for each lesson.

CHAPTER 7: CONCLUSION

What this study highlighted was that, by and large, the prosthodontic programme was essentially working and the department was on track with realising its aims and objectives. The department was also sensitive to feedback from students and was willing and did modify the course, within limitations, to make it more relevant without detracting from the aims and principles of the curriculum innovation. These may be taken up by the other educational programmes within the school in an attempt to refine their own programmes and ensure that they produce graduates who are not only able to provide comprehensive patient care that is scientifically based and technologically appropriate, but also able to appreciate, understand and actively seek solutions to current intellectual, social, behavioural, and philosophical problems in dentistry. This would therefore allow programmes to remain relevant by being attuned to what the industry demands of them.

The aim of this study was to adjudicate how the department of prosthodontics had managed to move from a traditional, teacher centered, lecture based pedagogy towards more interactive, student centered, small group focused and contextualised learning and teaching strategies and if it had been able to equip dental students adequately in the field of prosthodontics. The study evaluated how the programme worked out, in its own terms, using an illuminative evaluation approach. By adopting an illuminative evaluation approach, this study described how the instructional system or prosthodontic plan was realised in the learning milieu. It provided a close study of how a particular educational programme within its particular context was instituted. From this, greater insights were gained on the degree to which the aims of the educational programme were realised using specific education tools (PBL DLPs). In particular, the study of the realities of the learning environment unearthed issues which ordinarily were not apparent and had not been taken into account in the instructional system (issues such as assessment fatigue, as perceived by students). If the evaluation had been conducted utilising the classical agricultural – botany approach, wherein preordained criteria and tools are used, it is

doubtful whether many of these insights would have been gained. Illuminative evaluation generates a description of how programme aims and objectives are operationalised and takes into account any issues that may emerge which would ordinarily not be focused upon using classical evaluation paradigms.

As noted, benefits were realised by using the illuminative evaluation approach, however, the study was also challenged by limitations. Chief amongst these was the lack of prosthodontic specific DLPs. This may have provided a richer description of the actual programme and made deductions from the obtained data more meaningful. This may have enabled closer scrutiny of how the subject was taught and therefore created opportunities to then make realistic deductions pertaining to the question of whether students are adequately prepared in the field. This was also informed by the hybrid nature of the curriculum. The curriculum, as noted, was not a pure problem based learning one where all teaching and learning activities are aligned along specially selected problem based cases and all disciplines and subjects taught are then temporally situated to follow suite. As such the utilisation of non specific but prosthodontic rich DLPs had to suffice.

An additional opportunity lost was the inability to observe all the different teaching platforms such as the clinical sessions, the subject tutorials / lectures, the preclinical sessions etc. This may have provided an enriched data set to better evaluate what was being taught and thence make it meaningful to draw inferences. However, the decision was made to limit the observational aspect of the study to one platform due to the limited resources available – the time restrictions imposed by the nature of the MEd programme requirements; the researcher being the only person available to do the observations, the cost and time implications etc. As van Rensburg (2007) clearly argues in her study, illuminative evaluation projects are costly and need to be limited to research at a doctoral level or above. However, this does not take away from the importance of what this field adds to the knowledge – base and how this additional information can and does assist in improving programmes. The potential inherent benefits with this method of evaluation in educational programmes can never be under or overestimated.

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APPENDIX 1: CASE CANCELTATION LETTER

APPENDIX 2: HoS Letter of Permission

APPENDIX 3: Lesson Descriptions

APPENDIX 3.1A

Fictitious names have been used throughout the descriptions

Group A Lesson 1 - July 27, 2007

LESSON A1

The final year class (BDS 5) was scheduled to meet in the Dental Graduates Auditorium (DGA) at 1400 hours and most of the students and staff members (facilitators – three in total – Profs Tamlin, Andressen and Lizzard; excluding myself) were assembled in the DGA by 1403Hrs. At 1404Hrs, the chair of the session, Prof. Tamlin called for the attention of the students. He started speaking without introduction during a lull in the conversations of all those assembled.

There is no formal / structured introduction of the lesson as one would expect at the start of one.

He explained to the class how the sessions were going to run, drawing attention to the fact that the report back session scheduled for August 24, 2007 had been moved forward to August 17th due to the scheduling of the Practice Management module on that particular day.

Gives the students an overview of the process and how it is to run / pan out, essentially outlining the PBL process and reinforcing that which they know from their previous experience with the PBL format and ascertain that all participants are on the same page and understand the process that is to unfold.

He highlighted the importance of the report – back session,

focuses on the value of the report back session

explaining that it is at that session where the group is able to decide on how it should frame its presentations for the plenary session,

reminds the class to remember to start thinking about how they are going to frame their presentations

after formulating realistic learning objectives. He informed the class that the group he will be facilitating will have to have a different facilitator as he will be away at that time, travelling overseas

I will be away in London, having travelled from Rome

may not auger well for the 'group dynamic' having different facilitators driving one DLP

There was (a) very informal interaction with the students and a lot of laughter from the rest of the class and the other facilitators during this time. Prof. Tamblin then asked the class how they want to group themselves into the tutorial groups

gives the students the responsibility of grouping themselves: student driven decision making that underpins the hybrid / PBL curriculum: PROCESS

wherein the students suggested that they can group in their clinical groups comprising two groups of eleven students and one of ten students

group participant numbers not optimal for PBL process, indicative of the resource constraints experienced and highlights the resource intensive nature of the innovation: TENSION (Moust et al., 2005).

Following agreement to this suggestion, one of the facilitators – Prof Andressen – told the students that

You all (*researcher's emphasis*) can come to my group

demonstrative of lack of understanding of the process re optimal group participant numbers as anything above 12 becomes too cumbersome (Moust et al., 2005); could also be indicative of the convivial relationship faculty has with the students,

although the last group should go to the other staff members. He expanded on why he suggested this, explaining that it would be advantageous to the group as he could assist them on Wednesday afternoons as well, because he was in the clinics supervising

students and would therefore be available to them. In the end Clinical Group 3 opted to be facilitated by Prof. Andressen

example students' taking ownership of the process and making final decision as to how the groups will be decided.

Beforehand, Prof. Tamblin had asked the students to sort out their PBL groupings before all could move out to the tutorials rooms, which are housed in the Medical School's Centre for Health Science Education (CHSE) and was a short distance away. As the groups were leaving for the CHSE, the third facilitator – Prof Lizzard asked:

How many are in Group 3?

to lots of laughter, but no answer, from the students as they left at around 1409Hrs.

This section of the process – assigning to groups - takes 5minutes: time effectively utilised with minimal wastage

The small group that I was to observe (Prof Tamblin's) were all seated in the tutorial room by 1417Hrs

		IM	FB	FB	FB	w
	WF				CM	i
	IF				WM	n
	AF					d
	BM					o
		MOI		FAC		w
						s
Door		white board				

Takes the group about 8 minutes to transfer to the small classrooms

The DLP case to be discussed was titled:

How do we help Mark (Treatment alternatives) **highlights the general nature of the expected management / dental intervention wherein the title does not make it explicit which discipline is to be considered as the preferred primary treatment choice.** Dental Learning Package IV.6 (*see attached appendix*)

The scheduled meeting times appearing on the DLP were as follows

Session 1	27.07.07	2pm DGA/CHSE
Session 2	24.08.14 (<i>a typo as the year was 2007</i>)	2pm CHSE change highlighted at the beginning of the session whilst class was all assembled in the big auditorium; now moved forward to August 17
Session 3	31.08.07	DGA
(Plenary)		
Test	21.09.07	DGA

Without further ado at 1418Hrs

(9 minutes after leaving the DGA and a minute following attainment of calm once seated in the PBL rooms of the CHSE),

the facilitator started reading through the DLP introduction

This DLP has been designed to allow students to consider treatment

alternatives using an actual patient being treated in our clinics.

He asks the students if anyone knew about ‘clearing’. When he got no answer he started the ‘clearing’ process (he does not explain what it is, instead he delves directly into the process and starts the clearing process – e.g., of the ‘doing’ in [tell; show; do] manner of teaching) and declared that

I think I’m getting flu

He explained that he had been doing a lot of overseas air travel recently where he had attended a workshop organised by one dental company – VITA - and a university in Germany (University of Leipsich) who had developed a new system for mapping colour / recording shades for colour matching in dentistry. He explained the colour matching process and the chemistry of colour – explaining the concepts of ‘value’, ‘chroma’ and ‘hue’ in that sequence and further expanded on how the new system was to operate and how it is designed to check for colour - blind individuals and its (colour-blindness) gender relevance. This was light - hearted banter, interjected with laughter from the assembled students, with one student joking about how giving birth relegates one to colour – blindness. Prof Tamblin told the students that the SOHS was to get this ‘box’.

At the conclusion of his own clearing process, 3 minutes later Prof. Tambblin asks Stravros* to ‘clear’. Stravros declares that

I’m under a lot of stress and feeling the pressure and lack of time

Prof. Tamblin reassured Stravros and implored him to ‘hang in there’ and made jokes about Stravros having TMD and tightening of the facial muscles, lack of sleep, down

time etc another example of bringing in different dental topics that may relate to the case under discussion: keeping the ‘non-case-related’ discussion relevant / contextualised without making it explicit – creating a seamless transition between the ‘non active and active’ learning phases. Stavros then told the group that he was also preparing to give a presentation at the SADA Congress in Cape Town, therefore was busy preparing for that on top of his school work, to which Prof. T urged him to

Have fun (*at the Congress*) whilst you are learning

reinforcing the ‘continual’ learning action even during periods where it may seem as if learning is not relevant (these type of congresses are usually pitched at the graduate student and practitioner level, therefore an undergraduate student may feel out of place.

The next student who was asked to ‘clear’ by Pro Tamblin was Graham* (*seated next to Stavros, and to Prof Tamblin’s right hand side*)

How are you doing?

Graham* replies that

I’m drained from the week but happy for the weekend as I can rest!

(surprising, as it is only Wednesday. Most of the students in the group report being tired and it is also half way (July) through the year. Could be indicative of the loaded programme and students feeling overwhelmed with the volume of work they have to cover and learn for the assessments and final exams)

Stavros joked that

I’m looking forward to the coming weeks to study as we’re writing every
week

(confirms above deduction re assessment loaded course – later reiterated in the student interviews as ‘assessment fatigue’).

The facilitator reassured the students and made a comment

Study, study and more study

Following this, the other students volunteered to clear and were not asked individually by the facilitator (students’ have taken the cue from the facilitator and taking ownership of the process, making it student centered). Mmapula* told the group that she was ‘fine’

to which Prof Tamblin said

well done

(compared to facilitator’s engagement with Stavros’s clearing, this is scant)

Nandi* reported that

I’m fine from the MFOS block and recovering

Hemant* offered that

I’m happy for the weekend, but stressing as I’m starting MFOS block next week

Prof Tamblin then asked the group how the block was going (takes cue from the students as all of them seem to report being stressed by the block) and Janice*, Nandi and Stavros replied that it was ‘hectic’ but exciting (an eg of positive / enjoyable stress and finding the MFOS experience stimulating, even though they also report it to be hectic. The students are also exposed to the specialist surgical aspect of dental management which forms a small part of their overall training programme) as they were seeing interesting surgical cases and getting to assist in theatre.

Stacy’s* contribution to the ‘clearing’ process was a curt

I’m OK

which was reiterated by Kajil*. Janice then told the group that it was her birthday and her mind was not 'there' as she was looking forward to the evening when she would celebrate it. She got well wishes from Prof Tamblin (more engagement by facilitator re student's social schedule relative to Mapula's curt 'well done'). She also offered that time management was important after the SADA Congress in order to manage, as she was also attending and presenting.

Prof Tamblin proffered that

good point, as one has to have good study techniques

He went further to explain that it was silly for one to read up on what they know, instead one needs to identify what one does not know. He gave them an example of mind mapping as a study tool as it helps one identify what is not known. He gave an example of jaw cysts giving them pointers regarding good study techniques and tools. One of the issues that is continually raised at the departmental meetings when student progress is discussed following summative assessments when the marks do not reflect positively; or show that the students do not demonstrate good skills relating to answering test questions.

This process took about 8 minutes, after which Prof Tamlin explained my presence in the group, to laughter from the students. Mmapula asked whether I was going to give them a test on what I was doing.

As all students had not 'cleared' Patrice* offered that

I'm fine and taking each day and each week as it comes and trying
to work consistently, but I am anxious about the situation back
home

He told the group that he does not want to go back. Prof Tamlin added that

Your country is falling apart, and it's tough

The 'clearing' eventually ends at 1430Hrs, still no one notes that Dimakatso has not cleared.

Prof Tamlin then tells the group that

'let's start'

and asks them how they were going to allocate the various roles to run the tutorial process. He tells the students that there is no need for establishing ground rules and then instructs them to read through the case in order to decide how to carry on with the process.

For the next two minutes, the students (individually) read through the case with several of them highlighting certain aspects and underlining sections. Prof Tamlin also appears to be reading through the case and at some point asks Stavros about the length of the document. When it appears that the group has finished reading through Prof Tamlin asks how the group is going to run the process

Are you going to break into buzz groups or discuss the case entirely as a group?

He asks the students for their preference. Several of the students suggest that they will do that phase as a group. Prof Tamlin then makes them aware that they will need someone to take on the role of the 'scribe' **though alerts them to having a scribe who will record all the discussions**. Hemant volunteers **no need to elect** to be the scribe. He gets up from his seated position and walks towards the whiteboard. He reads out what is written on the whiteboard (left by a previous group, probably from the Medical School GEMP PBL session, as the rooms are shared with medical school). At this point there is a lot of talking between Stavros and Nandi which is out of earshot for me). Prof Tamlin hands out extra material - radiographs and study models pertaining to the case and explains that

This is an interesting case, which was treated by Dr Patel*. Do you all remember her – she was a registrar in the department?

Makes them aware that, even though it is a paper-case, these are records of an actual patient who was treated by staff whom they may have interacted with during her time at the school – making the experience real and maybe more relevant – some element of experiential learning and encoding for specificity demonstrated

He passes the Lateral Cephalograph (an Xray) to Mmapula, whilst Stravros and Graham examine the study models. He reiterates to the students how they should tackle the problem and tells them that they have to consider the different scenarios when they come up with the treatment plan; that they should consider the viable treatment options for the following scenarios, as if they:

1. are in community service
2. are starting up their own private practice in a rural setting and
3. are running a well established rich suburban practice.

Prof Tamlin explains the need for the students to consider the different treatment options with respect to consideration regarding the degree of difficulty associated with each option.

Five minutes from the time Prof Tamblin asked the group on how they preferred to run the process, he alerts them to the fact that they still do not have a chair to run the process **he had not given them the chance to do so, as he had started by telling them that they did not have to set ground rules – may have confused the students on the administrative process.** At this point, Stavros volunteers to chair the process. The students then assert that they will not need a time keeper as each one of them will be aware of keeping on time.

Twenty minutes from when the group met, the process of engaging with the paper case begins at 1437 when Stavros, as chair of the process, points out the important issues from the case that they need to engage with before they can plan the treatment for Mark. Prof

Tamblin then introduces the photographs **another set of extra material / resources introduced** taken of Mark. Stavros suggests that they should tackle the case as they would normally do in the clinics **offers a method of how to conduct the case planning**, i.e. follow a similar pattern:

- i) Initially record the patient's main complaint and unpack the history of the complaint;
- ii) followed by the dental history (with an analysis of the provided records)
- iii) then the social history
- iv) finally tying in all this to formulate a problem list in order to assist with the derivation of treatment options.

Stacy points that that Mark's concern seems to be with regard to his appearance **picking up pt's main concern: AESTHETICS** and other members of the group nod in agreement. Nandi volunteers that function **associated issues pointed out** may also be an issue, however, she does not expand on whether this would be an issue for Mark, his mother or the treating practitioner **and how this information can be obtained**. At this point Prof Tamblin makes a suggestion to Hemant that he should be more cryptic in order to get the keywords as the discussion amongst the group ensues **scribe had been attempting to be comprehensive with recording the notes and therefore not noting key points – demonstrates that Fac aware of what the key participant are doing**. He explains why, as Hemant is attempting to write every word that is being said, and missing out on the discussion.

Stavros brings the discussion back **there has been slight deviation during the discussion without focused discussion relating to the issue at hand – chair follows through on leadership role to bring the discussion back** to the key problem regarding the history of the main complaint. Prof Tamblin then adds extra information relating to the background about the patient, informing the group of students that Mark was originally managed / treated by Dr Patel and makes a jokes about Dr Patel's repeated absences due to her taking time off to go on maternity leave **how relevant this last bit of information is**

escapes me, apart from driving the point home that the case under discussion was indeed a ‘real’ case that as treated by a staff member in the School.

Kajil goes on to explain the relevance and importance of the presented dental history, however she uses ‘lay’ terms to offer explanation **student does not demonstrate engagement with professional terminology as required of them**, to which Prof Tamblin asks for more technical / professional terminology and offers an example of ‘partial anodontia’ to explain ‘congenitally missing teeth’ as opposed to missing teeth due to trauma or extractions. Stavros offers that the group should look at the dental history by unpacking it into the different disciplines **example of compartmentalisation of the learning process though may be giving students a way of managing the discussion and offering some degree of horizontal integration engagement with the case** available, whilst Stacy suggests that they look at the dental history chronologically **example of focused, integrative approach to the problem**. Before any discussion around these suggestions can ensue, Stavros starts talking about the treatment plan and offers a definitive option **demonstrating nil attempt to engage in the diagnostic reasoning process to arrive at the treatment options!** Janice questions the need for extractions at an early age and Stacy offers that they discuss all these points that are being raised around the actual case / scenario **drawing the discussion to the desired process and sequence of discussion – e.g. of aware student re diagnostic process reasoning and contextualisation of the learning issues**.

This discussion has been going on for about five minutes without any clear direction and at this point Prof Tamblin asks:

What happens to retained primary molars?

Prompts the discussion to a particular route to follow re the hypothetico – deductive process to assist in the diagnostic process; requires activation of prior knowledge from another discipline – ORTHO; ORAL BIO; PAEDS

Stavros answers that they become ankylosed and Prof Tamblin agrees with that answer as he nods in the affirmative. Further options are given by Stavros which I cannot hear.

Graham explains why things were done at which age and the implications thereof, and points out that treatment procedure time and age of the patient need to be considered.

Demonstrates knowledge integration in the points raised, offering rationale for the points raised

Prof Tamblin asks a question about why a chrome partial denture should not be considered as a treatment option, to which Graham explains why the metal based denture may not have been done, however he questions why a metal partial denture was not provided for Mark student not clear on why things were done the way they were?

Facilitator has taken the students several steps along the process quickly and making them see the issues 'backward' ie questioning reasons things were not done. The ensuing discussion then centres around public service vs. Private practice options and the financial constraints imposed by public service dental services discussion moved to FINANCIAL (too quickly), though they bring the service aspect in and alert one to the different emphasis on service delivery dependent on the service being utilised. To which Nandi adds how students as well influence treatment provisioning for patient because of the 'quota' a very topical issue in Dental training! process where students have to do certain procedures in any particular year in order to promote to the following year of study. There is general laughter from the group with some comment that

when one get allocated a patient who needs a piece of work that you have already done, you dump the patient and look through the waiting list book for a case that needs work that

you haven't done offering insights on why students do what they do in terms of service provisioning – little element of comprehensive patient care, instead service driven by clinical procedure requirements

Stavros then wraps up the discussion on the dental history 10 minutes since start of c/o discussion: note some discussion re tx option has already happened! and suggests that the

group discuss the relevance of Mark's medical history. There then follows animated discussion amongst the students and Kajil suggests that

appearance seems to be an important issue here

still takes it back to unpacking the main complaint and trying to reason the diagnosis

and offers a further suggestion that they need to consider appearance and relate it to 'size, at which point Stavros cracks a joke relating to Kajil's diminutive size. However, Stacy notes that they need to look at the point as an intellectual issue **power relations?? Both female students are vertically challenged.**

At this point Stavros asks Patrice **who has not contributed much to the discussion so far**

What do you think?

Who laughs and says that

Pretty much what everyone else is thinking

He (Patrice) brings up the issue of Mark's age and points to the relevance of age to the whole discussion, specifically relating it to Mark and his mother **takes up issue under discussion seamlessly, showing that had been cognisant of the discussion, even though was not an active participant.** Nandi questions the length of time and its influence re the duration of treatment. Graham comments about the importance of aesthetics at certain ages and queries that maybe there are outside factors that may be influencing Mark and his mother to seek dental intervention – and he offers the suggestion that maybe the Matric dance may have an element of peer pressure on Mark, hence the dental consult. Stavros asks the group to reflect on their own personal experiences at that age **personalising the intended service provision; demonstrates the multi-factorial aspect of the presenting c/o and what issues need to be highlighted and understood in order to offer reasonable options that will work for the patient.**

Nandi then offers that maybe Mark sees partial dentures as a treatment option for old people and not suited for someone as young as him. Stavros then directly asks Mmapula for her thoughts on the case as she had been quiet. Mmapula counters him and tells him

that she did contribute (looking at the pictures). Patrice interrupts Mmapula and comments on social strata using 'Sandton kugels' as an example and how they (the kugels) may be exerting pressure on Mark about his appearance and how this may impact on Mark's expectations of the dental treatment / management. At this point Mmapula says that she made a contribution about patient expectation regarding the dental treatment. Stacy then comments on Mark's mother's influence at different stages and how this may impact on the management of Mark's dental needs. She further goes to explain the relevance of function and how this can draw attention to the mouth and therefore make Mark more self conscious as he becomes more aware of his appearance. Mmapula and Nandi are making comments and adding to Stacy's contribution. Stavros stops their conversation and calls on Janice to speak out and Janice goes on to speak for more than a minute. When she gets to the end of her contribution, Stavros then asks the rest of the group if they want to add anything further to what Janice has said. He asks the group how they can ascertain what teeth are present, **as difficult to tell from just the models** to which Janice brings in the Lateral cephalograph radiograph as a tool to determine the growth and therefore date how old a patient is and hence be able to tell which teeth should be there. **prosthodontic options and diagnostic reasoning evident and how factors come to play. A lot of content discussion with reasons given**

Nandi does not wait for further discussion around growth when she contributes the importance of finances and the relevance of medical aid to the whole case. Prof Tamblin takes up that point and asks the group what the age limit for dependant support is and offers 25 as the cut off age **details that they are not taught , however fall under practice management**. I made a comment and pointed out the proposed Child Act **making them aware of proposed legislative changes**, which was a topical issue at this time having been reported recently on radio and TV media. Stavros says that maybe someone in the group will need to do some research on the bill **students not aware, chair recognising need for further enquiry into this issue**. He explains that they would need to look at issues of concern around the proposed Child Act and the legal implications pertaining to Mark's case **point them to the need for contextualising follow-up issues to the case and hence**

making the discussions relevant . He then brings in the models and notes that they will be useful for charting what teeth are present and what dental restorations have been done still no take re which teeth are actually present and minimal note made of previous comment on using available radiographic tools to assist the process. Dimakatso*, Mmapula and Nandi then comment on the need for analysis of the radiographs. Prof Tamblin then directs the group on what they can get from the models and radiographs and notes that they need to look at what is there thereby giving guidance on the way forward Fac may have picked on this and thus reinforcing need to use all available tools to consolidate information to assist in the diagnostic reasoning process. Stavros asks for the records to be passed around the rest of the group so that all can have a look at them. Stacy has the models and makes comments on what teeth are present on the models, both on the upper jaw as well as the lower jaw. In the meantime, Dimakatso, Nandi and Mmapula are looking at the radiographs and discussing them amongst themselves. Hemant shouts that

I am present

May be feeling left out as has not been part of the discussion and mainly concentrated on taking notes

Lack of discussion control as several groups of students talking at the same time amongst themselves

Nandi joins in the discussion among Kajil, Stacy and Janice and they talk about which teeth are present. Prof Tamblin seems to be reading what is written on the whiteboard, upon which he asks for clarity re some abbreviations used by Hemant. He asks which department did the 'Sp' abbreviation originate from, following Hemant explaining that Sp (supernumerary) meant 'tooth annotation'. Prof Tamblin, and several of the students are trying to sort out the confusion re exactly which teeth are present. The point of confusion being whether it is the deciduous or permanent canines that are present. The facilitator then offers suggestions for making it easier, giving different pointers re tooth identification. Stacy, Kajil and Janice offer that it is the third quadrant, however, Prof Tamblin questions why the tooth on that side has hardly erupted. There is no forthcoming answer from any of the students, instead Stacy asks about the anterior crown form re

morphological features which should be expected in this particular case. Prof Tamblin then asks the group

What syndromes are associated with hypodontia?

Instead of offering an answer, Kajil draws the group's attention to what has already been stated in the dental learning package (DLP) that

Mark has congenitally missing teeth

At this point (more than an hour to the conclusion of the lesson) Prof Tamblin suggests that the students should draw up learning objectives and gives examples

Development of hypodontia; diagnosis; further tests that may still be required

At this point, there are several discussion going on between

1. Janice – discussing the importance of removable partial denture and space issues
2. Stacy – questioning the impact of sinus size
3. Graham – asking “what is it?”

Stavros offers that there are different conditions that cause hypodontia and gives some examples, to which Janice points out that they need to formulate a diagnosis for this particular case. The Chair (Stavros) draws the groups' attention to why they need to treatment plan and Nandi states that they need to come up with a differential diagnosis and Mmapula asks about the effect of the hypodontia on any proposed treatment and asks

What other syndromes can affect treatment?

Graham does not wait for any answer before commenting on the relevance of the implant course that the students have recently attended and how implants may impact on proposed treatment. Patrice focuses the group to the fact that there is certain information missing especially pertaining to diagnostic tools. Stacy takes up on this comment and explains how the normal treatment process should follow. Patrice then asks about a Stefan Curve and questions the lack of provision of such for this particular case as it would have contributed to aiding in the diagnosis regarding the caries susceptibility for

Mark. Graham reiterates the importance of a proper diagnosis to aid in treatment planning. Stavros then points out that they need to establish why teeth are missing and therefore ascertain the type of syndrome that Mark presents with. Graham, and Stacy add further points that need to be considered and add that there is missing information pertaining to the medical history which may aid them to come up with a relevant diagnosis. Kajil expands on this. Prof Tamblin then adds that they need to consider which special investigations are required and how this would impact on potential treatment. This is about 8 minutes since he asked the group to consider drawing up learning objectives for further investigation.

Stacy comments on implants and their impact on bone and how they help preserve alveolar crest levels, however Graham stresses the importance of relating all this to the presenting condition. Kajil asks if anyone present has a Pathology textbook with them and Patrice tells the group that they also need to consider the importance of family history for the presenting condition. Prof Tamblin however reassures the group and asserts that there are no other associated problems and explains the need to find out more around the central issue of the case.

Graham then talks about what the 'ideal treatment' would be and how it would look once modifying factors are considered and that they will have to consider all 3 scenarios as stipulated in the instructions to the students. Prof Tamblin reminds them as well and confirms that they need to come up with 9 treatment plans. To which the rest of the group asks

Why 9 treatment plans?

Stavros explains the combinations (re the scenarios) to the group – explaining that there are supposed to be 3 treatment plans for each scenario and that there are 3 scenarios, therefore making it 9 treatment plans. Graham also tries to explain this in a way

reinforcing what Stavros has just explained. A short discussion ensues around how the SOHS does dental treatment planning.

Prof Tamblin interjects and explains the relevance of 'informed consent'. At this point Graham jokingly invites Prof Tamblin to the next session (even though knows that Prof will not be there). To which the facilitator retorts that the discussion will need to be carried out in the plane as he will be travelling.

Janice draws the discussion to focus on how they should conduct the self directed investigations and offers that they should look at it systematically:

Consider the upper and lower arches

What investigations are needed

Therefore what would be the treatment options available following derivation
of the appropriate diagnosis

Stacy offers that they should tackle it in the manner that the clinical records used at the SOHS are laid out. Stavros takes it back to the presenting picture by clarifying what they are tackling during which Nandi, Mmapula and DIMakatso are engaged in a separate discussion on how to tackle the case. Stacy brings Hemant into the picture by correcting some of the notes that are on the whiteboard especially pertaining to chronology of the presenting condition. Stavros brings the discussion to include the importance of dentures and Janice asks about extractions. Graham wants to find out where the previous dental work was carried out. The rest of the group laugh out at this. Nandi asks about the metal based partial denture. The facilitator becomes more directive and asks

Is there more information needed, for example evidence for longevity of
deciduous teeth

and the relevance of this wrt different treatment modalities eg - implants supported prostheses, root canal treatments etc and the evidence to support the different options is explained. Further, treatment options and how their choice is affected in private practice is explained?

He directs the students to the use of relevant journals, textbooks and the internet as resource tools to assist with their research. Stavros asks the rest of the group

What do you need to research?

To which he elaborates with some examples such as – retained primary teeth; how long they can last.

Stacy comments on the available radiological evidence and queries the ankylosis.

Prof Tamblin raises a question pertaining to implant supported prostheses and asks if there is enough data presented to support this treatment modality

What is needed?

Patrice asks if they will need additional radiographs.

Prof Tamblin comments on the complexity of the case regarding the lack of all relevant information and suggests need for treatment options and explains:

how to; why and what

and tells them that it is a fun process when working the options out.

Stavros says something inaudible.

Prof Tamblin continues urging them on to have fun during the ‘finding out phase’

Stacy throws a question to the group about the financial implications especially regarding the maintenance phase.

To this Prof Tamblin explains that each scenario needs to have alternatives within the treatment options and explains the complexity vs. Simplistic approach to the treatment

planning, including envisaged medical aid (third party funder) issues / implications vs. when one has to pay 'out of pocket' and not having a third party to pay the health bills.

Graham discusses issues around:

Appearance

Parental expectations

Operator limitations and its implication wrt meeting parental expectations

What is feasible before treatment is started

Stavros brings in two members of the group into the discussion, who have not been vocal during the discussions – the scribe (Hemant) and Dimakatso, and the latter says something that is inaudible to me.

He goes further to offer an option re a learning objective centred around studies on longevity of retained deciduous teeth. At which point Patrice asks what the parental expectations and their implications would be. This question has already been asked by Graham earlier at around 1531 and Patrice asks it again two minutes later.

Stacy however clarifies the process of the treatment planning discussion and its relevance wrt to parental involvement

Graham interjects this explanation with the question:

What if the patient does not actually want what his mother wants?

Kajil then reiterates the importance of including Mark in the decision making process and hence getting 'informed consent' from him.

Stavros draws the groups attention to Graham's comment about parental vs. patient expectations and takes them back to the written case asking

What is the role of the DLP?

He starts to link the presenting condition and asks relevant questions around

Hypodontia, possible associated syndromes, issue of the retained primary teeth and their expected longevity, the treatment options re implant supported prostheses and related factors around bone quality and amount (*this is about 10 minutes since he asked the group what they were going to research – some degree of learning objectives derivation?*)

Both Janice and Graham offer different ISP types and the need for multidisciplinary treatment / management approach and the relevance of such an approach. They explain that this is needed as it makes for better management of the case.

At which point Stavros draws the group's attention to the occlusion as presented on the study casts (models).

Patrice queries the need for Orthodontic treatment, and Stavros points out the need for research on

Fixed things on retained canine teeth crowns

Janice asks how one would restore the occlusion

How would you restore the occlusion?

Prof Tamblin then points the group to the fact that no one has mentioned clinical crown lengthening and for the second time (following a comment made by Prof Tamblin), Mmapula says that

I was just thinking that

And Prof Tamblin implores her to

Think out loud

To which the group of students seated near Mmapula (Nandi, Dimakatso and Janice) laugh. Without tying in Prof Tamblin's comment re clinical crown height assessment, Janice draws the group's attention to 'long tooth', whilst Hemant offers that the concept of immediate loading (re implant therapy) can be used as a treatment option. Janice expands on the theme of occlusion by commenting on the available posterior occluding

pairs (POPS) that are present. Graham queries the amount of space available for prostheses to be made – whichever type, ie be they removable or fixed. He does this whilst looking / examining the models to augment his argument.

Mmapula queries the need for aesthetic consideration, to which Prof Tamblin asks the group about whether they have considered the lip line and its impact on aesthetic and its importance to aesthetic analysis during treatment planning and he points out that none of the students has brought the issue of the lip line up during discussion. However Nandi mentions that she did bring it up earlier.

Stacy offers more detail on how to assess the aesthetic issue; such as assessing the smile line. She does this whilst looking at the provided photos and relates them to the models. Similarly she does the same for the issue of occlusion and uses the lateral ceph and points how it can be utilised to assist in assessing the occlusion. She reinforces that they may be a need for a proper occlusal analysis to be performed, however Prof Tamblin tells them that they can assume that the way the models are trimmed, it is the way Mark's teeth occlude.

At 1543, Stavros mentions the fact that they need to consider the evidence based principles during the discussions. Stacy continues the discussion on occlusion, to which Prof Tamblin suggests that the presenting

occlusion does not look bad

and makes the group aware that there is difficulty regarding the lack of clarity on issues relating to occlusion.

Stacy queries the positioning of implant restorations especially given the above points including the ones re space availability raised by Graham.

When there does not seem to be any clarification from any of the students on these questions, Prof Tamblin urges the group to stop

We need to stop now

This is 15 minutes before the scheduled end of the lesson.

Stavros asks the group if they need to add anything and when there is no response he reiterates what has been decided regarding the learning areas that need further research

Janice points the group's attention to Mark's school schedule and Nandi draws them to fact that they should not be blind to what the case requires of them, ie assessment of the risk / benefit for each treatment option proposed.

The allocation of areas needing further research takes a good 5 minutes, and in the end Stavros suggests that they pair up in their clinical pairs for undertaking of the student directed aspect of the case / exercise.

The discussion is concluded at 1550.

APPENDIX 3.2A

DESCRIPTION OF PBL SESSION AUGUST 17 2007

BDS 5 START CASE BASED DLP – PROSTHODONTICS & ORTHODONTICS
(MILSTEIN ORTHO CASE??)

DLP SESSION 2 – REPORT BACK

Fictitious names have been used throughout lesson description

START: 1401

FAC: Dr Boitumelo

	FB(mp)	Fl(sr)	MW(mm)	
MI (ng)				FB(msk
X				Chair-
MB (tc)				MM
				Scribe-
FCh				NG
(nw)				
				FB(set)
				FAC(jls)
				X
	FW(nv)		OBS(moi)	

Arrival times of students:

Stavros - 1403;

Mapula - 1404;

Stacy - 1404

Facilitator filling out forms and getting 'chair' info from students

Talk re 'still remember some of you clearly – Hemant!'

1400-1405

Dr Boitumelo, myself and most of the students arrive at the CHSE PBL rooms. The rest of the students trickle into the room with Stavros arriving at 1403; Mmapula and Stacy at 1404. During this waiting time there is light-hearted talk amongst the students and Dr Boitumelo is busily filling out the student assessment forms and making small talk with them, telling them that she 'still remembers some of you clearly' and this remark seems to be directed at Hemant.

1405-1407

It looks as if Dr Boitumelo has finished with the paper work and is now examining the study models that are on the tabletop. She asks the group if they enjoyed the case. None answer instead there is laughter from the group and Mmapula says that she is tired, to which Dr Boitumelo asks her:

'tired of the case or what?'

However she (Mmapula) offers no explanation. There then ensues a discussion about the state / condition of the study models as some teeth on the model are broken. Some of the students retort that Hemant was the one tasked with the responsibility of looking after the models, and he tells them that when he had the models the previous day, there were still fine.

Dr Boitumelo asks the group if they are going to wait for Graham, and at that moment Graham arrives and joins the group. Dr Boitumelo jokingly asks him "are you flushed

with success ?” with reference to him just having had a test in MFOS at the end of his MFOS block.

1407-1408

Stavros welcomes Dr Boitumelo and this signals the start of the PBL session. She jokes that they can call her ‘Prof T’ as she is standing in for him, to which the group laughs. Stavros explains what they decided on at the previous PBL session and how they are going to conduct the report back session and explains who is going to report on what aspect of the topics that had been identified for further enquiry. He invites Patrice to talk on the learning area he had to research on.

1408-1412

Patrice explains the ‘Child Act’ (reading off a prepared script and talks to the group as well as engaging eye contact with members of the group). He explains and highlights the controversial parts of the act (which he reads off). He confirms that as the act has not yet been signed into law it is still considered a ‘bill’. He explains the various ‘groups’ that he consulted with during his research – SADA, Medical, Law colleagues etc. Mmapula, Dimakatso and Hemant appear to be enthralled with the presentation and are watching Patrice eagerly and enthralled.

Stavros asks him a question, and Kajil follows it up with another related question. Patrice answers this and his response is affirmed by Janice and Dr Boitumelo who further confirms that it is still a ‘bill’ and therefore not law yet. She asks him what the official legal age of consent is but no one seems to be aware, so she provides the answer and tells them that it is 18 years with an additional comment that “they all want to be grown up before time”. **E.g. of the facilitator attempting to encourage discussion amongst the group by asking relevant questions pertaining to the learning area reported on (as stipulated in the Facilitator Guide).**

1412-1413

Patrice has ended his ppt and Stavros presents the learning areas he gathered further information on. He explains the relevance of the treatment plan and treatment sequence for this case. He offers an explanation on the treatment sequence for this case and asks the group about the extractions that may be needed for Mark's case, to which Kajil informs them that someone else will be presenting on the issue of extractions.

1414-1420

Dimakatso's turn focuses on the primary dentition. She reads from a prepared script (other members of the group-Mmapula, Kajil, Stavros, Graham seem disinterested with Mmapula examining the radiographs, Kajil looking at her own documents, Stavros doing the same as well as writing something and Graham is actually reading a book!). Dimakatso explains certain aspects pertaining to the primary dentition and during this part she is not reading off a script instead she is 'talking to' the group and the explanation sound more natural, well thought out and informed. She has switched her attention to looking at Dr Boitumelo. Stavros nods in the affirmative to a point that Dimakatso makes: ie when Dimakatso offers that orthodontics would be the preferred treatment choice as the primary option.

1421-1424

Stavros explains what was discussed by the group the previous day and Dimakatso interjects and offers more explanation. Stavros asks her if she looked at the primary teeth that are ankylosed and she answers by offering more explanation with reference to the articles that she used in researching her topic of discussion. She unpacks the detail required and offers evidence of what she is talking about, even when Stavros probes

further, she is able to offer compelling arguments for her opinions / answers and she gives relevant options with contextualised examples and relates them to the actual case under discussion.

Stavros asks if anyone in the group investigated the surgical phase to which Graham and Stacy say they investigated the role of implant supported restorations.

Graham asks something that is inaudible to me and offers a suggestion as to how to run the report back session and the rest of the group seem to be in agreement with this suggestion.

1425-1428

Nandi explains certain parts of what she and Mmapula gathered more information on and Graham wants confirmation regarding what exactly they are dealing with: syndromes vis a vis random isolated, unrelated pathologic conditions and Dr Boitumelo gives an indication that they are dealing with a syndrome case. There is a two way banter between Graham and Nandi regarding what issues are pertinent to the condition that Mark presents with. Stavros offers that they need to consider removable partial dentures as an option and discuss around that issue. Janice throws in a question about other possible treatment options for the immediate phase and Kajil alerts them to the possibility of considering orthodontic management.

The discussion still feels 'patchy and bitty' without a considered effort to link all the relevant issues that the students are throwing around. It seems as if they are throwing around broad issues and not unpacking them and relating it clearly to the case under consideration.

The discussion seems to lack integration and contextualisation of information gathered. Students report on the 'bare' facts and do not attempt to relate them to the actual case under discussion.

There also seems to be a lack of direction on how to run the lessons. This is evidenced by the fact that, a good twenty (20) minutes into the lesson, a student suggests how the lesson should be conducted. They may have been thrown out by the presence of a different facilitator in the middle of the case, even though they had been forewarned about this eventuality at the beginning of the case.

1429-1434

Graham takes up the report back and starts presenting on the issues he researched on; he reads off a prepared scripts using it as a prompter and explains concepts, adding his own opinion or take to the issue being presented. He adds a degree of light heartedness by joking that he's 'a copy of Prof T's book' (this is with reference to a prescribed text in the subject area where the author is the head of the department). The rest of the group enjoy a good laugh over this, including Dr Boitumelo. Graham then draws the group's attention to the importance of tooth morphology with respect to partial denture design principles and relates it primarily to the case under review. **There is an element of demonstrable' critical thinking' skill where the student demonstrates his own critical analysis of the issue under discussion**

Stavros adds further reasons for the reported symptomology to augment Graham's explanations. Nandi asks to add something and offers that they can consider crowning the first molars and attaching precision attachments to increase the retention, to which Graham asks her why they would need to do that. **No answer is forthcoming however**

A separate discussion between Stavros, Kajil, Dimakatso and Mmapula ensues around the case. **It seems as if the group has lost focus of how to run the discussion**, and this continues for about a minute, before Dr Boitumelo interjects and asks the group why they think the Lateral Cephalograph was provided in this case.

1434-1437

The students collectively answer that ‘we don’t know’ and follow this with what sounds like embarrassed laughter. Someone offers that maybe the radiograph was included as the case under discussion is an orthodontic case but does not explain why.

Dr Boitumelo then gives a brief explanation of the important features and issues with respect to the case under discussion. This turns into a mini-lecture on what issues to look out for in such cases. Stavros then mentions the point about vertical dimension and makes an assertion that maybe an orthopantomograph (Pan) would be a more realistic view to source.

Dr Boitumelo explains how radiographic evidence / tools enhance the diagnostic process. Other points she raises are wrt the use of removable appliances and the different designs with the associated components. To which Janice contributes additional information re using the retainer as a partial denture by the addition on teeth to it.

Another question Dr Boitumelo poses is wrt the relevance of the height of the clinical crowns vis a vis the provision of crowns and Stavros is quick to offer the recommended guidelines regarding the minimum clinical heights required for consideration before crowning of teeth. This is expanded on further by both Janice and Nandi.

Nandi mentions the issue of the timing of the request for treatment – i.e. Mark preparing to attend his matric dance, and therefore maybe becoming more concerned with how he would look and does not want to be different from the other students. There is a discussion around the impact / influence of peer pressure on how one looks especially when wanting to belong to a particular group and being ‘in’ with the crowd.

1438-1441

Stacy brings up (yet again!) the issue of the need for more detailed occlusal assessment and analysis. This is despite Prof T’s assertion that the students can take the presenting model trimming as the presenting occlusion. She even offers the point on the possible need for a diagnostic set up in order to facilitate the occlusal analysis. There then ensues a discussion around occlusion and its relevance to the presenting condition with one

suggesting that maybe they need to consider occlusion during the planning for the immediate treatment phase.

At this point Dr Boitumelo brings the group back to the case under discussion

‘Can I bring you back to the scenario, does it say anything about a matric dance?’

She also tries to bring Mmapula’s comment about Medical Aid’s importance to the discussion. The group takes up on this suggestion instantly and a discussion around the importance of medical aid funding starts.

After about a minute Stavros asks the group to focus the attention on specific issues relating to the case at hand. Dr Boitumelo then contributes more information relating to Medical Aid and issue of dependants. She brings the group back to what is required of them in this particular case and reads out the actual text from the DLP **note to self – quote the said text.**

1442-1453

Stavros offers that an implant supported prosthesis (ISP) is the best option and offers some of the issues that would need to be considered if this is the chosen option. There is a lot of lively discussion around the implant option with all the students contributing.

Having exhausted the implant opinion, Janice continues with the report back and her area of discussion relates to growth and classification of skeletal and dental relationships and their impact on provision of ISPs, especially in adolescents, considering the issue of submergence of implant fixtures. She gives reasons for the importance of timing of placement of the implant fixtures in such cases (i.e. paediatric cases).

Dr Boitumelo explains and alerts the group to the issue of orthodontic treatment (and specifically mentions that it is stated in this scenario). She leads them to start thinking about involving orthodontic specialists and the value of teamwork (including other

specialists) especially regarding the timing of treatment and different procedures. She explains the reasons for the need for teamwork.

She asks the group why they thought that implant supported prostheses were the BEST option (as stated by Stavros earlier) and passed a joke about 'titanium deficiency'.

Stavros's reply points to the reasons why crowns are not a suitable option in this case and therefore their suggestion re implants, to which the facilitator queries the biological price inherent with the desired option. She has to explain and give answers to her questions.

Stavros then offers the option of using an overdenture to increase the vertical dimension, to which Dr Boitumelo asks why the vertical dimension needs to be increased. Janice offers the option of using an orthodontic removable appliance as another option for the same purposes and Nandi asserts that those same features can be incorporated into the overdenture and the facilitator corrects them and tells them that it depended on the treatment sequence. Dr Boitumelo then goes into a 'questioning' format to try and get clarity from the students on issues relating to the vertical dimension and when none is forthcoming she leads them towards thinking about doing a diagnostic wax up / set up. At this point Stavros picks up the lead and comments on the need to ascertain the presence of restorative space and Dr Boitumelo offers that the presenting case has negative (reduced) restorative space.

She directs the group through adopting a systematic process to the problem at hand in order to assist with managing the presenting case.

Several students raise the question of extrusion and how to manage / instigate that, and they continue the discussion to include orthodontic appliances and how these could assist in managing the vertical dimension issue.

1454-1510

Following the discussion on orthodontic issues, Dr Boitumelo raises the issue of age and how it would influence the treatment planning. She leads and controls the discussion in a 'lecture-type' format: giving information and explaining concepts. She does not engage

the students, nor ask for any comments wrt to them understanding what she is talking about:

She takes over and

1. The first thing to do will be to decide ...
2. Explains why space creation needed
3. Gives options 2 ways
 - A) can patient tolerate increased VDO
 - B) use bie plate
 - C) overdenture fabrication as
 - D) diagnostic denture for orthodontic management

She discusses orthodontics vs. Prosthodontics care, making argument for prosthodontics management. She uses 'contextualised' language e.g 'OH freak' to drive points / issues home. Other issue she brings out for consideration include the decision to use primary vs secondary dentition as possible appliance abutments and she uses the available tools – study models, radiographs, clinical pictures – to drive points home and to demonstrate what she is talking about / explaining.

All this explanation continues until 1500 and the students are busy taking notes during this time. At the end of her explanation, she asks them question regarding realistic expectations, she also brings in the context re TV (and uses Beckham's plastic surgery as an example) to the case. Most of the questions are answered by Janice. Mmapula adds that there will be a need to prepare the teeth as overdenture abutments and Nandi recalls Dr Boitumelo's comment re using the overdenture as a diagnostic aid to assist with the treatment planning in determining how much increase in vertical dimension Mark can tolerate. She also makes appoint of why she would choose the option of an overdenture as first option, followed by an implant restoration as a later treatment option (Nandi seems to have taken over the discussion from the facilitator at this point).

After the contribution from Nandi, Dr Boitumelo brings in the point regarding the partially erupted canines and the challenges associated with this picture / scenario. She gives definitive options / suggestions pertaining to the orthodontic management:

1. as an interim measure, she suggests to provide a removable partial denture or splint to effect the required vertical dimension changes as well as establish Mark's tolerance levels
2. she suggests undertaking orthodontic to extrude the anteriors
3. she reiterates the need for further radiologic tests and suggests taking a Pan

The language used by Dr Boitumelo is very pedestrian – 'gooi the implants' – maybe in a bid to get the students attention.

She drives home the need for approaching the management of this case as a team and explains that the treatment depends on what other specialities can do for the prosthodontist / restoring dentist. She makes it clear that what is deemed 'best' is not the fastest and cautions the students from thinking this way – i.e provision of a quick-fix solution.

1510-1518

Janice raises the question of the use of surgical methods to increase the vertical dimension and offers the use of osteotomy procedures as an example. Dr Boitumelo continues to take over the discussion and gives an explanation of the proposed management strategy, reiterating the timing and length of time the treatment will take. She asks if there are other options proposed by the students and specifically directs the question to Stavros, who replies that 'what you've given, is'.

Stacy then brings up the point of offering Mark's mother advice and offers some suggestion as to what advice to give her. During this Dr Boitumelo emphasises the importance of a diagnostic set up as an aid to the planning of the treatment. Nandi then points out that one of the staff members (Prof Green) routinely tells patients that she can make them look like Julia Roberts, at which point Dr Boitumelo brings their attention to the post operative clinical pictures and offers how orthognathic surgery can improve the appearance, she talks about the involved time – frames, risks, benefits etc and directs the students to all these points and gives the necessarily reasons for some of the points.

1518-1529

Dr Boitumelo then gives the floor back to the group chair – Stavros – and asks them to discuss the alternative treatment plans: Rural vs Community Dentist scenario. Stavros leads the discussion pertaining to oral health and its maintenance. She alerts them to the challenges inherent with performing a full clearance as one student suggests taking all the teeth out and provide a denture. Janice suggests that they may be able to fabricate an orthodontic appliance that is aesthetic whilst relying on the growth spurt. The facilitator then offers further input regarding what Janice has just suggested. Dimakatso then suggests the need to consider the financial implications and the influence of the setting on the suggested treatment options, at which point the group goes into discussing the case where the family has moderate income.

Dr Boitumelo asks them for the proposed treatment option under such financial consideration. Nandi offers the need for genetic counselling wrt the other siblings / generations who may have similar affliction. Stacy suggests that the treatment offered should be the same with such financial considerations until the need for implant restorations. The facilitator then offers further explanation regarding overdentures and the potential challenges wrt to the setting (rural) – need for frequent review appointments, need increased skill sets both technical and clinical etc. The group then come up with other issues such as – transport, commitment, communication etc. The discussion that ensues within the group needs little intervention from the facilitator at this point. They then discuss the alternative option to an overdenture in a rural setting and emphasise on the need for restoring function.

At this time, there seems to be reduced energy levels amongst the students and the discussion is not as lively as earlier. This prompts the facilitator to ask them what is going on and Kajil retorts that ‘it is intense’ to which Dr Boitumelo tells them ‘this is a walk in the park’.

1530-1536

Following a lull in the discussion and noting that there isn't much discussion to follow from the students, Dr Boitumelo gives the group feedback on their participation for the session. She tells them that they failed to bring out the vital aspects of the case clearly, and failed to put these issues in a coherent manner. She gives them specific examples such as using orthodontics to facilitate treatment; going through a diagnostic phase etc. She points out that they did not point out what the inherent challenges with each option were and she gives specifics here as well – rural setting eg son / mother moving out etc; moderate income etc. She points out that they did not offer any treatment sequencing, reasons for the diagnostic tools at their disposal and the need for further diagnostics to be undertaken. At the end she asks them for any questions or comments, but none is forthcoming and the session ends at 1536.

APPENDIX 3.3A

DESCRIPTION OF PBL SESSION AUGUST 31 2007

BDS 5 START CASE BASED DLP – PROSTHODONTICS & ORTHODONTICS (MILSTEIN / MITHA ORTHO / PROS CASE)

How Can We Help Mark?

(Treatment Alternatives)

DLP SESSION – PLENARY

Fictitious names have been used throughout the lesson description

START: 1407 – WHOLE CLASS WITH ALL FACs (THOUGH Prof Tamblin WALKS IN SHORTLY AFTER THE START) IN DGA (LECTURE THEATER)

As the session / lesson is held in the auditorium I made no note of where each individual student and staff sat due to the vastness of the room. Most of the students, however, sat in the middle section and the facilitators sat in the section near the exit.

1407-1427

After some lighthearted banter from the group in the DGA, Prof Andressen (as the chair of the DLP) started the lesson by greeting all and welcoming them to the session. He gave a brief overview of the case and told the students that:

Group 3 will present the ideal treatment alternative

Group 2 to present the poor / rural treatment alternative and for

Group 1, he said that other members (students and staff) will consider what they will do. As he starts expanding of the presentation, by relating it to the students' future where they will be needed to make presentations, Prof Tamblin walks in.

Prof Andressen then instructs Group 3 to start, followed by Group 2 and then Group 1. The group of 3 facilitators – including another member of the professorial staff who attended to observe the proceedings: Prof Green - (Profs Tamblin, Lizzard and Andressen) start a conversation which is followed by laughter. I cannot hear what they are talking about.

Noah from group 3 then starts the presentation. He passes around the study models and radiographs and introduces the basic preventive option. The restorative treatment proposed includes the provision of simple plastic restorations taking into account the possibility of occurrence of root / radicular decay. He discusses the impact of orthodontic treatment especially considering presence of the ankylosed tooth. The discussion of the proposed treatment plan takes into account the possibility of rendering complex treatment options at a later stage in Mark's dental management life. He gives reasons for all the options he discusses.

At one point Prof Andressen's cell phone rings audibly and he jokes about switching the phone off. At that moment, Prof Tamblin's phone also rings!

Noah displays notes and plans regarding bone graph (?). The discussion also includes how the treatment should be carried out i.e., the treatment sequence. He also emphasises the need for social counselling with respect to the dental aesthetic requirements.

At the end of his presentation, Prof Andressen asks for questions from the floor, especially asking for comments on aspects of the option that anyone feels was overlooked. Prof Lizzard offers that maybe the questions should focus on what was presented after giving his overview on what had just been presented (**reinforcing the points presented**).

Janice offers that there is need to establish the vertical dimension and also the need to investigate possible underlying syndromes which will point towards a genetic cause. Prof Andressen reinforces the validity of Janice's point and asks the rest of the class if they understand.

Prof Andressen asks Prof Tamblin about the motivation for the 'ideal' treatment. Noah then gives an indication of what is to be replaced and restored, to which Prof Tamblin questions the need for orthodontic surgical determination and Mabel* accedes that they cannot answer to that. Stavros, however, brings in the orthodontic pre-operative diagnostic tools (Lateral Cephalograph) and the information that results from the record analysis that will aid the determination for the need for orthodontic surgery intervention. Prof Andressen focuses the question toward what motivated Group 2's presentation with respect to their proposed Ideal Treatment. There ensues a mini discussion between Pros T and Lizzard which is inaudible).

Mabel offers an explanation regarding the motivation and gives this answer standing at the podium. After this, Yasmin* introduces the concept of 'distraction osseogenesis' and Michelle* explains this concept by further unpacking the detail involved.

Yasmin then discusses the concept of genioplasty, following which Tasneem* discusses frenectomy. Prof Lizzard then explains the orthodontic consideration as pertaining to Mark's situation and tells the students that the case was actually treated when the DLP was initially developed and done by the students. E.g. encoding specificity

Prof Andressen brings in the issue of self esteem and how it may relate to Mark's case especially focusing on the gender perspective. This reinforces some of the issues presented by Group 3 who discussed the 'Ideal' treatment option.

1427

Prof Tamblin alerts the class to some of the points that were missed such as: treatment determination for the ankylosed tooth and the need for further diagnostic tests / tools before prescription of definitive treatment.

Prof Andressen starts offering alternatives based on the points raised by Prof Tamblin, to which the latter asks the class if 'Prof Andressen did the DLP?' maybe Tamblin realises that A taking over and not letting students drive the process Prof Tamblin then questions

the students further on the need for a diagnostic wax up and its relevance to the case under discussion.

Mabel then offers the information that a Kiesling diagnostic set up may be indicated, however, she does not give the reasons / rationale why this might be so. She then indicates that serial radiography and super impositioning of radiographs may also be of assistance with the diagnostic process in this case. **Critical reasoning not demonstrable, reasons for the extra diagnostic aides not given especially regarding their relevance to the case under discussion**

Noah offers the reasons re model surgery – ie why a Kiesling set up may be necessary.

Prof Tamblin probes the students further on other diagnostic tests that may be necessary and offers leads re how to determine the amount of bone present, or rather, how to determine the amount of bone present using the available tools. This prompts a whole class response of the need for CT (computerised tomography) scans.

Stavros then fills in some of the missing information re: mounting of models on semi-adjustable articulators; determining a diagnostic set up pre-operatively before any invasive tests / procedures are done. **E.g of activation of prior knowledge from Tamblin's prompting of the students by asking leading questions**

Prof Tamblin then draws the class to the issue of removable prostheses, by asking a leading question to direct the students to start thinking along those lines: 'what about metal vs acrylic removable partial denture as a diagnostic tool?'

At this point Prof Andressen asks Prof Lizzard why Mark did not wear a lower partial denture. Seeing that a side-discussion would ensue between the 2 professors, Prof Green alerts them to the need to follow the class discussion and not start their own mini discussion of the case. Prof Tamblin answers the question about Mark not having worn a partial denture and Michelle adds further to the explanation given. Prof Tamblin also adds a note that there might have been other reasons that caused Mark not to wear a partial denture and offers issues regarding Mark not been able to adapt to a denture due to the design of the prosthesis.

Noah then commented that it would have been beneficial if the partial denture was there for the class to see and assess it. Stavros however, gave more reasons for the unsuitability of a partial denture as a management strategy.

Yasmin then raised the issue of the patient's attitude toward dental treatment especially as he was accompanied by his mother, even in the consulting room. She commented on the relevance of Mark's age and whether it was the mother's expectations or Mark's expectations that should be given more priority / emphasis.

Prof Andressen then takes over the discussion on the psychological assessment of patients and adds a lot of points to this effect.

Mabel draws the class's attention to the need not to focus on a 'quick – fix' option / attitude, but rather to look at the case comprehensively with longevity of the treatment offered as the primary concern. To which Prof Tamblin asks her how long she thinks the treatment being offered by the group is going to last. At which point Noah, offers that it could last about 18 months.

Mabel also emphasises the need for a team approach towards the management of the case for improved longevity of any treatment offered.

1439-

Tasneem starts a discussion on the reasons for the missing teeth and the management of such, bringing the issue of genetic counselling in the management strategy, especially pertaining to the other siblings if they need dental intervention in the future.

Nandi (MSkh) then expands on this line of discussion, bringing in the aspect of other dental implications / conditions specifically ectodermal dysplasia and the condition's impact on the provisioning of dental treatment. To which Prof Andressen asserts that Mark's mother would have certainly informed the dentist if her child had the condition.

1441-

With no further uptake of the ectodermal dysplasia issue, Prof Lizzard comments on the relevance of the timing of performing a frenectomy especially with respect to the management of a diastema.

Yasmin and Tasneem give more information regarding frenectomies.

Graham draws the class's attention to the issue of finances and how that impacts on the provisioning of treatment especially related to managed health care and the issue of third party funders (Medical Aids) and Janice adds more information to this discussion about the requirement by Medical Aids for patients to obtain authorisation from them (Medical Aids) before most procedures can be done, especially those deemed complex and not 'run-of-the-mill cases. She points out how this act imposes a lot of stress for the practitioners and how this may impact on the treatments offered.

1445

Michelle starts a discussion on the question of function vs. Aesthetics and how this would impact in Mark's case. However before any input can be had from anyone in the class Prof Andressen explains capitation and how Medical Aids administer this (this does not address the case specifically as the case has clear instructions under which the treatment options are to be considered – one can therefore see this as adding information not really pertaining to the actual case).

This point marks the end of group 2's presentation and Prof Andressen gives them feedback and tells them that their presentation was poor especially relating to the verbal explanations and not the electronic content / style.

1448

Beverley's group then present and Prof Andressen informs the class that the presentation will be a power point one. Beverley discusses the need for a frenectomy, the issue of the missing lateral incisors and how these two factors are critical to the aesthetic challenge. As she seems to be talking only to Prof Andressen, Prof Green reminds her that students need to speak to the class and not the staff. Beverley brings in the issue of the relevance of the patients age with respect to staging dental treatment appropriately, as well as the issue of gender and their impact with aesthetics.

The presentation is quite short and minimal discussion ensues following it. Prof Andressen's phone goes off again and he answers it. At this point, a discussion around Government payment of dental personnel ensues and Prof Tamblin asks what that is of relevance to the case under discussion. He urges the class to concentrate on the issues inherent with the different scenarios as stipulated in the DLP. ? loss of focus from the students with little control by the facilitators?

Stavros brings up the point about the fact that the diastema is already closed therefore is not post orthodontic treatment (the models provided are pre-operative models and reflect the diastema closed). Prof Lizzard discusses the need for a frenectomy, following Prof Andressen asking the question. The latter also points out the difficulty of ascertaining whether it is the primary or secondary canine teeth that are present (Prof Tamlin's group question at the small group stage).

1454

Prompted by Beverley's suggestion of using prosthetic teeth to close the gaps where the missing teeth are, Prof Tamblin asks about the option of using a Maryland Type bridge especially in cases situated in rural communities. He reinforces the notion of using appropriate - technologies to answer and manage some dental conditions where resources are limited e.g., access to specialist dental centers.

1457

Janice, as the spokesperson for their group, presents their choice of treatment. She discusses the middle level scenario – urban setting with limited resources, where money is an issue. She starts the case from the beginning and not taking into consideration issues already discussed and she reads off what is on the slides without really offering much information. However, she does expand on factors influencing the treatment plan slightly.

The presentation ends at 1507.

Prof Andressen picks up the point on ‘partial anodontia’ that Janice talked on and explains to the class that there is nothing like ‘partial anodontia’ as anodontia means ‘no teeth’ and that therefore there cannot be partial anodontia. He asks them about the need to provide a metal based upper partial denture.

From the points raised by Janice, Michelle asks the question why there is a need to increase the vertical dimension and queries whether there is lack of restorative space and points out that if the latter is the case – i.e., no restorative space, they should consider increasing the vertical dimension (VD). Janice explains why they thought why it was important to increase the VD.

Prof Lizzard then alerts the class to the fact that the Lateral Cephalograph and study models can also be used as a tool to assess the VD. He explains that an increased anterior overbite observed on the study models could be an indication of decreased VD, and therefore presenting with the need to increase VD with the corrective management strategy. He gives more clarity on the issue of VD.

Prof Tamblin asks the class how they would reduce the overbite conservatively and the response from them is that they should allow the first molars to erupt more, to which he gives affirmation.

There then follows a ‘question and answer’ sequence between the staff members present with the students not participating in this.

Stavros then discusses Mark's mother, her expectations and issues around informed consent. Patrice comments on the Child Act (bill) of 2007 and emphasises that it is still at the bill stage and has not been enacted into law yet. The class then takes up a discussion around the bill.

During a lull in this discussion, Prof Green passes the attendance register to the class and reinforces the intention of the DLP informing the students that they need not have come up with a final treatment plan, however they needed to have considered all the advantages and disadvantages of the different scenarios during the small group discussions.

Discussion of issues not integrated and following a question and answer mode with the staff present dominating most of the talking and taking over certain points and making them into mini lectures. Not allowing students to develop their reasoning / justification of issues they raise.

Prof Tamblin only one seeming to facilitate discussion from the class and pointing them to issues that they seem to miss out and trying to provide an integrating thread to the student discussion – otherwise Profs Lizzard and Andressen 'giving' students the information and not letting students bring out the issues themselves.

Prof Andressen then informs class that orthodontic surgery is not warranted in this case, at which point he adjourns the session at 1523

APPENDIX 3.4B

DESCRIPTION OF PBL SESSION September 20 2007

BDS 5 START CASE BASED DLP – SPECIAL NEEDS PATIENT

FIRST MEETING

Fictitious names have been used throughout the lesson description

Session started at 1414 Hrs; and ends at 1457, with some students staying till 1504 Hrs
less than the allocated 2 hours

**Recording started in the CHSE rooms and I didn't record the class meet at the DGA
beforehand – groups allocated as per normal SOHS PBL process.**

Facilitator called for selection of chair and used a pencil to spin for: facilitator, scribe and time keeper. The mood was very jovial with lots of laughter from the group. Once the tasks had been allocated to the various students the Fac said 'Chair, take over'

	Zola	Dave*	Khotso	Themba	CODE	
Neo				Lukshana	Dave*	Facilitator
Verushka						
Priscilla				Sandra		
Sue	Fatima	Nicky	Ibrahim			

1416

Fatima volunteers to read off the trigger, and goes ahead and reads the DLP scenario verbatim (see attachment DLP IV.2 The Patient with Special Needs) and after she has finished, Dave remarks that the whiteboard is full of writing and suggests that it needs to be cleaned off as the group needs to do some midmaps. Khotso then asks if anyone has

tissues in order to erase what's on the board. As no one answered in the affirmative, he excuses himself and leaves to look for a board eraser. The group does not wait for him to come back instead they continue with the learning session.

Dave asks the group what the central issue of the DLP is, in order to start on the mindmap. Nicky volunteers – 'Special Needs'. Priscilla is busy writing her own notes.

Fatima tells the group that they need to come up with ground rules for their group, however Verushka says that there is no need for the rules. No one in the group counters this viewpoint, they let it stand without any comment.

To start them off, Dave asks them 'does everyone not have special needs?' Sue tells the group that they should stop asking Dave questions and should instead try and hold the discussion amongst themselves and come up with their own solutions; to which Dave makes light of the comment and jokes that the students are putting pressure on him.

As there is a separate discussion going on between Lukshana and Sandra, Verushka tells the former to stop talking too much.

Khotso walks back in at 1419 and starts erasing the writing on the whiteboard. At this point there is a lot of talking going on amongst the students, and it sounds as if it is nothing to do with the case at hand, rather talk about other issues amongst friends.

1419

Dave asks Verushka permission to speak and reiterates to the group that they need to come up with a mind-map for the case at hand. Verushka then asks the group to build a mind-map to which Fatima suggests that they need to look at the questions routinely asked patients and see how these will differ and lead on from there. She comes up with several suggestions regarding the different areas to start with such as 'socioeconomic issues', and Dave gives a positive affirmation of the suggestion.

When Khotso (as the randomly pencil chosen scribe) expresses difficulty with developing a mind-map, Sue volunteers to take over the role. This is prompted by Khotso having

asked ‘what goes in the middle (of the map as the central feature)?’ and following Themba’s suggestion that they will need to find another scribe.

Dave asks Priscilla to repeat something that she has just said, and she tells them that AGE should also be a point of consideration. Lukshana mentions something that I do not pick up and this is followed up by Priscilla bringing in the issue of CULTURE. Themba adds the aspect of RELIGION.

Dave seems impressed and encourages the scribe to

‘put it in’ (add it to the mind-map)

Themba says something to the effect that ‘but you can pick up, EDUCATION plays a lot’. Following the ‘education’ issue Sandra states that the location of the educational institution is important. There follows some heated discussion on this point between Themba and Sandra, and other students continue their own discussions and are not adding to the education discussion.

1423

During a lull in the discussion on culture and religion, Nicky raises the issue of LANGUAGE and how it relates and ties it into the discussion at hand. Priscilla points out that one’s socioeconomic status also points to their level of education and understanding of issues.

Like previously, several discussions are going on at the same time and Dave interjects and implores them:

‘when the chair is speaking, listen’

Sue jokingly tells Dave that he should not give Sandra that power! And there is some laughter from the rest of the group at that suggestion. Verushka clarifies certain points raised and reinforces the concepts. She also asks the group to further assist in the

clarification and explanation of the points raised to date and Nicky takes on the challenge.

1425

Sue raises the aspect of EDUCATION and the rest of the group start a discussion around this and how it impacts on a patient's dental IQ. Following on, Sue brings up the aspect of EMPLOYMENT and Ibrahim points out that it comes under FINANCIAL. Dave reassures the students that some of the points raised will overlap a bit.

He informs them that he has 5 big headings (in the Facilitator Guide – see Appendix ??) and that they've only come up with a few (looking at the whiteboard and what has been scribed there) –

‘let me see if I can give you a clue; and I'm going to give it to you on a plate’

At this point he reads off some of the points for discussion as depicted in the Facilitator Guide.

One of the students' remarks that it matters that what they discuss is aligned to something, following Dave's input.

Sue remarks that there is some degree of overlap when it comes to the issue of AGE, to which Nicky jokingly says that:

‘Yeah, as you get older’.

Sue lets the remark pass without asking for any clarification, and tells the group that they should go over everyone for each student's input. As Priscilla starts to make her point, Verushka interrupts her. Dave then suggests that they can think of the various changes that happen at each age / stage by using himself as an example to drive the point home. He leads them through all of the developmental stages and the whole succession of issues related to age.

Sue takes up Dave's suggestions and points out to Khotso that the first stage to consider will therefore be paed's and notes the sequence for consideration as: newborn; infant; toddler, adolescence. At this point several of the students volunteer other age stages, and Sue then asks them where she can position 'adolescence' on the mindmap. She also suggests that they can place PREGNANCY under adolescence.

There is some encouraging remarks from Dave about the groups' progress. He actually tells them that:

'good, cool, this is so close to the map'.

1429

Having exhausted the discussion on AGE, the group takes up Fatima's suggestion of FINANCIALS and suggests that they break this up into several aspects. This suggestion is dismissed outright by Verushka without offering any reasons for doing so, and no one in the group asks her for an explanation for her outright refusal towards Fatima's suggestion.

Nicky reminds them that UNEMPLOYMENT will affect a person's FINANCIAL status, and Priscilla adds that what one's OCCUPATION is will also impact on all these aspects.

Verushka asks them:

'are you happy with SOCIOECONOMIC?'

and even though Nicky answers to the negative, Verushka does not take her concern up and offer (or at least ask any other member of the group) clarity to help Nicky understand it better.

1431

Themba offers 'NUMBER OF CHILDREN' as an issue for consideration under the socioeconomic point, to lots of laughter from some members of the group. He explains how this point relates to what is being discussed.

Verushka asks the group if there is anything in socioeconomic / age that anyone needs to be included and Themba offers that they should also consider DEPENDANTS, and Nicky adds that PARENTS can also be included under this heading.

The Chair (Verushka) then asks if all are happy. She does not wait for an answer, instead she comments: 'cool. Now let us go to MEDICAL STATUS'.

Dave is busy reading his DLP pack and several students are talking amongst themselves without contributing to the discussion. Following something that one of the students has mentioned, Dave suggests that they should break down the main topic of medical status into several headings and gives examples of: congenital vs acquired vs systemic, and explains that this way they may be able to cover more ground with regard the discussion – i.e., by unpacking the main heading into smaller topics.

The group then discusses SYSTEMIC DISEASE and during this discussion, Dave asks them: 'what happens just before someone passes?' and Themba answers that the person goes through a TERMINAL stage of the disease process, to which Dave asks him to elaborate, which he dutifully does.

Dave goes on to ask the students: 'what would be a major or minor congenital abnormality?' Themba answers to that to some laughter from the rest of the group, but is inaudible to me. Verushka asks if there are any other 'big congenital' conditions they can think of; however no one volunteers anything. Dave then asks them for the medical term for heart disease and someone gives him the answer – CARDIAC DISEASE.

At this point, Dave tells them that he is almost ready to show them the midmap (but he does not do it though).

Sue urges the group to think of more congenital conditions that they need to consider:

'what other congenital conditions are there, there can't only be 2?'

Themba mentions something that I cannot hear and Dave asks him to speak louder and that he should not be shy (to reinforce and possibly appear more encouraging, Dave touches Themba's arm), but the latter does not have an opportunity to have his say as the ladies in the group continue talking and do not give him the chance nor space to voice his suggestions.

Themba asks the group why they cannot classify this section as 'DEVELOPMENTAL CONDITIONS'. Getting no response from the rest of the group, Sue asks them where AIDS would be classified and Priscilla reiterates that it will be classed under ACQUIRED conditions, to which Sue jokingly states that:

'so you get it from your mom'

1437

Verushka decides to move the discussion on towards SYSTEMIC CONDITIONS:

'shall we move to systemic?'

and Dave advises them to limit the discussion to about 4 to 5 of the more common conditions.

Nicky, Fatima, Themba, Zola and Ibrahim start listing / naming several systemic conditions and the scribe (Sue) writes them down.

Verushka then directs them towards TERMINAL CONDITIONS and Khotso, Themba, Nicky, Fatima and Ibrahim contribute several conditions in this class. Themba goes further to explain and elaborate on some of these conditions offered. At the end of Themba's elaboration, Priscilla asks where HIV can be placed, to which several members of the group reply: ACQUIRED. **Seems to not remember that this was asked and answered previously; maybe indicates need for reinforcement of this issue?**

Dave murmurs:

'Good'

looking at Priscilla.

Themba continues his clarification and explanation of the acquired conditions and also explains how to manage the process through the process of elimination. Verushka then implores the group that

‘under acquired, we will look at all the infections’

Sue then asks them:

‘when are we going to look into the terminal conditions?’

and Priscilla asks if they are going to discuss ALLERGIES under the infections heading. However, before any elaboration / response from anyone in the group, Sue tells them that they should now move to the terminal conditions.

Verushka wants the group to list all that has been discussed to that point before they move to discussing the terminal conditions. Dave asks them what the more common terminal conditions are and without waiting for an answer from the students he offers ‘CANCER’ as an example. Sue offers ‘CYSTIC FIBROSIS’ to laughter from the rest of the group. Themba then states that they also need to consider the ‘PSYCHOLOGICAL’ conditions. At this point there starts a directionless discussion amongst the group to which after a sometime Themba suggests that they need to move the discussion on.

Dave points out to the group that there is a lot of overlap between the learning issues. He asks Verushka to tell the group the importance of knowing the mind map for the future. The answer is given by Sue who does not disappoint in the answer. Verushka then alerts them to what has not been covered yet: MENTAL CONDITIONS and wants a reassurance that it will be discussed next. Verushka offers an elaboration of this learning issue with contributions from Khotso and Zola adding the aspect of DEPRESSION and Ibrahim, who offers: PHOBIAS and Fatima volunteers: ADDICTIONS.

As there are several learning issues thrown on the table all at once, Sue appears a bit confused and asks for clarity on exactly which condition is being discussed –

‘are we doing mental disability?’

Dave asks if he could offer some assistance regarding the difficulty in doing or discussing mental conditions. He delineates

- 1) Congenital - and gives Trisomy 21 (Downs syndrome) as an example and asks the group for some other examples. With no one offering any suggestions, he tells that Autism as another example.
- 2) To elaborate on the aspect of autism, he asks the group: if someone is not born autistic, how else can they get autism?

It seems that most know this as several offer: TRAUMA. And Dave asserts his satisfaction with this answer.

Sue suggests that they should therefore use TRAUMA as the second heading and suggests that they also need a third heading for those conditions that occur due to age related changes as people get older. Nicky suggests that AMNESIA could be a feature and Khotso suggests ALZHEIMER. These seem to impress Dave and he tells Sue to

‘stick that in Ms Scribe’

Nicky and Ibrahim are engaged in a discussion that does not include / contribute to the group discussion, or at least they do not offer the group the benefit of their discussion. Fatima is also busy talking to Verushka. She (Fatima) then explains that under addictions, they should consider ALCOHOL as it hampers normal functioning.

1445

Nicky mentions EPILEPSY and asks where that would fit into the mind map. Fatima however urges the scribe (Sue) to

‘just put epilepsy there’

and this is reinforced by Dave who urges Sue to

‘just stick it in’

and he goes on further:

‘yeah, OK, you can add SENILE DEMENTIA. Now we’ve got 1 left, this is amazing’ this he says reading off the mind map.

1446

Zola asks where CULTURE and RELIGION would fall under and Priscilla and Themba simultaneously contribute ETHNICITY which is affirmed by Sue. At this point Verushka says:

‘just put religion in’

Dave tells them that it is hard to differentiate culture and religion, and before much input can be had from the rest of the group to Dave’s comment, Verushka comments that:

‘so PHYSICALLY CHALLENGED’ is the last one

And Dave agrees with this.

Zola implores the group to look at unpacking the physical disabilities. To that Dave asks them

‘what else can go wrong?’

There isn’t any clear answer from anyone in the group, but a few mutter inaudible comments.

Dave reiterates the importance of knowing the mindmap and all that is on it to direct the learning issues pertinent to the case under discussion. He asks them if all of them have taken / noted the points down. Verushka then adds a comment about whether they are all happy with all that has been discussed.

At this point Dave shows the group the mind map in the Facilitator Guide and reassures them that the one they have derived is better than the provided one.

Verushka then suggests that they need to come up with special principles and both Sue and Ibrahim suggest that they can come up with a basic list for each patient and note the differences. Themba reiterates that they come up with guidelines for each patient and go through each special need case and take one topic to look at how to manage a patient with that particular condition.

Dave then suggests that they should divide into 5 groups and choose learning issues that they need to investigate further in order to report on them at the report back session.

Priscilla and Sue elect to research the MEDICAL ISSUES topic and everyone is talking amongst themselves deciding which learning issue to tackle. As there seems to be no headway regarding the allocation of learning issues / topics Priscilla suggests that maybe they should consider having four groups instead to even out the number of students per group. She explains that she is suggesting this based on the fact that the two of them have elected to investigate the MEDICAL STATUS aspect.

Themba then elects that he will form another group and goes ahead with allocating persons to the group – the students he chooses are: himself, Zola, Ibrahim and Priscilla (even though the latter had already elected a topic for herself and Sue).

Zola points out to the group another way of going about the process, following which Verushka asks who will be doing SOCIOECONOMIC ISSUES. She then allocates two students to investigate CULTURE & RELIGION.

Following allocation of topics to the various two person groups, Sue asks Verushka when they should reconvene as groups to start the student directed research aspect of the process. The group then goes into a discussion of when they can conveniently meet outside of the facilitator assisted time to carry on with the process of investigating the

allocated learning issues. Sue asks the group to start the next meeting at five minutes past the hour and they all agree to that. Verushka then suggests that even though they will meet as a group, they will then (at that time) discuss the issues in the allocated pairs.

1454

When it seems that they have exhausted how they will run this aspect of the PBL process, Dave then asks them:

‘are you doing that now?’

to which Themba explains and reiterates how they are going to go about the process and Zola fills in other points to complete the explanation.

Verushka then reminds the group that they will have a test based on the case at hand and that when they are researching the various topics they should bear this in mind. She further reminds them that each group should make comprehensive notes on their topics so that they can give copies to the rest of the group to assist each other with regard to the test. Themba also emphasises this point and appeals to each one to make twelve copies of their various topics in order to avail the copies to the other students. An additional point from Sue is that they should make sure that there is sufficient detail in the topics that they will present at the next small group meeting / report back session.

Dave reminds them to start with the most common conditions and give more detail on those aspects and then follow with the less common conditions where they do not need to be as detailed. He gives examples and explains to them that a common condition such as diabetes should be reported on in detail and he contrasts that with a condition such as albinism where the level of detail will be less. There is laughter from the students as Dave suggests this.

Dave then lays some ground rules with respect to how the report back session should be run. He tells them that each student must present and that they should not read – off their notes, but instead talk to the group. He advises them that they should only refer to their

notes as a way to build up their confidence. His suggestions are given in a light hearted manner without sounding directive. **Advice on presentation skills given**

At the end of Dave's suggestions, Verushka asks:

‘are we done?’

and she states that:

‘we shall get on with the research.’

Dave asks them whether they think that the questions raised by the DLP topic are relevant – i.e. if they think that there is a need to consider special needs patients during their learning process. They all agree that it is. He goes further to state that he believes that every patient is a special patient and he explains why he thinks that – every patient has to be a special patient as each is an individual and that point / fact makes each one of the patients a special patient. He reminds them that the next meeting will be on October 4th and that they should all be there by 2 o'clock. **In a way reinforcing and recapping the concepts in the DLP and all the issues raised – ‘rounding up’, ending the process with a review of what has been learnt in the lesson**

He ends the session at 1457, less than an hour since the group met as a small group and certainly less than the allocated two hours that the PBL session is scheduled to take.

Some students remain in the PBL classroom and they discuss how they are going to tackle some of the learning issues. This goes on for about ten minutes. The class empties at 1504hrs.

Some students remained and discussed suggestions and research functions for about 10 minutes; left at 1504

The majority of the session was very rowdy with several students talking all at once without any control from the chair, and the Facilitator leading the students and eventually

just giving them the mind map without waiting for students to derive own hypotheses through own hypo-deductive process.

Not a particularly enjoyable session to observe – issues were not thoroughly debated; instead just came out with issue and moved to next heading.

The group dynamic was very ‘chaotic’ and the facilitator appeared to have no control with respect to drawing the students towards a more cohesive dynamic and eventually gave the group a copy of the lesson objectives – mindmap- that formed part of the facilitator guide which the students are not meant to be given; the facilitator was also directive and did not allow students to discover for themselves the learning objectives / hypotheses for the particular case.

APPENDIX 3.5B

DESCRIPTION OF PBL SESSION

BDS 5 START CASE BASED DLP – SPECIAL NEEDS PATIENT

REPORT BACK SESSION

October 04 2007

Fictitious names have been used throughout the lesson description

Session started at 1402 and ends at 1534Hrs though short of the allocated 2hours, they have utilised more time (1hr 30 mins) than at the first session. This is also a reflection of the manner of the learning session, where more elaboration of the learning issues happens and as they have researched topics they potentially / theoretically can speak for a longer time when they explain the concepts to the rest of the group.

Verushka	Ibrahim		Themba	Sue		
Neo						Zola-absent
				Lukshana		Khotso -absent
Priscilla				Fatima		
	Nicky		Sandra			

1402

Dave walks in and jokingly says: ‘Sorry I’m early guys’ and with that he hands over the process to Verushka to start the report back session.

Verushka then proceeds to explain how the session will be conducted and gets affirmation from the rest of the group about the process to they will follow.

1403

Sue starts her presentation. She tells the group what learning issues she researched and therefore what she is going to concentrate the report back on. She is using the notes and reading off the script. The report back she gives is quite detailed and general. Most of the students appear to be actively engaged in the presentation, with Dave also listening. However, Themba, Fatima and Sandra appear to be reading their own notes. Themba actually flips through a stack of notes. Sandra then proceeds to jot down notes.

When Sue finishes off her presentation, Dave requests to ask a question, asking for clarity on a point raised during the presentation. Sue answers the question. Following this Dave uses this opportunity to introduce the concept of APPROPRIOTECH to the discussion to contextualise what has just been presented. He goes further to explain what he is involved in regarding the Delphi Questionnaire and brings the relevance of this to the learning issue just discussed. He emphasises the need for the students to keep the learning real and always bearing in mind the circumstances that they work in. The facilitator input contextualises the learning and gives relevant examples of what is meant by relating these examples to the case under discussion. There is also an element of autobiography by the facilitator to in a way make the learning experience for the students more significant for them

As the classroom door is open, there is a lot of noise disturbing the proceedings, and Themba goes out of the room to ask the students in the corridor to keep the noise levels down. Dave however, does not wait for Themba to get back, he continues the explanation. In an attempt to control te external inteferences, Themba inadvertently get left out of the lesson by the facilitator – is this intentional or an example of ineffective teaching? Maybe the facilitator does not want to create a break in the flow of his report /comment by not waiting for the student to return from the interruption.

Ibrahim is the next student to give his report back. His presentation style starts off effectively with him speaking / talking to the group and using his notes as prompter. He therefore is not reading off his script. However, within a short space of time, he starts reading off the script. He says a point that is gender insensitive and Dave interrupts and tells him that he disagrees with what he has just said. Dave asks the group to tell him why they think he disagrees with Ibrahim. No one gives an answer, and this prompts Dave to ask Ibrahim to read the statement that he is referring to and this is on gender issues. When Dave points out the insensitivity of the statement just said, the group erupts in laughter. Dave then explains why gender sensitive language is important.

Ibrahim then continues with the rest of the presentation. He becomes gender sensitive with respect to the language that he uses. The rest of the group laugh jovially at this change in the presentation style. His phone rings in the middle of his presentation and Dave tells the group that they need to switch off their phones: 'we should switch off our phones.'

In his presentation, Ibrahim explains a study that was conducted in the USA on rural attendance for dental management and draws on that to draw parallels with the South Africa reality. He seems to have all members of the group as a captive audience at this point. Dave gives encouraging affirmations regarding the presentation – 'good, good' he says.

More points are raised about the need to modify the management plan when treating a pregnant patient. He concludes his presentation and Dave gives him feedback. He applauds him on how he was specific with his presentation and referencing style. He encourages the rest of the group to adopt that habit especially when dealing with the scientific literature.

Sandra asks about the raised gender sensitive language issue especially relating to the use of 'him and her'. Dave tells them that even though they need to be cognisant of the

inherent gender issues, it should not be too cumbersome and they need to find a mechanism to address such.

Verushka asks the rest of the group whether they have any comment regarding the presentation before they move to the next issue. However, she does not wait for anyone to comment before she moves the lesson on. She asks the next presenter to start.

1413

Sue immediately delves into her presentation without so much as an introduction of what she is going to talk about. She talks about paedodontic issues that are relevant to the case. She reads off her script. Priscilla seems to be taking notes and Themba seems to be concentrating on his notes. Dave seems to have been dozing off and his papers fall off his lap.

As Sue is talking, Dave interrupts her to point out a certain feature of child management. He asserts that he does not like being intrusive, as a way of explaining the interruption. He explains that it may also be appropriate to bring a child patient into the dental surgery not to actually undertake invasive treatment on the child, but to introduce the child to the environment by encouraging the child to sit on the dental chair, moving the chair about, letting the child to it themselves, getting the child to feel and touch the various instruments that are used etc. This he explains, is a way of reducing the historical fear that patients normally have with regard to visiting dentists, and as a way of breaking that habit from early on so that child patients are introduced to dentistry in a fun manner and that their first appointment is not a painful and anxious experience.

Sue then continues with her presentation, and takes up from where Dave ended and gives further management strategies when handling a child patient. Priscilla opens her bag to bring out a textbook which she consults and Themba gets pens from his bag. At this point, Sue is not reading her notes, she is rather explaining points to the group and there is a nice flow to her explanation, it does not seem forced or contrived. She also relates the

points she introduces to her clinical experience in the Paedodontic clinic and how she handles her patients. Lukshana writes something in Fatima's script.

Sue comments that another student will handle one aspect (management of patients with congenital conditions) of the presentation and therefore she will not go into detail on that particular aspect.

As she has ended her presentation, Dave asks them if they have ever treated a patient with Trisomy 21 and explains that it is very difficult to get the patient to cooperate. One of the students responds that she has treated such a patient and confirms that it was very difficult and challenging to get a child patient with Trisomy 21 to follow the instructions given and that it made for a very frustrating clinical session for the student.

Dave asks them several questions, including whether they had ever done certain treatments – fluoride, whether they had managed a pregnant woman. He asks Verushka to stop him if she feels that he is taking over by asking too many questions, but she does not stop him.

1424

Verushka decides to give her presentation following Sue's as she dealt with adolescents, which follows paediatric issues. She unpacks her points and gives pointers on what to look out for with such patients. She seems to be talking only to Dave and does not attempt to bring the other students into her presentation. This is made more apparent by Themba's apparent concentration on his own notes; Priscilla writing and Lukshana and Fatima's side conversation happening during the presentation.

When she presents on the geriatric issues, Verushka seems to be disinterested and she reads more from the script and there is little explanation of the issues raised. However, she does produce a neatly illustrated table as a summary of what issues she concentrated on. Dave commends this. She explains the relevance of the loss of elasticity with increase in age. The rest of the group laugh when she brings in contextualised examples of the point she raises to bring it home. She encourages her colleagues to be more gentle with

geriatric patients and not ‘roughly pull on the cheeks and lips when retracting the tissues during dental treatment’, because of the loss of elasticity of the tissues.

Following her presentation, she quickly assumes the chair role and asks if anyone wants to comment or raise any question..

Dave comments about those patients, especially the elderly, who attend the dental clinic / hospital even when they do not have appointment, because they are lonely and use the opportunity to socialise. The students laugh at this. Dave suggests that one way of managing such patients would be to reassure them and talk gently with them to ease the loneliness. He asks them not to be dismissive of the patients, rather to have an understanding of the space that people find themselves in as they get older.

He also points out the need to look out for the malnourished geriatric patient, and urges the students to delve into the dietary habits of such patients. He explains that there will be instances where the elderly neglect their dietary requirements for various reasons, primary due to self neglect because of loneliness. He states that there is a need to monitor such when confronted with the elderly patient exhibiting such signs.

He gives Verushka feedback relating to her presentation and tells her that it was good presentation.

1431

Lukshana then presents on the teenage patient. However, she does not introduce her topic, she just delves straight into a point. She talks about certain management strategies on making teenagers more comfortable with dental treatment. Priscilla volunteers a point regarding the issue of ‘age of consent’ and brings in the point of smoking and how it affects dental health. She comments on how best to ask the teenage patient about this at the initial appointment, especially if a parent accompanies the child. She also points out that this issue will bring out issues relating to privacy and the ethical challenges that such presents.

Lukshana points out that parents can also exacerbate issues when clinicians have to manage minors. She gives examples of her experiences in the MFOS clinic and how at times it is difficult to render treatment to child patients with the parent present. Dave asks her what she then did in such a situation, and she explains how she handled the situation with the assistance of the staff member. She reports that the staff member had to ask the parent to leave the surgery so that they could treat the child as he could realise that the parent was only making the child more uncooperative.

Verushka also adds that at times the parent being present may make it difficult to find out what is wrong. Dave picks up on this and ask her: 'what would you suggest?' however, he does not wait for her response and he states what he would do. He explains that sometimes the parent's behaviour is a reflection of how they (the parent) views dentistry and expose their anxiety. He therefore urges the students to see this as 'adults being big kids'. He warns them that they need to be psychologists and pick up on such subtle situations in order to make up for a pleasant appointment. The students seem to love this point.

1434

Verushka then alerts the group that Neo will present on the cultural issues.

Neo begins by stating that they looked at culture and explains how she will present the learning issue. She seems to be focusing her report to Dave and is not engaging the rest of the student group. Dave interrupts her asking if he could stop her for a minute and asks her to look at everyone when she talks and not just focus at him. At that point Fatima reports that she is feeling left out and the rest of the group laugh lightheartedly. Neo further clarifies who will explain which aspects of the topic under discussion. Lukshana appears to writes something in Fatima's script and the latter seems to read it.

In the presentation, Neo brings up an incident that happened with Themba's patient who was a sangoma and the challenge the students had when they tried to administer local anaesthetic agent in order to perform dental treatment on her. She gives further examples

of cultural practices between different groups of people e.g., in certain communities where husbands speak for their wives; Chinese communities who believe that the number 4 is evil and that we (dental personnel) often throw around the word 'four' as part of our terminology describing the different side of the mouth and that we need to be sensitive to issues like these. The rest of the group is loving this judged by the laughter that emanates from this part of the presentation.

Neo concludes the presentation abruptly, which prompts Dave to ask: 'is that all?' when Neo tells the group that: 'that's all I have'. And Fatima seems to agree with Dave as she comments that they want more.

Dave then relates examples from when he worked in another province where he had huge language challenges. He explains how he managed to overcome the language barrier by learning some words in order to relate better with his colleagues and patients. He explains the bridging that normally follows when an outsider tries to learn a few words of the local language and the willingness of the people to include the outsider especially following an attempt at learning their language. He encourages the students to do similar when they go out to the different communities on starting their professional lives.

1441

Sandra then takes up the rest of the cultural issues report back, and it directly follows on what Dave has brought up. She explains that she will be focusing her report on language and how it relates to dental fear. The students laugh at her comment about how her suggestions on how to handle this issue may be important for them as future dental practitioners in helping them manage their dental patients better.

She seems to be focusing her attention on Dave as she is looking at him and displaying minimal attempt at engaging with the rest of the students.

She also follows Neo's example in using examples that the other students can relate to – she gives Madonna as an example when she talks of the presence of a diatema and how that is seen in different communities.

When she expands on religious issues, she starts off by soliciting opinions from the rest of the group about their feelings relating to muslim women who wear veils and their preference for female dental practitioners. She contextualises the example by explaining that this issue is prevalent within the Dental School and more veiled muslim women are coming in as dental patients (and students, as she herself wears a veil). She explains the challenges such situations may present both for the student and the patient. However, she comments that it may be easier for students as they may place their training needs first and therefore be more amenable to treating all genders, but may be more difficult for such patients attending the Dental Hospital where they have minimal choice re influencing the dental practitioner they would be managed by. Another example she brings up is that of Jehovah's witnesses and their abhorrence or reluctance to accepting blood transfusions even when they need it urgently. At the end of it all, she informs the group that: that's about it'.

Dave tells them that as dental practitioners, we are not going to be administering blood transfusions and explains that we are also not equipped to deal with all medical emergencies.

Verushka asks the group if they have any questions for Sandra and Dave points out that Fatima has not said a word and Sue makes a note that Khotso is absent, to which Dave asks the group who will report on the learning issues that Khotso was tasked with.

However, none of the students raises a question.

1447

Verushka then announces that Lukshana will report on the 'physically challenged'. There is laughter amongst the group about a comment made in connection with the Oxford Handbook.

Lukshana proceeds to give her comments on the learning issue and speaks to those in front of her and Dave, with minimal engagement with those seated to her side. Themba seems to be concentrating on his own script and Priscilla seems to be reading the front

cover of Neo's DLP whilst Sandra is writing something down. The group laughs at something that Lukshana says (which I missed). Lukshana points out the need to address the physically challenged with RESPECT and even goes to explaining the need to have a degree of formality re the use of Miss, Mrs, Mr etc instead of 'you'. She gives practical management advice and introduces Fatima to elaborate on the topic.

1453

Fatima explains that she will report on the 'handicapped children'. With her discussion, she mentions the author names for the articles she draws her deductions from. She speaks to the group and does little reading off her prepared script. She relates her presentation to the previous one on 'creating a friendly environment.

She talks about the need to use mirrors to demonstrate where plaque deposits are with child actively brushing teeth; using adjunctive aides such as electric toothbrushes to assist those clients who may find it difficult in developing the required manual dexterity to achieve effective manual tooth - brushing; actively engaging the caregivers during this process.

1456

Lukshana then takes over the next phase of the presentation and elaborates on the 'sensory defects', discussing the issues related to patients who are blind, deaf etc and how they can be best managed. She brings in a point made by Verushka during the latter's presentation. She brings in other examples from the Oxford Handbook. Fatima interjects and makes a point re establishing guides with patients. Dave also gives an example of his own niece who uses sign language. He points out that sign language is not universal and that each language / region has its own sign vocabulary and hence the importance of the health care professional to be aware of such and possibly be knowledgeable about this so as not to be confused or in the dark when attempting to communicate with the audibly challenged patients.

Verushka asks for comments from the rest of the group following Lukshana's presentation. Sue remarks that it is important to prepare the surgery (operatory) before appointments for blind and deaf patients, though she does not explain why this is so and no one asks her to elaborate. Priscilla then makes a point about COMMUNICATION and states the importance of effective communication between the clinician and patients. She brings up the point relating to Sue's patient who was deaf and how they had to use sms to communicate instead of verbally in scheduling appointments. Sue reinforces what Priscilla has stated and comments on the importance of finding out from each patient what works and thus developing strategies for each individual patient instead of using a 'one-size-fits-all' methodology.

1500

Verushka then invites Themba to give his presentation. Themba informs the group that he is also going to present the work prepared by Khotso. He engages eye contact with members of the group, explaining how he is to present the material – break it down into two conditions and will start with the most common condition: DIABETES. He explains the different types / forms of diabetes and the need to ascertain which condition the patient presents with. He reiterates the special needs issue with respect to diabetes especially emphasising the issue of complications due to the medical condition. He also passes around written material to each member of the group. He elaborates on the associated anxiety and adrenal stress / insufficiency to dental care.

Several students – Priscilla, Sandra, Lukshana appear to be reading the notes that have just been passed around. Dave is also flicking through a stack of notes. Themba continues elaborating on the medical condition and how it is important to the delivery of dental care.

Neo summarises what Themba has presented and she stresses the importance to clinicians of getting a comprehensive medical history from patients.

1507

Themba then goes to present the material prepared by Khotso and he explains that he has to read Khotso's prepared notes, which he does.

In the middle of the presentation, Dave reiterates the importance of updating the medical history of every patient especially in private practice care.

Lukshana suggests that instead of Themba reading Khotso's prepared material, they can all read it for themselves at their own leisure as each have a copy. Verushka asks if the rest of the group agree with Lukshana's suggestion, however no one answers her. She then suggests that they should just go through the material – giving Themba the go ahead to continue presenting.

At some point Themba tells the group that he is having difficulty reading Khotso's writing and Verushka intervenes and reads off what is problematic. There is elaboration on the cardiovascular conditions and their relevance to dentistry.

Fatima and Lukshana appear to be having a separate silent conversation between themselves, with Fatima at some point taking a pen off Lukshana and writing her a note.

Themba finishes the presentation by elaborating on the relevance of taking paracetamol and NSAID.

1514

Verushka then calls upon the last student to present – Priscilla, to which Fatima makes a comment: 'save the best for last' and Priscilla tells her to dampen her enthusiasm – 'don't be that enthusiastic'.

Priscilla then goes ahead to explain what she is going to talk on and how she is going to do it. She uses her notes to prompt the presentation as she engages the group.

She hands Themba a stack of notes, which he duly passes around to everyone. Dave asks for clarification on a point she has just made to do with whether something is a symptom

of something. Priscilla then reassures him that she is going to cover that during the presentation – ‘I am coming to that’.

Sandra then picks up some notes which are in front of Fatima and passes them to Neo, Verushka and Ibrahim. Priscilla does not break any of her presentation and continues, drawing attention to the importance of Hepatitis B relative to HIV regarding infection control in the practice of dentistry. She contextualises HIV to the local scene. She elaborates on the oral indications after having explained the general picture and goes through them systematically. Dave asks about the cervical implications generally, and Priscilla corrects her earlier statement regarding the issue. Verushka and Sue are engaged in a side conversation, however when Priscilla asks them for the question, Verushka tells her to carry on with her presentation as they have no question.

Priscilla then expands on the issues of allergies and does a good job with this section. She gives common examples of known allergies and their impact on dental care. Dave then draws the groups attention to the potentially dangerous allergies and Ibrahim offers penicillin as a potentially dangerous allergen for dentistry. Dave gives the group an explanation of the aetiology of the penicillin allergen. Priscilla then goes into a discussion of terminal conditions and specifically outlines squamous cell carcinoma, explaining that 94% of all oral carcinomas are of this kind. At this point Lukshana takes out the Oxford Handbook and flicks through it, Priscilla asks her to explain several pictures on this carcinoma. Dave asks Priscilla on ORN (osteoradionecrosis) and its relevance to dental care to which Priscilla gives the correct response and Dave tells her so. Fatima and Lukshana are engaged in a side conversation. Priscilla explains the TNM classification of carcinomas and Ibrahim also silently mouths the different stages as Priscilla explains them. Priscilla explains the relationship of the classification system and survival rate related to the management and eventually brings it into the dental setting with respect to the EMOTIONAL STAGING and how this impacts on the provision of dental care.

At the end of Priscilla’s presentation, Dave gives his feedback and tells her that even though it was large topic, she covered it well.

Verushka then asks for any questions or comments from the rest of the group. However, she does not wait for any response and immediately gives the floor over to Dave.

1528

Dave starts with his feedback to the group of students by asking for responses to the issue of cultural/religious issues pertaining to ‘burkha – clad’ muslim females and provision of treatment by the opposite gender and uses himself as an example. He asks them what would be problematic with him wanting to treat such females and what the issues would be.

Verushka comments that issues like these have come a long way in terms of tolerance and understanding by both parties. Fatima adds that ‘the greatest thing is that more time be spent with each other (the different groups) so that we can start to appreciate and respect individual opinions’. Sue also adds that we can all learn from one another that we are essentially all the same. Priscilla brings in the issue of their own exposure at tertiary education level, whereby they have built friendships across diverse cultural lines and that the lessons learnt are that what is important to one is also important to the others and the fact that as students they are all going through the same issues especially educationally. Dave adds that it is also due to the fact that they as students, also work together and that this goes a long way towards understanding each other across the diverse groups. He also adds that they will also retain their friendships post qualification when they go through their professional careers. He ends his feedback of this note – ‘that’s all, we’ll meet at the plenary’.

Verushka tells them that they will all present and reemphasises fact that each one of them should make copies of their sections for the rest of the group. At this point, Dave gives them a copy of the Facilitator Guide mindmap.

Verushka implores the group to work on their presentation in 2 weeks time and Sue suggests that they either meet again before the plenary or do what they did before.

Verushka asks whether they should meet again at another time - so that they need to

come up with the date and time and circulate the notes beforehand. Dave informs them they should pay attention to the gender noting – ‘no him/her’.

Lukshana thanks Dave as he walks out of the room and the session comes to an end at 1534.

APPENDIX 3.6B

DESCRIPTION OF PBL SESSION OCTOBER 18 2007

BDS 5 START CASE BASED DLP – SPECIALIST NEEDS PATIENT
MANAGEMENT

DLP SESSION – PLENARY

Fictitious names have been used throughout the lesson description

START: 1407 – WHOLE CLASS WITH ALL FACs

1407

The class starts congregating into the DGA slowly and the facilitators are also present – Prof Green, Dave and Helen. They are talking quietly amongst themselves and the students are doing likewise.

The session starts when Prof Green distributes facilitator evaluation forms.

Prof Green has distributed evaluation forms amongst the students and the latter are busy filling them out. The students are reasonably quiet during this time.

The students occupy the 3rd to 5th rows of pews whilst Prof Green sits behind Dr Mistry (Helen) in the 2nd row. Dave sits on the pews located to the periphery next to the exit door.

1410

Dave is busy helping Prof Green with the desktop which seems to be malfunctioning and there is a quiet discussion amongst them.

Xavier asks Prof Green whether they (the students) can leave the session / lesson early if they finish the test early, to which she says ‘No’. He does not ask for her reasons for

declining the request and merely accepts the answer; does Prof Green give a reason for her refusal.

There follows a light – hearted, possible sarcastic / cynical discussion about being a student between Prof Green, Xavier, and another (student) voice.

Helen and Prof Green continue a discussion that is inaudible to me and Dave leaves the theatre without excusing himself. Helen seems to be doing something / texting on her mobile phone. At this point, there are several discussions going on between various groups of students and there is little control of the session by the facilitators or the chair of the session (Prof Green). Other students are still busy filling out the forms handed out at the start of the session.

1413

Dave walks back into the room. Moosa gives Prof Green a completed form and Priscilla seems to have finished completing the form, however she does not hand it back. Moosa continues to pass several forms forwards as more students complete the forms and hand them over by passing them forward. Prof Green is observant of the process and at one point asks the students:

‘OK, all done? Pass them down the side’.

She asks Xavier:

‘what did our group prepare?’

She further wants to know which group prepared what – whether any of the groups prepared a play or presentation. She asks if there are 2 powerpoint presentations or only one, however none of the student groups answer, instead there continues to be some animated talk amongst the students. Prof Green then tells them:

‘let’s have a presentation in the middle’

There continues to be lots of talking from the students. Several students stand up unprompted and walk towards the front of the room. Xavier is part of the group and informs the class that they have to present first:

‘We have to go first’

More students stand up and walk to the front of the DGA. (As Xavier walks to the front of the DGA he walks into the recorder cord, and fortunately it does not disconnect as I check moments later).

1416

The first group to present is Maria’s group. She introduces how they envisaged the DLP and therefore tackled the problem presented. The first issue up for discussion is AGE and how to manage it.

Moosa takes up that part of the presentation and explains the relevance of age to ‘The Special Patient’. Other members of the group appear to be concentrating on their prepared scripts and Petra appears to be writing something as she is standing up. Angela is seating down.

Moosa gives an eloquent presentation and he ‘talks’ to the class using the prepared script as a prompter. He explains how to approach AGE and its management. He recommends that one should start with the simple strategies before moving to the more complex management strategies and gives an exemplar of starting with how to manage a small child before tackling the management of adults through to the geriatric patient.

Prof Green then stands up and walks to the front desk where she takes a seat and retrieves some paperwork from her handbag that she reads through whilst watching Moosa talking. Xavier and Kgomotso are whispering between themselves during Moosa’s presentation. The remainder of the class seem very attentive during the presentation, however, Ibrahim does not seem to be paying attention to the presentation.

1421

Moosa finishes of his part of the presentation and Maria then takes over. She informs the class that she will talk on the geriatric patient and illucidates that those are patients above the age of 65 years. At which point Prof Green has an expression on her face that causes much laughter amongst the students. Maria reads off from a prepared script. Khotso appears not to be paying attention to this part of the talk. Maria then changes tact and when she explains points, she actually engages the rest of the class and does not read off the script. In the middle of Maria's talk, Xavier walks towards the side of the podium to take up a leaning position on the podium. Maria then starts giving real examples using her own clinical experience to explain points and explains how she handled such patients in terms of calming the patients to enable her to carry out the proposed dental treatment:

‘I talked using a soft, reassuring and calming voice’.

She speaks directly to Prof Green when she mentions the issue of biological age and disease. She gives examples of what to do to make it (dental treatment) easier for the older patient.

She concludes the presentation.

1424

Xavier, standing by the podium, then introduces the topic he will present on: SOCIOECONOMIC. Moosa and Maria then move away from the front of the queue to the side of the podium, placing Angela at the front. Xavier asks the class:

‘what would you guys say with regards to who sees dentists more?’

Kgomotso expands on the question when no one offers a suggestion. Themba makes snide remark:

‘Aa soka (*aaah, get away*)’

In response to Kgomotos's explanation.

Xavier then offers evidence from the literature regarding the gender disparity when it come to seeking professional dental services. Dave then questions whether those reports are on the different racial groups (ethnic groups). Xavier offers an answer which is inaudible to me, and Dave asks him to differentiate the word 'race'.

Xavier assures him that:

'we are going to get there'

He then goes further and explains the old South African classification of race and compares it to the new racial classification Prof Green offers a comment to the effect that:

'we are all one race – the human race'

There is some discussion between the remaining group, especially Verushka and Samantha to which Dave nods in agreement to whatever comment they made.

Kgomotso says:

'OK, thank you Dr Brankovits.'

She goes on and explains a study done in the USA comparing rural communities and urban dwellers on their treatment seeking tendencies and reports that rural dwellers in the US seek dental treatment more than the urban dwellers. She offers a comment that everyone would be shocked by these findings as in South Africa more urban people seek treatment compared to rural communities. She questions the issue of 'diet' as a factor in this finding.

Moosa and Maria then take a seat in the front row of the auditorium away from the podium.

After Kgomotso has exhausted the possibilities of such disparity, Xavier discusses the issue of gender and their treatment seeking tendencies, and concludes her commentary. His report is not stereotypical re gender disparities.

He then moves on to discuss issues pertaining to EDUCATION. He explains the relationship of education to urban dwellers and gives examples specific to dental scenarios in both radio and TV adverts.

Kgomotso adds to this explanation by expanding on the fact that illiterate persons struggle to find words to use in order to explain their dental needs or requirements compared to literate people. She explains that this may lead to distortion of information, especially when dental students are concerned as they may lack the necessary experience / skills to decipher this information.

1430

Having concluded the discussion on education, Xavier then introduces the issue of FINANCE. He explains how finances play a huge role in treatment planning decisions. He also brings in some of the treatment options that are expensive – e.g implant supported restorations. He gives examples of those treatments that they, as undergraduate students, have to grapple with – acrylic vs metal based removable partial dentures.

1431

Kgomotso discusses the impact of TRANSPORT issues. She asks the class directly:

‘What do you guys think regarding transport?’

It seems as if she is asking Themba directly. Verushka answers, by stating that:

‘I think it is an issue especially with public hospitals’.

She then goes further to explain herself and brings in the factors of scheduling appointments and the use of public transport by the public patients. Xavier then brings up the challenges that he faced with one of his patients that he treated with Kgomotso. They explain that the fact that they have specific types of procedures / work (quota) they have to fulfil puts a considerable amount of strain on them. He explains that this particular patient had problems coming for appointments as he worked one week on and one week off and that they had to try and maximise the time they scheduled with the patient by attempting to do as much treatment as they could within the scheduled appointment. Kgomotso then stresses that it is important to consider where the patients would be travelling from for their dental treatment, especially considering the kind of transport at the patient's disposal. She urged the class to try and schedule appointments that do not burden the patients as this may result in patients not attending or honouring the set appointment. Xavier explains how he decided to therefore only treat those patients who received government financial assistance and it meant that they did not have to pay for any of the treatment rendered and therefore had money to spare for transport. He added that in certain instances they had to give their patients transport money as they felt compelled to do so in order to get the work done for their course and as well to entice the patients to honour appointments.

1434

Kgomotso then goes to discuss the issue of HEALTH INSURANCE. She explains the relevance of health insurance and the earning capacity of patients. She explains that with respect to patients without any form of health insurance, it is important to bear this in mind and treatment plan accordingly. She gives several examples of different treatment options for patients with and without health insurance presenting with similar clinical scenarios.

Xavier reiterates and reinforces the importance and relevance of aligning expectations, approach availability and accessibility to the dental office. With this, this pair ends their presentation.

1435

Sayed and Natasha then take up the next presentation and remark that they will discuss and expand on issue pertaining to CULTURE. Sayed tells the group that she will focus on issues relating to SMOKING and related habits and she starts with the example of BETEL NUT CHEWING, common amongst the Indian population. She is reading off a prepared script and is not attempting to engage the class nor look up at them during the presentation.

One of the students approaches Helen and appears to be asking her something.

Natasha expands on Sayed's presentation and reiterates the need to look out for betel nut chewing amongst the patient population and explains the cancer link with this habit.

Angela sits on the step near the podium with her back towards the presenter.

Sayed explains the issue of CAT and Ethiopia and this is further expounded on by Natasha wherein she the point on the management of language diversity and how that is relevant to treatment provision. She provides literature evidence on studies done in the USA on linguistic diversity and how that impacts on dental treatment provision. This she reads off a prepared script.

Xavier and Kgomo are now seated behind Moosa and Maria. I did not notice when they moved to the new position.

There is an inaudible discussion taking place between Linnette and Ellah. They are seated at the front by the podium and still need to do their presentation to the class..

Sayed and Natasha continue with their presentation with the former discussing certain aspects pertaining to people of Latin descent and the latter takes these points further. In the middle of the presentation, Natasha realises that she's made a mistake regarding a point from the study that she drew most of her conclusions from. She informs the class of such to much laughter from them.

Sayed then continues with the presentation and links the information to what Kgomotso discussed earlier on point about the dietary considerations (the study on Alaska and pregnant women and chewing sugar free gum. Natasha discusses aspects relating to periodontal treatment. She explains the need for effective patient education relating to periodontal management and stresses the fact that patients need to be made to really understand the need for good periodontal health.

This part of the presentation then ends.

1441

Linnette introduces the aspect she will be speaking on – The Medically Compromised Patient.

Both Natasha and Sayed go and sit behind Xavier and Kgomotso. Nicky conducts an inaudible discussion with either Ameera or Sudeshni – it is difficult to tell which as they both wear the burkha and they also both wore spectacles.

Linnette discusses issues of dental relevance with the medically compromised patient and reels off a whole list of conditions that the dental practitioner has to be aware of when managing such a patient.

When Linnette finishes this part of the presentation, Ellah introduces the fact that she will be discussing issues pertaining to INFECTIVE ENDOCARDITIS and relates it specifically to the history of rheumatic fever. She reads off a prepared script initially, however when she explains certain points further she does it without reading off any script.

Linnette continues after this with a discussion on the RESPIRATORY SYSTEM, specifically focusing on ASTHMA and points out what the condition is all about and how important it is to always have an asthmatic pump / inhaler available. She stresses the fact that asthma patients need to carry such with them always. She reads off a prepared script on how to handle a dental emergency in the dental surgery / room. Under

central nervous system conditions, she discusses the management of a patient with epilepsy, however she does not elaborate on the dental perspectives re this condition.

Ellah then explained the endocrine influences , specifically focusing on the DIABETIC patient and how to manage such cases in relation to their dental needs – she made realistic suggestions such as: when to schedule appointments, dietary advise to give patients in order to manage the cariogenic potential etc. She stressed the importance of the patient knowing their disease type and mentioned that type 1 required antibiotic cover (**not recommended however – wrong information given here**). She added that due to the medical condition these patients usually had poor wound healing and that it is important to monitor them after any invasive treatment.

The other part of Ellah's presentation focused on those patients who are undergoing steroid therapy. She emphasised the fact that steroid cover is essential and suggested that the clinician needs to double the steroid dosage prior to any dental intervention and explained that this was to reduce the chance of the patient suffering adrenal shock.

Linnette then talked on the hypo / hyper glycaemic challenges associated with the diabetic condition. For each challenge, she gives the symptomology, associated signs and how to manage each.

She goes on to discuss factors associated with the dental management of those patients who present with conditions affecting the gastro-intestinal system – and focuses specifically on pregnancy. Examples discussed include the use of antibiotics by pregnant women and how these pharmaceuticals may affect the developing foetus.

On her section about anticoagulant therapy, Ellah mostly reads off a prepared script and does not seem to attempt to engage the class – and this is shown through by the conversation going on between Nicky and either Ameera or Sudeshni; Themba playing with an empty plastic bottle during the presentation and looking through the door. She finishes off the presentation by discussing how to manage aural and visually challenged patients. Even with this part of the presentation, she is reading off and not engaging the rest of the class. This is different from her earlier talks where even though she read off a prepared script , when she explained points, she would engage the other students and not

appear to be reading a prepared script. Fatima is also having a side discussion with a colleague and does not appear to be part of what Ellah is talking on; two of the students in the front row appear to have their eyes closed – *are they sleeping, or just listening with their eyes closed?*

1448

Either Sudeshni or Ameera is presenting (as stated earlier, it is difficult to differentiate which one it is due to dressing mode, for simplicity I will refer to the presenter as Ameera).

She speaks on the MENTALLY CHALLENGED patient and talks about the difficulty that a practitioner would have as they (dental students) do not have the necessary training to deal with such cases and therefore causes a lot of frustration on how to deal with such patients when one is confronted with. She actually speaks to the group and not from a prepared script. She gives examples of how to refer to these patients: deaf – hearing challenged; blind – visually challenged; dumb – intellectually challenged; deaf and dumb – hearing and verbally challenged. She also gives useful tips on how to manage the patients and emphasises the importance of not using negative terms to refer to them – never to refer to the patients as victims, rather as survivors e.t.c. Some of the students who have presented laugh at this comment. She advises that one should not greet the care giver first, rather should start with the patient and also to ask the patient why they are requesting a dental consult.

She also emphasises the fact that the operator / dentist needs to be comfortable to manage patients with this kind of condition.

Petra then continues on the same theme, using the script as a prompter. At this point, Ameera goes and takes a seat on the chair at the podium. When Petra ends her part of the talk, Ameera continues it and gives more management strategies to assist with managing such patients. She suggests that it is important to have feedback from the patients about

one's management and the practical management and suggests the use of mini surveys, suggestion boxes e.t.c.

1452

John (standing at the podium with Angela to his left) gives his talk and there is a lot of overlap with the information already given by Ameera. He talks on patients with PHYSICAL CHALLENGES. He does link his points to those already talked on by previous students. He reads the definition from a prepared script and also gives strategies on how such conditions may manifest and suggests ways on how the operator may manage them.

Xavier and Kgomotso are involved in a side discussion amongst themselves. At the same time Fatima is laughing in a funny squeaking noise at something.

1455

It is now Angela's turn to give her presentation. She does not introduce her topic and just goes straight to talking about TRANSPORT and how it links to those patients with mobility issues. She gives pointers on how to move patients from the wheelchair in the dental office / surgery. She also comments on the fact that it is useful to have a wheelchair in the dental surgery / practice in order to assist those patients who may be unable to walk for whatever reason. Another point she discusses is the issue of reduced manual dexterity and its impact on oral hygiene practices for the patient. She gives suggestions on how to assist and advice patients affected and practical advice on how a toothbrush may be modified for this situation.

At this point Helen goes out of the auditorium and Dave appears to be sleeping. She ends the presentation by recapping on all the points she has talked about and the class clap at the end of her presentation.

Prof. Green then thanks the group for the presentation and gives her feedback on the quality of the presentation. She compares this presentation to an earlier one given by the BDS 3 class earlier that day and comments that this class demonstrate an increased level of clinical experience, good presentation skills in that the transmission of information relevant and that it appears the other students take it in and are engaged during the small group presentation. She makes a point about the issue of immigrants (brought on by comments from Kgomoto's presentation about the study on Mexicans) and contextualises it to the local situation with illegal immigrants in South Africa, and how they may be considered a drain on the resources.

At this point Helen comes back into the auditorium.

Prof Green then makes a personal example and explains her own situation when she arrived in South Africa as a 15 year old child from Europe and how it felt to be an 'outsider' especially since she could not speak English nor any of the local languages.

She also describes a study that she undertook with another colleague involving chewing gum and how having someone who spoke the language made it easier to get the relevant information from the study participants.

She asks the class if any of them have ever had to manage a mentally challenged patient:

'Has anyone had a patient who is mentally challenged?'

Xavier answers in the affirmative and comments that his supervisor at the time advised him that she was worried he may not be able to work with the patient due to the challenges, however he reports that he was able to cope and did manage to get the patient comfortable to be able to treat him at each session / appointment.

To which point. Prof Green encourages the students to not be scared of such situations. She adds to Angela's part by giving other ways of managing the wheelchair bound patient.

Xavier and Kgomotso have gone back to sit behind Fatima.

1503

There is a break as the next group prepares their presentation. There is talking amongst the students during this time. Xavier asks to Prof Green if he can go somewhere and he is given permission to do so, but to

'hurry up'.

She then focuses her attention to Helen as they discuss something during this time.

John seems to be examining some intra oral radiographs (X rays) with Verushka and Lukshana.

There seems to be a problem with the digital projection and Xavier is attempting to assist, however 9 minutes later, the student concedes defeat and the next group starts their presentation without any projection.

1512

Mohamed starts off the group's presentation and informs the class that he is not going to go through everything and then introduces the DLP that it is about the Special Patient and as such he will be talking on the MENTALLY HANDICAPPED (remember Ameera's point about being sensitive re the language one uses with respect to such cases - maybe saying: MENTALLY CHALLENGED would have been a more palatable option). He does make reference to an earlier part of the presentation (Ameera's part). He explains that he will be dealing with types of medical handicap. ??Nellie?? comes and sits near the front to my right hand side – probably will be presenting next. Mohamed uses his notes to act as a prompter and does not read off the prepared notes. As he talks, he looks at the class and talks to them.

The class laugh at a comment that Mohamed makes relating to patients with inappropriate expectations (due to their diminished mental status, I guess as he offers no

explanation). He goes further and comments on the potential of some dental procedures inducing some element of 'sexual arousal' in some patients. Obviously this elicits lots of laughter from the class, with Themba laughing the loudest! He comments that such patients can be 'impossible' (challenging) patients to manage and he relates a case he had when he could not achieve anaesthesia. He also makes reference to Nicky's presentation about depressive patients.

Fatima and her Lukshana appear to be holding their own private discussion.

He then discusses issues relating to several associated conditions such as: bipolar (mania and depression), alzheimers etc and how to manage them in the dental setting. He emphasises the need for a comprehensive explanation of how the dental practitioner will manage the dental condition to the patient and touches on the need for possessing good communication skills. He reports that another member of the group will talk to this point. He sums up his part of the presentation and states what is to be presented next, i.e. introduces the next part of the presentation.

1521

Lee, as the next presenter, takes the floor after Mohamed (who goes and sits on the floor in front of the stage next to where I am positioned) and starts discussing PHYSICAL DISABILITIES and how they impact on dental management. He discusses visually and aurally impaired patients. He gives practical advice on how to manage them in the dental surgery and uses simple realistic examples of the strategies involved – e.g. how to give simple oral hygiene instructions. He also quotes the relevant scientific literature with respect to the management of the young patient afflicted with physical challenges. His presentation flows and he talks to the audience, using his notes as prompters.

1524

Tasnim takes up her part of the presentation and introduces her topic – **SOCIOECONOMIC FACTORS** – and she makes reference to Xavier’s presentation when discussing the issue of affordability of treatment and also touches on transport issues (as discussed earlier by Kgomotso) and she adds more insight on these issues. She uses the script both as a prompter to explain points and also reads off much of the prepared script. She also discusses the issue of **RELIGIOUS BELIEFS** and highlights some of the issues pertaining to muslin females and the issue of the ‘veil’ and the possibility of them asking for female dentists to manage their dental issues. Another point she discusses is the issue of **LANGUAGE**. One of the points she raises is the challenge that the lack of a common language poses in the health care setting and therefore making it important to seek the help of a translator. She proposes that the dental assistant may be used a translator, as an example. To sum up her presentation she highlights the fact that most of the factors pertaining to her part of the presentation have been discussed by earlier students.

1527

Brayner, another member of the small group, introduces her presentation and explains that she will be discussing the **MEDICALLY COMPROMISED** patient. The quality and style of her presentation ‘flows’ as she is talking to the group and not reading any notes, or using prompter to inform her talk. She advises that it is prudent to always check with the patient’s physician regarding the medical condition before commencing any dental intervention. This is after highlighting the relevance of obtaining a good medical history from the patient during the consultation phase / appointment.

She also highlights the importance of **INFECTION CONTROL** and advises to consider each patient as an ‘infectious’ patient in order to control for any inadvertent exposure to undue infections. One other issue she highlights is the management of the **TERMINALLY ILL** patient. She advises that these patients should be dentally treated if it is *really (own italics)* necessary. She ends the presentation on this note.

1528

With Lee seating on the floor next to Mohamed, Charles takes to the center of the podium and explains that he will be discussing: PAEDIATRIC, PREGNANCY. GERIATRIC and ADOLESCENCE factors to consider in dental management. At a pause, during his talk, Helen tells him that she also wants to hear a discussion on other groups as well, but does not elaborate which ones.

1529

Prof Green switches the lights on, at the end of Charles's talk and says:

‘...this is just to wake you up...’

The class engage in light laughter at this comment and a couple of the students – Fatima and Verushka are talking amongst themselves; Neo and Tasnim appear to be reading something under the table.

Charles then answers to Helen's request and appears to be addressing her only and Prof Green reminds him to:

‘..talk to the audience and not Helen...’

He is using his prepared notes as a prompter as he explains the points under discussion. On the issues of the pregnant woman, he advises that dental treatment should be avoided in the first trimester and he explains why this is advisable; he advises that dental treatment is recommended in the second trimester as most of the embryonic system and organ development has occurred and there is reduced chances of interfering with this process with the dental treatment. With regard to the last trimester, he advises that it is advisable to not intervene in the last fortnight by attempting routine dental treatment. He recommends the use of lead reinforced aprons / shields when taking radiographs; to avoid prescribing tetracycline antibiotics and to stick to paracetamol as the preferred dental pain analgesic.

Samantha, John and Lukshana appear to be in a conversation between them during this part of the talk.

Charles then reminds the class that he will discuss the issues associated with the management of the geriatric patient. One of the issues he highlights is their desire for attention as most of them lead 'lonely' lives away from their families and hence use the opportunity of a dental appointment as a social event, even when they do not have any dental problems. He recommends some management strategies to deal with such cases. On the aspect of MEMORY ISSUES, he advises that it may become necessary to give written advice and not only rely on the verbal discussion that one would normally employ with the younger patients. He ends his presentation on this note.

1534

Prof Green advises Sammy:

‘...please do not repeat previously said points as we are running out of time...’

He discusses COMMUNICATION SKILLS and elaborates on issues pertaining to: the physical setting, privacy, noise and interruptions, non verbal communication (proximity and personal space), ‘acting like listening, eye contact, facial expressions, touch, voice pitch and tone, silence, verbal, anxiety issues. He explains most of these points with several instances of laughter from the class when he touches on some of them e.g., the issue on facial expressions, inappropriate touch e.t.c.. He ends his presentation with a quotation, which elicits laughter from the rest of the class.

Prof Green then reminds them of the DLP they did in their BDS 2 programme where they dealt with issues on communication with patients and brings an example of ‘nodding vigorously’ depicting impatience. She informs the last group that has to present that they is 25 minutes left and asks them:

‘..how do we handle this?...’

When nobody answers, she tells them:

‘...I want each one of you to say something that occurred to you during the presentation or something that you want to add...’

Verushka turns to face the rest of the class, where she is seated, and starts discussing how to handle paediatric patients. She gives strategies on how to introduce the child to the dental environment and surgery – by starting with ‘non-dental’ intervention and using simple language and gestures that the child will understand etc.

Sue then adds more information on how to manage both the adolescent and geriatric patient. On the issue of the latter, she stresses the relevance of the effect of chronic medication and conditions to the dental management. She highlights the fact that most geriatric patients may be more forgetful and hence this may impact on treatment times and treatment types / options offered to the patient.

Verushka then adds that it is important to be aware of tooth eruption dates / times to be able to assess dental development with paediatric patients.

Priscilla highlights the issue of terminally ill patients and the need for the dentist to be aware of the different stages of grief. She points the stages out – shock, anger, denial, grief and finally acceptance. She points out the importance of staging and phasing the dental management / appointments at the appropriate grief stage.

Prof Green then adds points on NEEDLSTICK INJURY and the associated HIV risk. She reinforces the issue of teamwork with the establishment of a good referral base/team and points out the need to refer to a qualified psychologist. She even gives out the contact details of such a practitioner.

She gives the students feedback on the importance of taking time to research the learning issues identified at the first small group session in order to inform the learning and discussion at the subsequent report back session.

Neo talks about LANGUAGE DISTRIBUTION MAPS and gives an example of a situation that happened in the clinic with a patient of Chinese descent and the number 4

and the superstitious beliefs that inform this number. Retelling this story elicits a lot of laughter from the rest of the class.

1549

Sandra then starts her part of the presentation and addresses the issues of DIVERSITY and AESTHETICS. She illustrates her talk using the different groups – Cape Coloureds; Native Americans and highlights the different aesthetic expectations with regard to dental treatment. She also discusses the issue of the need to have a good rapport with patients to assist in dealing with financial constraints issues. The examples she gives are relevant and contextualised and she brings up what happens in the (SOHS) clinics where some patients have an expectation of students providing them with transport money in order to be able to attend the dental appointments.

1551

At the end of Sandra's presentation, Khotso discusses CONGENITAL DISEASES and their impact on the provisioning of dental treatment. The example he uses is the management of a patient with a cleft palate and how student behaviour is important so as not to cause embarrassment for the patient and he gives an examples whereby because it may be an interesting issue for students to observe such patients, they (the students) may hover around the patient when someone else is treating them and hence cause the patient to feel embarrassed by such behaviour.

He outlines management strategies in dealing with patients afflicted with such a condition. He stresses the need to be empathetic and aware and mindful that patients with cleft palates are prone to caries and for the operator to stress the need for frequent dental appointment for the monitoring and management of the condition (the caries). He advises that students (practitioners) should not ask patients the same question repetitively. One suggestion he gives is that the practitioner may ask the patient to write down the answers

to whatever questions are being asked. He emphasises the avoid pitying such patients and avoid seeing them as not being normal.

1553

When it is Themba's turn to present on the learning issues that he has researched, he starts by reiterating the fact that it is important for the practitioner to obtain an adequate medical history. He then relates his own experience when he treated a patient who was also a Sangoma and how they reacted to the issue of having to have a local anaesthetic and the patients interpretation of the procedure (he reported that the patient thought he was going to be killed) and therefore told him that 'according to my rituals, I cannot be injected with anything'.

At this point Prof Green brings up the relevance of the knowledge gained from the Diversity DLP that was done in BDS 3. She brings up some of the findings of that DLP with respect to the Zulu culture regarding their displeasure towards disease and how science can be used to explain how disease is caused.

1555

Lukshana talks on the issues relating to handling the PHYSICALLY CHALLENGED patient. She elaborates on the infrastructural needs that need to be addressed, such as the accessibility of the dental rooms via ramps, lifts, escalators, elevators etc; the provision of sufficient space / room within the dental surgery itself for patients who may be using wheelchairs to get around. She emphasises the importance of not having a constrained space and the need to pay attention to the dental surgery set up when one establishes a practice.

1556

Fatima is the last student to present. She remarks on the fact that most of the issues have been addressed and that she will not go over it again, however she does go on to talk on most of those issues that have been discussed. She suggests the need to consider doing the maximum amount of dental treatment under general anaesthetic in those patients who may be too challenging to handle in the conventional manner. One of the students then remarks that the issue has been discussed already.

There is a lot of laughing amongst the students during her presentation, however, she ignores it and continues talking about what she is presenting. She provides evidence from the literature on aspects that she is presenting and gets confirmation from Helen that she (Helen) also has similar evidence. She ends her presentation by stating that:

“...I did not find anything different (from the rest of the class), so I will
answer
questions...”

As no questions are forthcoming, the presentations end.

1557

Prof Green asks the class if:

“...would you like to take five before doing the test?...”

to which there is a resounding

“...NO...”

1558

The session therefore ends on this note and the class prepares to write the assessment / test that is scheduled for this DLP / PBL experience. I leave the auditorium at this point.

APPENDIX 4: INTERVIEWS

APPENDIX 4.1

Fictitious names have been used throughout the interview

INTERVIEW STUDENTS - 1

Ok, it's recording. It should be recording now. We've got 8hrs of recording time. What I want to do, is really get an essence – do you have any yearbooks on you? Any of you?

Some inaudible mumbling from the 4 students

Ok, fine, that's fine. I just wanted to get an essence of your take on the programme. Your take on the programme

(Pause) with respect to?

Prosthodontics and dentistry

Fixed pros in general or the whole of PBL?

Yeah – the whole dentistry, because what I want to find out for my project is to find out whether we are doing what it is that we said we are going to do. Because, remember that the new curriculum is informed by the new principles of interactiveness of students in tutorials and empowering students to find information and not feeding them information, and giving uh, giving timely constructive feedback alongside continuous assessment and all the new ways of teaching. So I want your take on that. You can, you can, you can lead me through how the PBL programme is helping with respect to Pros and, say that particular PBL that I sat through – the last one

We haven't had any uhm, tutorials to do with fixed pros .itself we haven't done anything in Fixed Pros. like bridges we haven't had like a patient come in for fixed pros... but with PBL we haven't had uhm

No, no the Pros programme does not have a PBL programme specific to it, it would have, there would what we tend to do, what we try to do is to use the principles of the new curriculum in how we teach, say during the Pros tutorials, are they interactive; during the Pros uhm course is there interaction and is there timely feedback – those kind of things; and are you being empowered enough to feel that you can ask when you want to ask and you can get as much as you can from the facilitators, from the teachers-let me not say facilitators because

I think it actually signed off, that we have to do .as such.

Because you have dates, you have to get everything done by a certain date, so you're working ahead. You know what to do

And I think you guys are quite strict which actually is good at the end of the day which actually is good... when we get into the clinic we are better prepared so we're not going to be stuck when we get to see patients there. We can make our mistakes now and we get a chance to you check it

And I think with PBL has actually brought us up to speed because in those groups you're like almost forced to speak, they're like if you don't speak, they'll ask you to speak you know. And usually people who're quiet they start speaking more and I think it's works better like when you go down into the clinics, you'll be better with your patients and with your supervisors and everyone else. So I think it does get to help a bit

In your groups as well.. in large groups coz you get people.. who tend to speak up above the rest

I think it helps you build up your confidence actually, you know, say you're in a small group first and then at the end of the day you have to speak to the whole class. But first you're with that small group that helps you you know help you build up your confidence

It also helps you with real life situations as well – you have to deal with..

So now, if you try to translate what you've learnt from PBL and translate it to say the fixed pros techniques how has that helped? Coz there you're in a larger group but do you feel that even though it's a larger group like what Ms Kajil* has just said, that you can speak out if you need to, or are there still, is there still a sense of uhm certain students overpowering

Well I think you can just go up and basically work at your own time anyway, so in a way set your own pace.. you can actually do it

You were going to say something Ms Khadija*?

I was just saying you can if we I think if we needed to come up to speak now I think we're not scared or intimidated as we would be

Usually we are (Laughter)

I have something that I forgot, uh I should have made a note of it, I've just thought of something now. Ok with respect to the Pros tutorials, you've said you haven't had any tutorials

With fixed pros or with PBL?

Or with PBL-

like how we have all this with PBL where they give us a situation with a patient – we haven't had one with fixed pros where a patient comes in and .. so we can't really relate it to fixed pros itself

Ok

We'll start because we've had in Restorative, Partial dentures, aesthetics, occlusion and all of that, but we haven't had one on Fixed Pros itself

In the final year you get the case presentation uhm sessions where you look at patients, at treatment plans and you – or cases – treatment cases and you plan them and you plan them accordingly and they'll give you the different options to look at

And I guess that

But with the the Pros tutorials that you've had, say the fixed pros tutorials that you've had and the removable pros tutorials that you've had how how have those been?

Those, I think those have helped us a lot with understanding the stuff uhm more better, because if you're going to read in the textbook and then you come (link up) to the tutorial it's just helps you more better to understand the the work

You don't always understand what you read in the text book the first time around and then you discuss it amongst your friends, you find that actually you understand it a lot better

Do you discuss that before or after the tutorials

(laughter)

When we have a problem when we get stuck.. when you've realised that what you've read what she's read is two different things .. we've understood in two different ways

And does the discussion happen continuously or is the discussion informed by the assessment, when you have when you have tests to do, is that when you discuss or would you discuss normally in the course of the day

We've got so much work to do with all the other subjects so if you're stuck with something that day then you'd discuss it at least you know

Ok ok, so you do speak Dentistry when you're out of the

(laughter)

Yeah we have to

That's interesting. Ok, now the tests, let's go to the tests. Ok does having, having the dates beforehand help

Yeah, much help – it helps a lot

And when do you get the dates. When do you normally get the dates of the tests

We'll for most of the subjects

Well basically at the beginning of the year

And do most do most courses do that?

Most of the courses do that – but we wanted to - we haven't had that and we've had problems like two weeks before you find that you have an exam and that's stressful because you can see the position – you're doing all the other subjects as well so you have to concentrate on everything and then all of a sudden you have another exam coming up which is like, the day before and if you have the dates set from the beginning, even if I have two papers one day after each other, it wouldn't stress me out as much because

Like last night

And on average how many, how many tests do you have a week, or have you had a week say since the beginning of the year

At least one, one a week

Is it? So there hasn't been a week that you

In the beginning of the year we've had some free time, and then but these last two blocks these last uhm – third and fourth block – we've had no free time, nothing in the last six months we've had

Is it? And in the last two teaching blocks on average how many tests a week

I think we're writing about three

Three a week

Like we'll have like an oral exam and we'll have another on another subject

And then that uhm bringing in the clinical time – how does that help OK say the the clinical time in the sense that when you're doing your clinics you're supposed to be engaging with the supervisors for them to continually assess your understanding of the subject matter as applied clinically. Doesn't that help with the written assessments – written tests?

For me uhm with like Restorative and stuff I I don't think so

But with Pros I do find it helps a lot

With Restorative why don't you think so

Uhm maybe restorative I just coz we're so used to it I think with restorative we've done it for the last two years we've been in the clinics so, because we've been in the clinics for the last two years we're like almost know exactly what to do what's going on and the reason why you do this

why you're doing that so with pros itself like with Partial dentures and stuff it's really helped to be in the clinics, understanding it, once you've seen it in the mouth, how it works and stuff you understand it much more better

Especially because partial dentures you don't have a technical course to it, so you just get, you have to do it following reading about it. Ok. And and do do the, or does the quality of the teachers say in in with Partial Dentures, does the quality of the teachers help

Yeah it does

In what sense

Every supervisor is different, I think it depends on what supervisor you get as well

That's what I've been thinking

(laughter)

How, how, how how is how is how is the supervisor knowledge or attitude helping or not helping your learning in the clinics

difficult, every supervisor have different ideas, see you can have one supervisor telling you to do something it one way and then you have another supervisor wanting you to do it a different way but then the supervisor before that so you do tend to have a bit of a clash in that sense, but I think it does help you overall because then you get an overall understanding of what everyone one wants you to do

Now where does, the fact that you do you do have a manual? And is that a Partial Denture manual?

Yeah

And, you're supposed to be working according to the manuals, so how then do you if if there is a clash with how supervisors tell you how to do it say with clashing with the manual, how do you overcome that coz essentially if the manual is supposed to be the one that is guiding you and you're supposed to do it by what the manual says

(Laughter)

It's a hard one

Have have you been in that kind of situation

No

Ok maybe not partial dentures, with the complete denture manual

Well complete dentures I think everyone follow the manual

Even the supervisors

I found that with the partial denture, the manual was not as easy to read, not as good as the full. The full denture we had a proper manual, but with the partial denture we didn't. We had beautiful pictures in our partial denture manual and the full denture was like I think everyone knew it, everyone knew exactly what was going on yeah, but I think it's coz we've maybe got that fixed that partial denture book

That's the bible

We've got that book (lots of laughter) so I think that's why we don't have such a manual

Ok, ok, and then what the book prescribes is what is being taught

Yeah

And that helps

Yeah

Ok now with fixed pros? And the e-book; i-book; e-book?

I think the i-book does help because the pictures and stuff if you're reading the pictures same time you're reading

And are you reading it

Yes

(laughter)

I've got the e-book so to a certain point and we don't have any other stuff – the metal stuff, I don't know what the latest stuff

What's the latest stuff

Like what we're doing now like the post and core and stuff like, we don't have stuff like that

Is it in there**Are they still doing the CD**

I'm not sure

We don't have those

I find it difficult with my post and cores compared to when we started off in the beginning when we had those ceramo-metal

I think it helps having that, that's what is needed now with post and cores

Uhm, because the copies of the, I don't have the e-books, I don't know. The copies of the e-books that I have the chapter, that I suppose you'll all have is the: veneer prep, the class II inlay, the ceramo-metal, and the occlusal splints – and the full gold crown, you don't have? Or was it the demo on the lecture

We've got, we've got

And the fact that the fact that you had to give back the CDs for them to be updated did that did that ever materialise?

Yes it did and we did

The new ones?

Not the new stuff that we're doing now

No, no back then when they had to update the when they had to update the CDs

We had to give them in

That was quite a few weeks ago – July/August August, early September

Laughter

And then the condition of the the condition of the space that you have to use for Techniques, any comments on that

Uhm, I think it's adequate

At the moment, yeah, it's just that that's some of the heads are not working, so that, otherwise

(seems as if the students had not really given the condition of the lab much thought on how it impacts on their study and delivery of the work expected of them)

But even with the fact that with the heads you cannot move them to the to the height and the angle that you want and the foot

Ok that has been a problem

I think, I think

(laughter)

You know, I'm not like bearing in mind that the Lab has to be it's supposed to be a simulation of the clinical setting

Oh yeah definitely

Ok, in your own experience without me leading you on, what are the challenges that that particular space poses on you in the way you work

what we're trying to see whereas in the clinic we're not going to have to do that, coz we can move the chair any way we want

Even with the lighting, like uh like I find like in the Lab the lighting isn't that good. Like you can't actually see, even for my test I really did struggle with the lighting, so I'm sitting at the place that I'm actually sitting now like it's got a few lights like where it's like but the other places like where you guys are and stuff the light you can't move it you can't you know you can't get the light properly to where you want it

Ok and then in uhm the fact that the heads are also not don't have the same structures as a real person has that hindered or facilitated positively the way you work

I think negatively in a way I guess with the head we just turn it however we want like she said we like pull it all the way back, you can't do that with a patient's head

But the fact that there is no tongue, there is no cheek, there's no saliva?

I think it's a good way to actually start off we have to start somewhere, so rather than putting teeth on the table and drilling like coz I think that's more of a reflection of what we need to deal with clinically

It just helps us with practising it

Makes it a bit easier when you're practising

Yeah, it would because you don't have to contend with the tongue, with the cheeks, you know with the saliva so you can work in a dry field except the position. You know you're not getting used to to positioning the head properly. Now, if you go to if you go to the stuff, the instruments and the tools that you use – the teeth, the models – what is your experience

My main thing was like the teeth, that we don't have enough teeth like we use one and if you make a mistake it's like we don't have another one to practise on and the only way to get better is by practising

(Laughter – some inaudible comments)

You can't make a mistake

So how then how then have you managed that challenge for yourselves, especially if you have to use sixes, which are a premium

(Laughter)

It's like take off a little, take off a little

Haven't you been advised to use other teeth that are not premium teeth to try and

I've I don't think there's enough for the whole class to actually even practise on

Is it

We have practised, like practised on the lower teeth and like centrals, like for a bridge and stuff

Yeah it does help but (laughter) it's like even time as well

And when you, when you bring these concerns to the course coordinators what happens? Or have you thought of bringing the concerns up?

Actually we've never like sit down and discuss it in the class which nobody

Haven't really thought about it that far?

I think we need to address that

And then the models? The issues with the models?

(lots of laughter)

So we can't even practise because we don't have the models

That's an ongoing issue that I raised in 2005, 2004? When did I come back? 2005, that you know the two classes should have their own own sets of instruments or, or armamentarium so that we don't have to interchange. Back then it was uhm coz I was only dealing with the BDS 4 back then was you know having uhm prosthodontics have its own things and not sharing with Restorative coz the models were being shared with Restorative BDS 2

Maybe maybe the students should be issued with their own instruments at the beginning of the year coz then

You'll be able to look after them and not

And if you lose it then you'll have to buy another one

That's fair

It's fair coz you know

But with the cost of the course so high? I mean how much is your tuition

About forty thousand

And then still then you have to buy handpieces, you have to buy sets of instruments, would that also include sets of teeth, sets of models uhm? By the end of that you'll be paying a hundred thousand for the programme maybe. Now given that you know that these are the challenges especially with the instruments, I mean you have instruments that are a minimum optimal right and say the the mixing bowls that you most of the students don't look after, they just leave snap or set acrylic in there, how how knowing what you know now, how would you try and manage as students with this reality?

Well I guess it's like you have to have all the students in this. It can't just be one or two who's cleaning up after themselves because if the other students don't do it then it going to end up being messed up – the bowls are going to be a mess. So you have to be like almost like teamwork over us, like once you've used it you clean it up

Doesn't matter

But with the with the with the uhm (what's the word) encouragement that you get from the supervisors, myself included, that you need to keep the instruments clean, isn't that message not filtering?

It does, but I think speaking to everybody

So

For example I don't like to use a bowl that dirty, but unfortunately is not my instruments in that bowl so you just work with it like that, no matter what you say

But even that the new curriculum, (this is not really new anymore) the curriculum that you're doing is supposed to empower the students to be able to address those kind of issues with the course coordinators what has the class done about it

I think

But amongst yourselves

No, I think coz we've got so much else on our minds at the moment like everyone's got tests and just tests and tests and tests so ... the small things like we don't have time to think about it coz we're so busy with everything else

And the small things and we really don't pay attention to the small things the bigger

My motto is if you pay attention to the small things the bigger things take care of themselves and looking at the fact that we started in July the fixed pros techniques started in July and you provisionalising as early as then when it wasn't as hectic as later were you as a class not aware

of the challenges and try you know at least even informally discuss that discuss it amongst yourselves

I think people might have

We don't have any

People we're like how can you leave it like this, how can you leave it like that?

Nobody ever owns up to I did that?

Laughter

No

Is it, that's interesting, so now, OK. Given what you've gone through this year, how would you then propose it changes for next year, or make it better for others next year – improve it for future years

We'll be working in the clinics I think is a different situation because we've got people to sterilise the instruments for you, keeping them clean; well we'll clean them ourselves before they've been to sterilisation hopefully they do come in clean. I mean to look after them

How

You've got people to sterilise instruments No we'll clean it ourselves before I mean you actually look after them and stuff

But do you in the clinics, do you clean, don't you clean the instruments, not clean as such, but don't you tidy up

people will take it to sterilisation

So if you get to clinics right, and you get a mixing bowl that's full of uhm set acrylic, who's going to be

I know we've had a situation where we were in Pros had we just came to we had a pros session and we were coming in and everything was a mess – there was alginate all over and stuff. There was nothing we could do – we went to the nurse and asked we were like who was working here coz we wanted to speak to the person who was working here and like you'll find some students will walk there, they will know who it is but they won't tell you like who was working there. They just won't tell you

So I don't know, maybe they don't want to get their friends into trouble or something

We've had that, we've had that

Is it

We've had that. We're like uh: who, who, who's been working

Other students?

Who's working here, coz they had the session there before us. Who was working here coz because we don't leave it like this so when we come there it should be like neat and tidy like how we leave it

They wouldn't tell us who left it like that

We went looking around; we went we went all over asking everyone do you know who was working there?

But doesn't it affect your other patients schedule in the clinics

Yeah but, you know, I don't know, they ask also, then they have a free session and then they there was someone, I don't know who was working there

***There's a chair: you know what Dr Boitumelo sits and does those chair allocation schedules. So you'd know who's supposed to be. Well technically, we should all know who's supposed to be in what chair at what time. So the first port of call would be to check the uh chair allocation and then check if that particular student was there**

Yeah, but I think the problem was that difficult if they didn't have a session that time – so it wasn't their session; they just came in during their free time or something like that.

Ok, then I would ask: do the students then adhere to the chair allocation schedules, or not?

Yeah, most of the time they do

We don't

Is it? Because I know that when I used to do Removable Pros supervision, students did not adhere to that: At the beginning of the year, in the middle of the year, and even towards the end of the year, unless the supervisor insists that you know, you are allocated to rosette 3 chair 1

During our session times, we we definitely are at our at the chair we're meant to be – but when we do extra session or when we come in during our extra time, I don't think people will sit at the chair they're meant to be at

Ok

I think but during the session that we are there we sit in the chair we're allocated,

But otherwise, because I've had instances where I well I've been in a session and students are in and out with the Removable Pros where students are not in the chairs that they're

supposed to be and I ask myself then what's the point of having a chair schedule; allocation schedule if we're not going to abide by

But then in our class, like during our session we're all in the chair we are allocated

That's the whole point. That's the whole point, excepting on a Friday.. in Poly 2 where on a Friday you get whole lot of BDS 5 students on Restorative chairs – and I wonder where the restorative patients/students are

Laughter

Because, funny we don't have any – restorative – we only have it on a Tuesday

... situation, or there has been a situation where BDS 5 students go in a Friday morning and use Restorative allocated chairs where students are supposed to be there – restorative students – and yet they are not there. Because space space is tight to accommodate all the students and all the clinics during the hours that we have.

Ok, now the yearbook, we go to the year book – we haven't touched on that. Uhm, does it help that you get you get an outline of the objectives and do you get an outline of the objectives and outcomes for each course at the beginning of the year?

Yes, we do

We do, except for one or two subjects we didn't get in the yearbook

And then when did you get it? Did you get it at the beginning of the year or at the beginning of the course?

No, in one or two subjects it wasn't in yearbook and then I think the subject itself had to give us

Which subject was it that wasn't in the year book

Uhm which subject was it – general surgery and stuff. What was it? I can't remember now

Let's not – the Dental subjects?

Oh the Dental subject were all there

Even the Fixed Pros – the Fixed Pros course was in the year book?

Ok. So you don't use the yearbook as a constant reminder of what is

Laughter

in the beginning of the year if you need it, if you need it

Is it? I would have thought that you're you're constantly referring to it coz it outlines what it is that you need to do; uhm what the promotion requirements are; and all the assessments assessments that you need and the weightings of the assessments and

Laughter

This year's yearbook looks very complicated and

Is it

This year most of my class think everything was tidy and it was like two A4 pages and 1 page, so it's squashed up into 1 page

I couldn't

Like last year was easy we had each compartment separated like Restorative and Pros. Each one was

We had each one there, it was just like

How

It was like

Laughter

I definitely found I found that one was too hard even with Radiology, like some of the and stuff

Ok. Interesting stuff. And then do you have uh do you ever get either at the beginning or maybe in the final year I guess I don't know. Would you, or have you had global outline of what is expected of you, not per year, but globally for the course? I suppose you'd get that

In a file, which sort of ties everything up – but not Dentistry

And those are the three things that you need to do. But in terms of Dentistry, what what the Dental School or the Faculty of Health expects you to do or to know or to have for the Dental degree to come out as Dentists?

I can't remember

What did you get in first year?

Is it marks?

Pardon? No, no what information did you get in first year at orientation say or registration?

We had a meeting with the Dean where he told us exactly what the course was about what was expected of us. I mean

Were the different components addressing you – do you remember that was some time ago

I know the first day we got here we had like I think we didn't really we didn't

I know Dr Manana was there, she was uhm she scheduled a whole lot of, a whole lot of people come speak to us

(Laughter)

Like we don't know where we are

(Laughter)

Ok

We did have, I think we did have some people come speak to us – some lectures I can't even remember

If I go back to the scheduling, in terms of what you need to do in a day is it too much, do you have time breathing time in the course of it

(Laughter)

It was quite

Did you have any sessions where you were free, and if so how many a week did you have

One week

One a week

One a week

Yeah

They gave us one session a week that was like two hours and the rest of the time we were full – we were scheduled – till 6 o'clock.

On Tuesday, Thursday, I think twice a week we're usually here from 6am

No No No Tuesday Wednesday, Thursday

Only three days

Fridays we finish early and then

And the early is what-4 o'clock

(Laughter)

Do you start, did you start uhm each day at half past seven or is it some days

Some at seven some

Like the clinics we start at half past eight and we had lectures like on Friday morning

we had lectures like on Friday morning and on a

Oh oh Thursdays

So twice a week you come in at half past seven

And in sometimes terms of

Yeah. So we'll have our test at half past seven

Oh

and the day carries on a s normal, you don't

And how is it And with respect to the tests how, have, uhm say if you, if the students want to change the test date. If you are given a schedule at the beginning, how does that impact on the plan or your each individual's plan for studying?

I think our whole class, we would when it comes to test dates, we always speak as a class. We discuss the test dates. We always have to like, we be in agreement

And then, have you changed a lot of test dates this year?

We have changed a few, quite a few

Yeah

Because it was like, I think it was starting to be too much from having two tests a month. And that's because they weren't scheduled in the beginning of the year

Ok

These tests just came up in the middle of the year

That was my next question, you know if they had been scheduled at the beginning of the year it would have been a different situation

Suddenly you'd have another test – it was too much to handle

Ok. And what's your take on that with respect to planning for the tests schedule each year

I think it should be organised from the beginning of the year. We should have a whole test schedule from day one

Yeah

And it shouldn't change, but, and they shouldn't be tests added even in the middle of the year – like listen we have to have one more test on this or you have to have two more tests on this, I think it should be scheduled from the beginning of the year and there shouldn't be just added in

you submit your test dates for the whole year and then they just come up with a

Because the problem comes in where you have to add in tests dates. And when you're add in test dates they get just themselves and there is just too many too close to each other, that's why we fail the test

Ok. Now the year book is supposed to have a list of the schedule of the tests even if they don't give the dates, so if you get the year book with the list of all the tests that you need to do surely doesn't that help in alerting you to the number of tests that you need to have

I think you get to the end of the term and then you realise Ok we haven't done a test in this subject and

Ok, now with that challenge that you face how has your class's participation in the Education Committee, in EDUCOM, helped for these kinds of situations coz there should be a student rep in EDUCOM for each year

There is yeah

There is people but

Has that helped

they go to the meeting and they come and discuss it with us

Yeah

Usually they discuss what they spoke about and stuff

they don't really have anything they'll do about it they'll discuss what goes on in EDUCOM and they come back and discuss it with us and then

No decision are taken

Uhm no decisions take. Coz that's one way to highlight the issue with the schedules. Because the idea the whole idea of having the year books and being upfront with everything that you

need to do and are going to be assessed on is so that things are planned and everybody knows as and when it's going to happen

Coz you know where you stand

Exactly

Yeah

Exactly

How to prepare

Now if you get the schedules if you get the schedules right in an ideal world you get the year books, you get all the schedules set out and uhm you find out say towards the end of the year by the third teaching block you might get you might get the majority of the class not meeting those requirements, how would then adding extra dates assessments hamper or help? I've been trying to get you think out of the box, coz one of the comments that you made was that uhm –Khadija* made – was that uhm adding on of tests dates

Yeah I think it just stresses you out more if you are already behind with the work and then you have more test dates as well as with like I know, if you you you did bad in one subject you did really well in the one subject you wanna you gonna start concentrate on in this subject and you're gonna slack of in the other subject, you know you, it's just I think I think it's hard

Uhm. Coz we just had a situation where we set out the the the number of assessments that needed to be done and by the middle of year we knew we're not going to we're not going to get it. You know, so we've had to remediate and add extra tests and this is just on one course so if there are more courses doing that

It's just going to make it

It just makes it, it compounds the stress

Yeah, it just makes it very stressful

Laughter

So the challenge is for the students to be on top of things. So, but then you get what is required at the beginning of the year

things like projects, sometimes patients don't come and then you try to concentrate on your studying and you put extra time in the clinics to see more patients coz the you're running behind in the clinic

Is it? And then why why is the the the the issue of patients not coming – which clinic is most affected?

I think Resto

For me it was restorative in the beginning of the year. First I had some patients who just didn't come. It was really frustrating

You'd phone and you'd phone and then the patients, they say they're coming and they don't come

And do you get access to phones, to call patients in

I just we use my cell phone. And then you can use the clinic's in the clinic you can use the phone, but then by the time you get through to the switchboard – switchboard, and

we have problems as well

It takes forever to get through so, so I end up using my cellphone, because I just get, I can't wait for so long

So if you don't have a cellphone as a student

Yeah, (laughter)

Yooh! Ok and in Pros any issues with patients not coming

It's been all right

Yeah. I had a bit of a problem but then I still I got my quota

Ok, and the amount of quota that you need to get for Pros, what do you think of it

For Pros, we have 1 full, 1 full and then 2 partials

Because the the angle that the Department comes from is that it is minimum you know, it's not even moderate. It's minimum requirement so it's the basic basic numbers

I think they should change and look at who have got quota who have actually got more more or a lot more

The problem is I think also with the patients. Some people it's just it's it depends on your luck as well. Some patients are like really good and they come all the time and then a patient just might not come

they'd rather delay treatment coz they're going on holiday, something like that..

Some people, it's like it depends on your luck as well, you might not have the good patient, you might have the bad patient

And the supervisors, do the supervisors help in managing the patients if you have difficult patients like that, putting expectations upfront to the patients that because of the teaching institution and they are they 're being treated by students who are limited by schedule they need to make a commitment to come in on those times that the students are limited to

I think also the idea that at the beginning to actually tell your patient that 'I need you'

Obviously they'll say 'Yes' to you

Yeah

But do the supervisors come in and then re-enforce that message to the patients for you, or do they let you leave you to do that patient management stuff by yourself

I think that when it starts getting off hand then they come in, it's like you know if there is two or three sessions that a patient hasn't the supervisors do come and say 'hey listen, you don't want the treatment stop being well just get a new patient and you have to go on the waiting list again' and some people get too scared

And then the files?

Oh!

(Laughter)

I have my own opinion on that, but I want your own views on that – how do you manage all that?

you didn't put it to me

(Laughter)

Oh the students always have the files even though we are not allowed to like you'll ask, you'll go to the to the Reception and the Reception will sort of tell them – the students has the file – but we don't have the file, we're not even allowed to leave with it because Dan checks out our bags all the time, the Security guard. We're not allowed to take any of the files

So what about making copies of them

Yeah, we do do that

Is it standard for the whole class or is it individuals who do that

No we were told that, I guess everyone because everyone I think we've all had the experience where a file has gone missing at some time ourselves

It delays our start, if it's missing you have to start all over again from the beginning

So I guess everyone ??

So this year hasn't been too much uh an issue

Yeah, no this year for me I've actually it wasn't much of an issue

We've learnt the hard way

Yeah, we've learnt the hard way. Like the year before the last one

No files get misplaced quite easily. In fact I'm sitting with a problem file. I need to write a report, so. Coz my my my advice to students is to make copies of the records and also make sure that they write what happened at each session so that you know whoever, even if you have a different supervisor or even if somebody else uhm takes on that case, everything is there they don't need to be asking 'what happened'. But there're there're few cases where patients are seen, there's nothing, what the file number is, the intake notes, or the procedure sheet isn't there, the file is there, but the procedure sheet is not there or nothing – the procedure sheet is there, the patient was seen, but nothing gets recorded. So you guys are not guilty of that

They are legal documents

Coz they are legal documents and they don't belong to us, they belong to the Hospital. You can make copies of. And I find I find that I find that with radiographs if a patient has a panalipse done, I find I find it safer to put all the intraorals in the panalipse envelope and then send it to radiology, coz Radiology is good with their records, they don't normally go missing

They are organised

They are really organised with their radiographs. I would never I would never leave the periapicals back in the file coz they'll go missing

Ok, any other thing you want to enlighten me on. What do you think I should consider

I think just the time, time is the most I think stressful part to us coz there is just so much in so little time. I think that's the only thing I

But the time is constant. What's what's changing is the amount that you need to do

Yeah

And also and what changes is that you're getting more mature, so by the time you hit this level you should have developed study techniques to help you deal with all the extra load, unlike in first year where we, you know the School takes, the curriculum takes it into account that you know it's new, the different way of learning and you they don't bombard you with too much, by the time you hit fourth, fifth year you're mature. Especially because you've been

you're in the clinics already and it's just a matter of applying what did in the tutorials or what you read. But do you read extra to extra on what you're supposed to read?

If you don't understand something, I think if I don't understand something then I'd read to try and get a different idea of what it is

And you get a book list

Yes we do

Yeah

Ok. Thank you, it's been most enlightening (0:47:31 ended)

APPENDIX 4.2

Fictitious names have been used throughout the interview

INTERVIEWS STUDENTS – 2

Sarah* - (0:47:33)

Ok, what I'm what I'm really interviewing on is your take on the curriculum and the course, the Prosthodontic course. And whether the principles of the curriculum as explained to you I guess when you started or as you're going along whether we're fulfilling them as the School and as a department – the department being Pros department. Ok. So the things that we discussed uhm with the other two were issues of uhm the yearbook, whether you it's useful, and how it helps you or does it help you; the space that you have to work in whether it you know it helps or doesn't help; the resources that we have; you know the issue with patient files and all those things.

So basically everything

Yeah

A global perspective, coz what I what I'm doing my project is comparing what we do currently with what we had planned we were going to do, to see whether we're on the right track. And if we're not on the right track how far out are we and whether we're aware that we're falling off track

Well, I think uh with the curriculum that what what we've experienced so far well personally what I've experienced so far like uhm I find ??the feedback that you get from everyone else is all negative, everything is negative and like I try to tell them like personally in the clinics yes there are problems. We are limited sometimes, uhm the time and sometimes we're not sure of the procedure we're doing and obviously we're under pressure most of the time because the hours are so long so we're tired and we have other things going on. But it's Ok, it's not like as bad as everyone says it is. Personally that what I feel. However, the ?? subject well one subject in particular I've noticed that uhm we we like we have like one assessment for the year and that's it and

May I ask which subject this is?

Surgery, this year. We had you know we had a mark in June which was just a viva uhm but that mark it might count at the end of the year, it's not actually uhm, really I know it didn't count for us at the end, basically now it doesn't count. We've had one written exam which is our final exam, I think it was two weeks ago, I can't remember and an OSCE on the same day. That was it that was our assessment for the year and that's uhm I well it was quite stressful coz you don't know what what you're working it is like

Is the ?? book

No, so it was it was it was very stressful

And was this outlined in the year book or

Well we didn't we had it wasn't in the year book, but they did give us a pack that

At the beginning

Yeah

And this is what it said was going to happen

But we, obviously well it was the first time we were exposed to the subject. We didn't know like what it would entail and how it would affect us at the end of the year. In retrospect what we were doing like studying and everything it was it was pretty crazy

Because you had to go to the clinics as well

Yes and uhm

I mean the surgery clinics

Surgery uh entails like every Wednesday at half past seven in the morning we have ward rounds and we get doctors from outside coming to give us lectures in Medical School after that. I think it's on until about half past ten and uhm they don't even come to say ??

Sometimes they don't even come. But that wasn't the problem the problem was just like a proper, we don't like, Ok I know that's not like the issue, a proper uhm set notes or something. It's just like all these different doctors just come and lecture us and then, well that wasn't the problem, the problem is just that ?? this year that was what I found very bad. Otherwise uhm with Techniques we were warned before.

Oh by other students?

Yes, definitely, they told us it's so stressful or whatever. But our class has really enjoyed it this year. It's been great. Uh I know that our work is not finished that we're still struggling with provisionals and whatever

And keeping things dirty

But it been fun, it hasn't been the environment that we expected it to be like

OK

Like we didn't it was great uhm it was really nice, still is still have quite some work to do. But it's ok. Uhm, other subjects that we've done well uhm Oral Path and

No the Oral Health Sciences

*The Oral Health Sciences and uhm we've had Medicine as well which was, it was OK it just totally different subjects to what we do. So it was it was definitely nice to have something different. But also what the problem is are our working hours. I know like we shouldn't complain and whatever, but sometimes it gets too much from 8 to 6; 730 to 6, almost every day is very hard

And how often are you do you have a free session

We have one free session a week

For the PBL programme

Uhm, PBL actually we've done only 3 this year

Uh hum

So yeah we were free in that time, but uhm

But then it was allocated to PBL so you would be doing PBL stuff

*And when we weren't in PBL we were doing POH I think, yeah, and Uhm but the PBL that we did the I like the fact that it's every alternate week – that's nice – and it's not it's not one of those subjects where you feel pressurised coz you can go there and you can talk and just you know it's not like something where you have to study for uhm and like beforehand and like you know it's like stressful, it's nice to know that you can tell people what you've learnt and researched and like everyone else so that was OK

Haven't you used – sorry to interrupt – haven't you used those techniques that you learnt at PBL where you can think on your feet and discuss uh a concept that you haven't been exposed to, say the first session where you're exposed to a case. Can't you use those same techniques in uhm say Fixed Fixed Pros techniques where you can, even though you haven't prepared for the session and you're expected to do something, can't you then try and discuss that to try and understand it a little bit more before you have to go out and prepare for it?

I would think that it can apply to anything

No, ??

*Well personally I've always been uhm, well my father has told me if ??? I've always asked the questions who what why and when so as we go through that like anything even when I answer questions when I'm writing exams and you go through those questions you automatically just get what you need from there and then you realise where you're at and what you should do and go and study. But uhm I don't think we actively use this. I don't actively use what I do in PBL with my other subjects, yeah. Because uhm it's different, I mean if it's a new concept like Fixed Pros is a totally new concept to us and each year PBL it's like has to do with something that you're made aware of, here I didn't even know I don't know what's a crown or a bridge before I

came to the Techniques course. Basically because I've never had one done or no one I know have has had one done. In first year I didn't know what caries was, I didn't know that that meant rotten teeth, but it's fair – that's the nice part of our journey.

Let's go back to the negative things with students – but other students – where is this negativity targeted at, is it the whole course or specific components of the course?

Uhm, no it's the whole course uhm

Fourth year, the whole of fourth year?

No, no, no, it's not fourth year we've been told by older students, that's what I mean, yes

Yes that's what I mean, are they saying were they saying that fourth year is

*They were saying fourth year is, obviously they yes yes they would tell us: there is too much of work; uhm concentrate on Pharm, Path and Fixed Pros because those are difficult. Yeah, uhm so yeah and and like they look like death because we're in third year and we have free time and all of that and you look at the fourth years and they really look like death, they are like you know like tired and haggard and I mean I mean that I know I've always been someone that hasn't worked in first, second and third year very hard, but when it came to this year after I saw that last year I said no I can't do this I have to work and that had paid off ?? and uhm

But it's not hard work it's working smart

Yeah, working smart and working continuously. You can't just start cramming at the end and uhm our supervisors and our Lecturers have been telling us that part continuously, but you come from uhm School and at School it's more like easy comparatively and and you think OK if you can do Matric you can do anything and then you come to Dental School

My take is if you can get into university then I mean the hurdle is getting into university then once you're at university you apply yourself

Yeah. Well any ?? no limitations and actually sometimes there aren't any I mean sometimes you can one can ?? and yeah, but then as you said the negativity came and then I mean we got the negativity from the students and the when you experience it for yourself it's it's actually not as bad as what they said actually it's not bad at all because uhm, I don't know maybe they've had that experience. Uhm, also it comes from the fact they say like uh I mean, uhm you know like supervisors would uhm ?? that's also sometimes we experience it in Pros especially coz sometimes our supervisors change and different supervisors, not in Fixed Pros in our Removable Pros, yes at the clinics, and then some supervisors obviously as you grow you get different techniques but for us we don't know yet so it's difficult, it's difficult for us to grasp everything uhm so like say when you're taking impressions and someone would say something and then someone else would say something and I mean we we've had such problems now I mean our Lab work has been sent back to us three or four times this this in the past few weeks and we're

all studying for quota and that's very difficult coz our supervisors are signing off and then the technicians would tell us: it's not good enough. So that was that's another problem most students in our class face, yes

Uhm, so it would be more the quality of the work that you're giving to Tech to the Technicians?

Yes, but but I would feel that if our supervisor knows what, I mean they have their work you know you know they tell us what like OK it's wrong it's wrong we accept it. But I mean they they tell us 'no, it's fine' and then a technician would tell us 'no, it's not right' that has been???

How have you then managed that

We have to retake it, they refuse, the Technicians refuse to

Don't you then take it back to the supervisor to find out

Yes, but I supervisors do change because some stand in for others

Oh OK

So then that that was a bit difficult, but I mean you just have to do it. The thing is you like, you know what at the end of the day you have to just work

And the issue of having a manual, say in in Removable Pros, having the manual to work with and uhm doing what the manual expects of you compared uh compared with changing supervisors has that the changing of supervisors has that impacted on how you're supposed to do it from the manual

Uhm no. Actually, for me uhm I follow the manual whatever you read up I read up before I go to the clinic, the manual helps a great deal because when you're stuck, you don't know what to do and then and then all of that so yeah, it helped me and and those supervisors that are against the manual I've never experienced that, but I know that some people have uhm. In partials I know that uhm the person that wrote the book uhm when when one of our somebody in our class was using it according to the book exactly the book was out and then uhm Prof said Prof said uhm 'why are you using the book?' and then they say 'but it's our prescribed book' and then he said 'well you don't need to use it if, sometimes it's wrong' and so it was that was very confusing, but I mean I've never experienced it, yeah

I'd find that confusing ???

It was actually

That's the prescribed book

Yes and that person has written that thing and then the same person says 'no, your work is wrong' and then you say no but here it is written here and this is exactly as written in the book and then they say no sometimes it's wrong

Oh, interesting, interesting. OK If you go to focus on Techniques – Fixed Pros Techniques – now and the space you know the physical space that you have, what are the problems or challenges that you've experienced

Uhm, yep, oh yeah and then uhm the place is that we're there all the time we feel negative about it because we're just so tired of it but uhm if I find a working space we can manage it's not it's not ideal I mean I would like to have more space I mean everything available to each student without having to share without sharing and all of that but uhm I think I don't actually find it problematic, however, the heads are a big problem and uhm sometimes the footswitch (??) doesn't work and air doesn't work and handpieces don't work and

The footswitch is short; you can't position the head were you want

And the lights, the lights have their problem uhm and uh well sometimes the Bunsen burners don't work, but we don't always use the Bunsen burners

Given that the curriculum is supposed to empower students to address these issues with the School's management and in this case because it's educational things, with EDUCOM, and that there is student representation on EDUCOM has the class ever felt the need or seen the need to address those kind of issues at that level – do you know?

Not that I'm aware of

Is it?

I mean I don't I don't recall ever us ever doing that

Is it?

Yeah

And what what feedback do you get from the student rep on EDUCOM for your class?

We don't actually get any feedback

Is it?

They I mean they just say that the EDUCOM meeting is coming up uhm does anyone have any problems to address, but I don't know of any problems that have been taken up or anything

Is it, they are not taking that Lab thing?

Uhm, not that I'm aware of

I suppose it's because it's longstanding and from historically, maybe other students have, other classes have brought it up and much has not changed

I don't I don't

Ok. And still on resources but not uhm not focusing on techniques, looking at the patients' side and clinics – issues of files. Ok issues of patient files (phone rings). Yeah

Uhm, patient files are a big problem. When they get lost it's so frustrating

Have you experienced it?

Yes I have

This year

I have experienced it, yes

And how did you?

Uhm, the well not in Pros but in Restorative, uhm the files just get lost and then they give you a duplicate and then all your documentation in there is lost – the radiographs, uhm

Do you make copies for yourself?

Uhm, not of the radiographs

No, of the procedures

Yeah and the treatment plan. We do actually need because we've learnt the hard way when the files get lost

And what does the Restorative Department advice?

Uhm, they advise us to actually uhm make copies. But we've just taken to uhm writing it up and everything and uhm and then just going and making copies but, going and making copies all the time another thing is the copier doesn't work downstairs that is very difficult. We have to take our own paper which I guess if resources are very limited, then we have to, but uhm it's not working in the uhm where the Technicians are in that place, they say it's not working, and then we have to go and ask in front. Sometimes we ??

(laughter)

But sometimes she actually does make copies for us. That's that's very difficult

I find that notice intimidating for myself!

And then we have to go uhm Medical School which is so far away in order to make copies

And you have pay

Yeah we have to pay. But it's just that that inconvenience. It's a huge inconvenience. Sometimes I personally I know shouldn't do this, but I take the documentation out until I've finished with the patient. I will, I write it up – everything, the supervisor signs it and then I put it back in when I'm done, because uhm I can't afford to have it lost. Yeah. And uhm for Pros, those yellow files, uhm

Uh hum the partial denture files

Yes, sorry the partial denture files we don't, we keep it with us.

Uh hum!

We keep it with us. We we don't we don't mind handing it in when they ask us to we give them, but in the meantime it's very very difficult. I mean, it's like in Resto if you're doing endo and you're writing up and then you finish, Dan wants to close at 6 and then you have to hand the file and then you have to continue ??? and you can't find the file, you don't know what's your working length, your master apical file

It's too difficult

So uhm, that's that's the big problem files, finances and then it comes up to 8th floor and it ??? gets lost, they say that, files are continually, then I don't know what happens to them

My my suggestion would be, I'm just thinking on my head, that that you know, if that's a real concern maybe get a get a book, you know where you're going to, or a file, where you compile your own records so that for each patient you have that file on you and everything that you do, you record on there

Now that we're talking about it and thinking about it but it's just that everything ??? don't actually sit down and think about it ???

Coz the only the only thing that you really need to have a copy of then would be the signed approved treatment plan

Uh, yes, I think that's that's that's a really

And if it's in an arch-lever or if it's in a file of everything all the clinics that you do you know, it's easy enough to carry coz it's not too huge a document to have to develop

I think that's that's actually a good idea

Laughter

Uh, I'll advice that next year. You know. I'll advice my class to do that that for their patients they make copies of the the initial history and the treatment the approved treatment plan

I don't know whether this is relevant but uhm this is something I I remember as a class we found it quite like a problem when when uhm when we have a lecture and then the lecturer will give us a pack of notes and then they say distribute it amongst the class. That sometimes gets too much coz we have so many subjects all the time I know that we shouldn't be talking about costs and all that but as students sometimes it costs a lot of money

Yeah

And we're not working yet so we don't have that money and our only place it comes from is our parents and some of us are not lucky enough and and so that's very difficult. I don't know whether because I know in our fees statement it does say notes and all of that

You pay for that

Yes we do, we are paying it but some we just don't get it

I thought I thought the School's policy was that the departments would make copies available

They make four they are there's four groups you know so they make four groups then they say give you four copies and they say like

But don't you have don't you have the option to go up to each department's office and ask the secretary to make copies?

Not that we've been made aware of, but if if that's then then that we should have done that, but I didn't know about that

See these are the kind of issues that would then need to be raised by the class reps on EDUCOM so that they make the School management aware of the con the issues that students have so you know so that a workable solution can be reached

Well, I think that's an important issue, yeah

Uh, it is coz my next my next question or my next uhm discussion would be with with respect to making appointments for patients. How do you do that?

Uhm you, we well, for Pros we apply at the front and we I I that's what I do. I I know some people go to the book and then they book what whichever patient looks suitable for them and well I don't do that because it's in future it's going to be difficult, perhaps ?? who's going to work in your practice

But you also also for you have to select according to what it is that you need to get out

Yes, no but that's you can't you write what you need removable like upper and lower full/full; partials , you are given that option so you do it we do it, but some people I know choose according to like uhm if you're H1

H1 or H0

Laughter

Whether you're H1 or H0. I know it's difficult. I have an H1 patient, it's really difficult she can't afford, I can't afford to deliver it to her so she said only next year so obviously my quota's not going to be met. But this is the patient and this

And then have you made the supervisor aware of this and have you made a note in the procedure so that at least it's there

Yes, yeah I have

You cannot be thought of as shirking your responsibilities

Yeah, I have that

And then how how then do you make appointments for patients – do you use your own phone or do you use..

Yes. The clinic, that phone they don't answer, the

Switchboard

Switchboard doesn't answer, uhm now I am aware that they're they're not busy but like this week I've noticed ??? I try to phone my patients for attending ??? asking me but if it was correct usually it rings and rings and rings. I just end up using my own phone

But that also now then adds on to your costs

Yeah. It's really, it's very expensive. Uhm and some patients' uhm don't have cellphones they can only be reached at their work place of work I mean. We can't send an sms that's so unprofessional so we do have to call them and it's really expensive, it does add up.

And the EDU, the class reps on EDUCOM?

Uhm, I don't think we ??? as a class because also in the class some people can afford it and some people can't and and I'm sure the people that can't I don't know but I don't know whether like the people that can't would say you know what I can't afford this or whatever. I I don't know

So as a class do you do you sit and discuss the issues that you have as and when or is there a regular time that you meet?

No, if something happens then we discuss it as a class. At the time I must say we are we are very we stick together and we do yes and if something happens we we try and resolve it and uhm

yeah, we don't have problems in the class, we can talk usually. When something comes up we do talk about it and obviously there'd be differences of opinion uhm but yeah we deal with it

Ok

And we so write letters if we have a problem like uhm like with test dates whatever, we will sign as a class and then we will say please can we you know, but we we don't actually fight or anything like that

Ok, uhm with uhm the class's uhm relationship with supervisors, are there any challenges there, is, as a class member are you able to approach any supervisor whenever you have issues, whenever you have problems and you don't have you don't understand. So there's nothing you don't feel intimidated to go to anyone and ask..

No

OK

But uhm obviously when it comes to the professors, whichever professor they are, they're still professors obviously???

Laughter

Why?

They know so much. It's not a more like fear, it's just like they know a lot, I don't know. Yeah, they are approachable all of them are uhm everyone. You do hear from the older ones. A lot of the fear is from the older ones ??? you do hear from them that 'oh this supervisor are', but I I haven't found a problem basically

Keep an open mind

Yeah

And experience it for yourself

Because you have to otherwise you'd be so scared all the time

Uhm, uhm

And then you learnt for yourself. If some, I mean I'm sure I haven't experienced it but I'm sure, like, if there's someone that's not approachable, I don't know, but so far it hasn't been

But the thing is to be mature enough to know what it is that you need to find out and approach the relevant people in order to sort yourself out

Yeah, and also you can't go and just stuff around and say: I don't know that to do, you have to have some idea about what's happening. I mean we're already in fourth year so we should know something

But also the the curriculum is such that you need to be self learners

Yes

You know, you need to take responsibility to find out for yourselves and if you don't understand anything then know where to go or who to consult in order to to

But sometimes Dr Mokgadi, it's the time, we we don't hardly have the time. I mean we finish at 6, we have to go home, most of us are live away from home, we have to cook, clean, read and sleep as well as studying and doing assignments and

And lunchtime you want to just

Yeah. What do you do with a week where I had like nine assessments or tests uhm whether it was practical test and written test. Nine in one week! And that week we had lunchtime lectures as well. It was crazy, I don't know like every it was just bombardment and now ok now it's over, so in retrospect I'm like I can't remember how stressed I was but I mean it was bad.

But isn't that supposed to be I well, my understanding is: that kind of issue is supposed to be handled right at the beginning of the year with the yearbooks where all the assessments are mapped out

They didn't. They're not. That's that's the way it was. The problem we experienced, especially that nine week uhm nine test week uhm it's just that at the end of the time it just comes where your your lecturers tell you. I mean they think that they they doing, no they think that they're doing us a great favour by saying decide as a class and you have to write a test, decide as a class; and then Ok, that's fair enough but we have like say 4 weeks left in which to do so many assessment, we have no time! We, literally we wrote at ten to seven in one morning in Radio coz there is no time to write it

I understand, was it your class that came in on a Saturday to write

Yeah

The Radio test

Uhm. It was the sup or the final or something, yeah. But I mean there's there's just no time to schedule tests. I mean wrote during we write during lunch, we write in the mornings

You have tutorials at lunch

Yeah

You have tutorials from 6 to 8. You still have the 6-8?

With Maxfac

Is it next year?

I don't know, I know last year the fourth years had a 6 to 8, but I we didn't have one.

Uh, I think they've stopped the practice.

Yeah

Ok, uh interesting. At then the issue of continuous assessment right. Are you benefitting from it and do you see any need for continuous assessment or would you rather prefer the blocked out time

Continuous assessment works fine, it works wonders because otherwise we would leave it

Honest

You know, I mean most of us, we have so much to do if we had the free time we're not going to take that time and say: OK for a test that's in a month or at the end of the year and start studying. Personally I wouldn't do that, I mean continuous assessment, I mean and then at least you're kept you remember things better, I mean continuously when you're being assessed you go through the stuff more times than you would obviously like when you're writing at the end of the year. I find it works for me

Uhm. And do you think that the BEST system in the clinics helps with that?

The continuous assessment?

Uhm

Uhm, I don't see how they're related?

In the sense that you are graded with each sessions

Yeah

And the supervisors are supposed to engage you to check whether you understand what it is you're supposed to be doing for that particular session

Yeah, yeah definitely. I mean the BEST so far it's been fair uhm, but what I really like is where the supervisor, you can always query why and where did you go wrong! It does always happen because at the end of the session you're really busy packing up and all of that. But if you do query some the supervisor will tell you this is where you went wrong, next time

Don't you get supervisors that are not interested in giving you feedback but just giving you the symbol?

Uhm, no.

Ok

Uhm but but I don't always query it I mean sometimes you know you deserved an E and not a B because you did not perform at you best and yeah. I don't know about Ts, but sometimes you deserve it coz you screw up majorly and you know what you've done wrong

Uh, are there times when you think that your supervisors have uhm assessed you more lenient than you would have assessed yourself and would you bring that up with the supervisor to find out why

I don't think I'd bring it up

Laughter

Give me any good mark

Laughter

But uhm, actually no I haven't though I I've had supervisors that have always been fair

Ok

They have always been fair. I wonder who ever ???

Ok, well I guess one wouldn't really bring it up but sometimes you want to know why they think you deserve the mark that, whether it's a low mark or a high, why they think you deserve that mark so that if you thought that you didn't deserve it, was too high, then you'd know how to the pitch yourself and as well

That's true, and also I another thing that we found uhm , it was like uhm it was last year they have a certain ranking thing , I don't know how it works here but uhm I know like certain supervisors have I don't know, it's like a formula or something that they have, but I know that like our supervisors are regarded as strict ones for our group uhm and then I know that the Group 1 their supervisor they had like the more lenient supervisors and uhm we all had Bs and Es and all of that but and that's weighted I don't know it's weighted per supervisor?

Uhm there is a formulae where the marks are Rater corrected so that you know the the lenient supervisors are balanced by the strict supervisors

Yes, but that was quite unfair because I know like our marks were very high but I know that we did work hard. But I know that Group 1 works equally as hard and I know that they are also they can be they can be better than us also in some areas I'm sure, but because of their their

weighting or rank or formula or whatever, I know that they had less lower marks than us. They were quite upset.

And they did bring it up?

I guess we've just learnt to just accept it

Why?

That's the way it is

But the curriculum empowers you, well it's supposed to empower you to bring these things up so that at least you understand

Yeah

What is

I I do know that some of them went to query it with how they were scored and then we they were explained this is how how uhm the formula works

Ok

And all of that, But uhm I was on the other side of it but I still found it a little bit unfair coz some of them did deserve it. I mean I got higher marks than some of them and I know that clinically some of them are better me which I accept and I feel that that was unfair towards them

Uhm. Ok. Interesting

Uhm, how is it uh decided who is lenient and who is stricter?

You know I don't know. Anything that is to do with maths, at this point in time I don't, you know I've got this block against. But I know that the BEST system has a formulae to work that out so that you know the ones with uh lenient supervisors don't get the benefit of that all the time and then the ones with the stricter supervisors are not penalised all the time. You know so, and also remember that the BEST symbols themselves have certain weighting so that takes that into account as well

Uhm that seems like a far away thing

Yeah, that's the package that the the package uhm issue. I suppose the School decided it works, it would work well for them. Ok. Any other things?

Uhm, no it's just that at the end of the year we're very very tired! Yeah

Now, if we go back to the PBL. How has the PBL programme helped you with the rest of the course? Or not helped you?

Honestly, I won't say that it has helped me with anything else that we've learnt uhm, first PBL I was with you Dr Moipolai, I was in first year uhm

The Greek lady

I I I really I really enjoy PBL I like it I like going there I like learning of things that we we wouldn't normally learnt. But uhm it hasn't really helped me with anything else like that

Ok

Well last year we learnt about squamous carcinomas and this year we learnt about it in Path, so it does sometimes does have some linkage or whatever, but not greatly

Ok, now the fact that in next year you're going to be getting the case the case-based sessions for PBL to do the treatment options or management options whatever they decide to call them, do you think that it would be beneficial for that stage in your life because you'd be in the clinics most of the time having to treatment plan each case?

Yeah, I would think so. I don't know what it's about like

You haven't talked to the senior students to find

Well they haven't told us anything, well now that we'd like to avoid them, I think all that negativity ?? But uhm they uhm I'm sure they because I mean after this we're going to be out on our own I mean we have to we have to learn to do it ourselves now, so I think that would help it would help in the clinical situation a lot

And you would have to be integrating all this

Yes

This information that you've had for the past four years

Yeah. Some sometimes it's difficult to integrate things like uhm especially when you're in it, like now when we were **in Path** and **in Pharm** and then it's not sometimes?? that you bring everything together and it it was difficult at first because everything is in compartments and but now that at the end of the year when you've finished the course and you understand the way everything fits then it's OK. But uhm that's what it would help to integrate it to learn well to have more opportunities to integrate stuff.

Ok. What would you say was your most memorable experience this year with the course?

The first time something was signed off

Laughter

No! Why?

It was so frustrating at first to I didn't know, well I did know what was going on I knew the basic principles and it's just to get sent back to do it over and over again and when it got signed off it was the greatest feeling ever! But uhm it wasn't like the other day I delivered my partials patient, it was – for me it's memorable because it was job satisfaction where I delivered, well I didn't deliver it it was a try in and I showed her what it looked like and she she had many medical issues and she hasn't had teeth before and now she had them in. She was so happy! She was like dancing in her chair and she was so happy

How old?

She's uhm about yeah she's forty years old

That young

Yeah she's very young and I mean she she was ecstatic and I she had been complaining coz uhm it's hard for her to leave work and her boss has been taking money out of her out of her pay because she comes to us to the clinic and all of that. And she's the one where we had to repeat all the all the impressions on and it was frustrating and now that she saw it and she is so happy! She it's it's so nice to just finally be that 'you know what, you are making a difference' and that and that is that was the most memorable

And the worst

Uhm, I failed some things but I can't remember what

Couldn't have been the worst, if you can't remember what it was!

Yeah, it wasn't it wasn't as bad this year. It wasn't. I cried a few times because of the frustrations, you know, it just gets too much

Patients or

No

Assessments, time?

I think I failed Perio or Oh no I failed Paeds and Restorative. I was ??? repeat the test and it was like the world's easiest thing ever! I would be exempt from everything but writing this Paeds test and it was so it was just too much

But, but you wrote it, how did it feel?

Uhm oh no! It was fine it felt OK but I know that we had lots of other things happening at the time and I didn't give it enough attention and all that, but I know that. But it's just frustrating to be one of those that are sitting and writing when I could be using my time for something else. And I thought you know what and I cried for that as well, but it was. This year has been relatively quite good

That's good. Especially coz you doing uh next year is the last year

Yeah

And this year has been chock-a-block with assessments

Well, this year I just we I came into it feeling scared because of everything

Oh you were mentally prepared

I was mentally prepared and that's what helped a lot and I noticed that with my friends they hadn't been as prepared and they kind of we do have lots of fun I mean we do go out. You have to make time for yourself, but there are certain weekends where you just want to say you know what I can't and some people don't know where to draw that line. So that's that's what helped me this year

So you're more mature

Laughter

I think it's time to grow up

Laughter

Well really we do stupid things like one day after Fixed Pros when we left the Lab it was 6 o'clock, it was Monday we were tired so so tired and we walked down – you know that little cart that goes around the and it peeps at you we found it charging in the corridor, going to Medical School so we unplugged it and we pushed it to the next to the next outlet and we closed the door behind it so that people who ever passed there would think that it was stolen, but we didn't push it we put it in neutral and we laughed so much it was just so great to relieve some stress. It was just so funny!

And there was nobody to say hey what are you doing

It was just so funny, it was just so stupid but it was just one of the things when we needed to let go. It was very dumb now when I think about it

But I guess it was a stress-reliever

We laughed so much Dr Mokgadi, we were doubled over laughing and it wasn't that funny

Well at 6 after Fixed Pros you have to??

And you get tired,

It is tiring

I know. But but I needed a DSTV so because we don't have DSTV we get Desperate Housewives on Mondays on SABC 3 so that was the greatest way to end the day and ??

Uh

but uhm yeah it's been OK

OK, thank you that's been enlightening, thank you very much

Ok Dr Mokgadi

(ended at 1:30:46)

APPENDIX 4.3

Fictitious names have been used throughout the interview

INTERVIEWS STUDENTS - 3

Priscilla - Started @ 1:30:48

Oh yeah, its' going. Now what we what we talked about Come closer, so that hopefully your voice will will get there. What we what I'm really looking at is your experiences of the curriculum especially looking at Prosthodontics and seeing whether what you learn in PBL you're practising it or it's being translated into the Prosthodontic curriculum. Now things like small group teaching; the inter-activeness of supervisors or facilitators or lecturers whatever you decide to call them; and your own experiences with the curriculum

Ok so basically whether it's uhm what we are whether what we're learning in the clinics and our structured courses being carried over to PBL or either what we're learning in PBL is being carried

What you're learning in PBL is being translated to, the principles of PBL are being translated to the component learning. Just hold on. Ok what whether the principles that you get taught or get exposed to in PBL are translated to the component teaching and learning – not the content of the PBLs themselves

Ok principles as in general principles like patient handling

Yes

Integrating everything

Integrating everything and uhm being more being more able to interact with the supervisors and not fearing them, getting constructive timely feedback with respect to your assessments or the way you your performance is during the year and things like that

Well personally I do feel that you build up more of a relationship uhm with your supervisors in PBL but I never I've never been in a system where there wasn't PBL so

OK

So I don't know how

Looks different

How it would be different. Uhm

Ok

Uhm if we didn't have PBL but you do mix with your class mates especially in first year during PBL and your supervisors, but I don't know if PBL if it's only the PBL system more or if it's the

Dental School is such a small school we interact more daily anyway with for our supervisors and uhm as far as the curriculum uhm well coming from first year, PBL now for me is a more constructive exercise than it was earlier. I know that that the full point of PBL is to stimulate your learning and to make you find out about things that you've never heard about before but personally I feel I can I can enjoy PBL more now than I have more knowledge

Uhm

And that I can apply it to situations I've been in and when I read something new I can think: this is what I should be doing with my patient or oh yes that was that was what was happening with that patient or in that situation whereas in first year I was kind of just feeling around not knowing what it was about

Ok

Just reading it up and reciting it basically

So would you would you say that uh maybe the PBL program then needs to start in the first year or later on

I I think it can start in first year but then I think it should be more structured towards what you do in that year

Ok

Because I feel it would be more constructive if it's it's not a revision but almost like uh you've already had the structured lecturers in that and PBL then you already have that interest you already have that background knowledge and PBL just uh encourages you to find out so much more and interesting things and things you didn't have time for in your structured course, things like say last year we were treating patients but we hadn't learnt about bleaching yet

Good luck

No no I think it's just realising something

Ok, and then Ok now with still with the with the curriculum you are handed yearbooks at the beginning of each year how have those helped or hindered your progress

Uhm

Or are is it are they of any benefit

Uh they are of benefit

How

The problem with yearbooks that I have found, if I can be frank is the supervisors, is that it's it's not always adhered to by the course coordinators themselves

Ok

And then it's it's September uhm they'll add something that wasn't in the yearbook because as far as I understand it the all the test dates and everything has to be organised say in the first

Two weeks

Uh two weeks – six weeks – or something like that and then it's put in the yearbook and then you sign for the yearbook to say you agree with that and then where you agree with the yearbook and then in September the yearbook is changed or the course coordinator decides no they want to put an extra test or something like that. And I know a lot of times uh it's both ways, it works both ways a lot of times it's the students that request 'can we change this date' something like that

Uhm

So I think the yearbook is good just to know what you're supposed to be doing from the start. Basically: you have to pass these components, this is how you have to pass them and you know what to expect

Ok

But it's I don't know if it's working in terms of the scheduling and and in terms of actually what happens in practice at the end of the day

Is it a lot of components that uh change the or add on to the yearbook later on

Yes, especially in the OHSC

Because the yearbook is for OHSC not the other, the non-OHSC

Yeah the other the other well I don't know about whatever about the others but with the yeah a lot there's a lot of change

Is it

And sometimes it's on the students' request. Like sometimes we just want like when this year when we were writing say eight exams then we asked 'can we rather have a three hour test than two one hour tests in two weeks' coz we don't have the time to write it. But yeah it does change a lot and it tends to become very confusing for the students and you kind of at times you don't know where you are and stuff like that

If the request is asked for by the course coordinators what hap is there a lot of that happening where the course coordinators ask to add on anything?

Well usually they don't ask usually they tell you

Ok

Uh this is what you need to write another test you're doing it at eight

Oh and then it wasn't stipulated in the yearbook

Yeah it's not it's not always stipulated in the yearbook. Sometimes it is and there just wasn't time during to write it and then they ask to fit it in the last three weeks but sometimes it wasn't stipulated

Can I ask which components, coz I'm just thinking from the Pros side so far my experience has been that all the all the requirements the assessment requirements have been put into the yearbook with the stipulated dates as to when they should be

Yeah when they should be

Finished, however, the the only the alterations have been from the students side requesting extra assessments

Yeah

Because of a failing

Because of

A failing mark

Yeah, or because it's it's basically, I wouldn't single out one,

Ok

I wouldn't say just Pros or just Resto and and it's not that it happens every day it's just it tends to happen near the end of the year where

Ok

Where it's kind of like everything has to be done now especially, I saw especially in fourth year with us it was just yeah. But uh it's it's general. I wouldn't say it was just Pros or just Resto or just Radio or anything

And the scheduling of the assessments were they were dates were dates put to them at the beginning of the of the components or the course or the programmes or was it that was it incumbent on you guys to agree with the course coordinator

Uh well

Regarding

For some courses it's uhm the dates were put, and for some uh it was it was they discussed it with us and asked 'you know what, what dates exactly' and for some courses it was scheduled at 630 on a Friday morning or 7 on a Friday because there is not time in our timetable or on a lunchtime or on a Saturday or we would be writing three exams in one day you would be running from one test to write another test that was scheduled in a lunchtime, so things like that so

Uhm, interesting! Now with respect to the resources that we have, how have they impacted on your studying, things like having to book or have to book patients or who books the patients, if it's you do you use the University phones I mean the Hospital phones or your own phone; the space in the Lab has that been frustrating or good?

Well Ok, uhm what's frustrating sometimes in terms of resources in terms of materials and things is if you have to come in your own time we have to come in extra, and and you don't have models or there isn't enough Snap or there is not enough acrylic and then you have to ask ask in the Lab and then then it takes you an extra hour of time which you don't have to do work that you really should be doing because you're running around looking for

Stuff

Or for something, small things, small things that hold you back, small things that you just, where you have to sign out an Ash 5 OK you can sign out an Ash 5 but you can't find the person that you supposed to be signing it out with which is understandable or uhm

Don't you get uh issued with instruments in BDS 2?

Yeah we do. Ash 5s we do, but like general little things uhm uhm just to say something like that that you have to sign out for. It's like general it's not it's and it's across the board it's kind of and uh things like

Models, models

Yeah models

Teeth

But yeah well, teeth, obviously but teeth are more uh. Yeah if you ask for the fourth 11, they're not going to be an issue.

Considering that it is a training, this is a training programme and uhm you are expected to make mistakes so if they're putting minimum numbers or maximum numbers that you can't have more than three of a particular tooth

Yeah, that was *quite* especially in the beginning in the for my first say inlay that was a problem because you're stressing so much about getting a tooth to do it on because you could only do it on a 36 only do it on a 26 or something and you can't go and ask for it because you only have three and you've already tried three times and you've messed it up three times and you are learning with every try but it's not at that stage where it can be signed off yet. And then you're stressing because you're thinking: 'well I'm never having this signed off' and then that adds on to the thousands of other things you have, it's like something else that you have to deal with but

Apart from just the learning

Yeah, apart from learning, I mean, you're worrying more about something like getting a tooth to practice on than actually just doing it sometimes because there is limited numbers and resources and, and things like that

And has has –sorry to interrupt – has the class ever sat together to discuss these kind of concerns and brought them forward to the course coordinator?

The thing is we've been experiencing this from first term and it has been talked about talked about by *every* DSC.

Oh

To *everyone*. It has been talked to supervisors about by the time you get to fourth year you've given up. By the time you get to fourth year you're like: 'I'll try and handle it'

In the best that you can

In the best that you can. Because also we understand that it isn't always the supervisors' fault. I mean, they get given a certain amount of things and they also have to organise the course, they try teach us and they try and help us as much as possible but they're also stopped by factors like money and ,and

And what does EDUCOM say coz you have student representation on EDUCOM

Uhm. My personal experience – I'm on the DSC and I'm President and sitting on EDUCOM. My personal experience of EDUCOM is that it's not really effective and uh the concerns either get I don't know shunted around or it doesn't really get heard or nothing really gets done. Uhm, especially we had an experience this year when the second years and last year when they *really* had a problem they, they were stressing and there was some, according to them, some problems in their course and they had to go to EDUCOM, they had to go to the supervisor, they had to go to uhm to the course coordinator, and some of them got what they saw as victimised

Oh, in this day and age?

Yeah, well some of them got sued, or she she told them that 'these five students I'm going to sue' and I I mean I don't want talk out of

Yeah

I mean it's not this one person I don't know the situation because I'm fourth year and they're second years. But for them that was very stressful and that was it was hindering their learning in a way that they're stressing about something other than learning. Stressing about handling the relation the system or handling the supervisor or handling of materials or something else other than learning

Yeah. Interesting!

Well I think very frankly

No well, please do because it what's going to happen with the the uhm information that I get pertaining to the curriculum is going to be presented to the School so that any limitations and shortcomings hopefully the School tries to address. Obviously without naming any individuals coz that's not the point of the the of the project. The project is just to see whether what it is that we want we said we were going to do we're we're realising it

Yeah

Coz one of the things that's come up with the other interviews is a question of having to use your own resources, your own phones to book patients

I do that all the time

And having to keep files because of the mishandling of files in the front

I mean I keep my I keep the files. Our supervisors tell us to keep the files because when you're an hour late starting your patient if you have a 4-6 session that's a problem. And if the patient has to go home and everything and then I mean I've often duplicate files I think for at least every other patient this year, where I've had to open duplicate files for. Because if we have a 4-6 session like in Pros, I had a 4-6 Monday session or Tuesday session and the accounts is closed

Uhm

And then the file is in accounts and you can't treat your patient without a file, so then it has to be duplicated or so you may as well keep it

Aren't you advised to make copies of those files if you can get a copying machine?

Yeah, uhm, we're lucky even now now we can use the one in the

Lab

In the Lab which helps so much because as Dental students I mean we even get teased about it we spend *all* our time in the library making copies – every single lunchtime we'd be making

copies. Uhm because usually we get given one copy per group that is one copy for every ten people

And you have to make your own

You have to make your own and sometimes it's stacks and stacks and stacks. I've made, I mean the people place know my me by first name because we spend *all* our time just making copies to try and hand out. And and uh so it helps now that there is one, but

But haven't the departments put into place a system where student copies can be made through the department?

It's it's supposed to be like that but uh (sigh)no one knows about it and

EDUCOM?

And uh yeah well the secretaries here they won't allow you to make it. So what's happened with us: I was the Path rep, I was Oral Path rep and they would get give us, Path generally doesn't give notes, so they gave us also one copy per uh some of the lecturers, and uhm Prof Green and Prof Andressen said: No it's fine they will vouch for us. Yeah

Uhm

But it wasn't official

Is it?

And, so they vouched for me here and I said to the secretary is asking me no you can't; they're telling me I can't do it and I said 'No, but Prof Green and Prof Andressen said that they'll vouch for us and we can do. So I made it for Path, but for every other course; courses like Surgery where there were tons of notes from you know, we had to do it ourselves and lots and lots of of uh of course where we had to make copies for

And are these concerns brought to EDUCOM?

Uhm, I don't know about this personally, I think Fatima has has brought, this copying thing I think, we've been, that that has been brought because we've been complaining about it

Since

Since first yeah. Although it does get, well by now we're at that stage where we don't even ask anymore we just do it, yeah

Because you pay for course notes and

Yeah, but we don't, they, well we get one copy each and sometimes we get load it from a flash disc from the lecturer's

Ok

And we print it at our own cost and I mean a copy costs a lot yeah

Yeah I know it does. I did a lot of this as a post-grad student – photocopy – Yeah, that's interesting. Anything else with respect to resources and materials?

The only other thing that really was a bit of an issue is uhm the 4 to 6 session. We had a 4–6 session for Pros

Removable

And, yeah, yes for Removable Pros and if you do an alginate impression you have to pour it immediately and I mean you get chased out by the guard basically so you can't pour it yourself and the staff, the technical staff, leave at 4, so even if you try and do it fast and you're done by 430 you have to do it but your patient is still sitting there, things like that I mean that was really, and people keeping it in their fridge, taking it home, keeping their alginate impression in their fridge. Stuff like that happening because you you don't know what to do I mean you're being chased out and and something like remove uhm removable dentures where even your secondary is alginate.

Uhm

I mean, it's and you have to send it over to the Lab, you have the next patient, then you have to go pour it because the technical staff they're not there, they don't work overtime. Things like that. And you can't get your patient in at an earlier time because you only have a session at form 4-6. So that's a bit of an issue for us

Yeah, coz I suppose as as staff members you never really concerned we're never really cognizant of the challenges that you guys face

Yeah

But I thought I thought that the Lab had a system where one of them stayed at least until 5 – all those notices up?

Well we get told when we go there that uhm sorry, they don't work overtime.

Oh yeah, you have to pour yourself the plaster the plaster room staff

Don't work overtime and the Technicians don't want to do it

Yeah, coz it's the plaster room staff responsibility, Ok, yeah. And the space –clinic space, Lab space?

Uhm something that's that's a bit frustrating in the space is uhm uh well in the clinic when I'm working especially, apart from like a chair that is not working or something like that then

generally there's no problem in the clinic as I'm working. Uhm Lab space I'm often lucky to every time have a seat but the problem, especially with the with the Cons Lab is half the chairs don't work, I don't know ten chairs don't have Frasaca heads and then where I like I think we were busy Fixed Pros like 3 months when I finally did get to manage to get a Frasaca head to start and work, so. Well at least for the first month I was working outside and it's very different it's very difficult then if you are doing a Pract Test to suddenly

Have to manage it

Have to manage it. Luckily we like anterior teeth, so that's Ok it's like upper anteriors it's easier. Uhm and then I got one organised and it broke again, and. Things like that I mean Frasaca heads, and, I think generally the hand-pieces the the system work, but it's more the Frasaca heads

How do you guys manage to complete the course – not breaking?

I don't know. Because it affects everybody yeah, the best we can do for that (mirthless laughter) Cons Lab affects (laughter) It's just like its' so unfair for falling apart and you are doing a Pract Test, some of it is moving and it can't go up

And you get a supervisor like me who says 'has to be in the head'

Yeah. But I mean, logically it's different at that angle and if you're working on a patient you have to be able to work at that angle and but also and then those

Footswitches

The footswitches! I mean I'm tall I'm quite tall and the one I had my Pract Test on I had to sit like this (demonstrates) and had to sit more to one side and work the whole time like this and then if you have the Luopes you have to sit back

Uhm

And try. So I don't know someone who's shorter than me trying to use the suction and

Like Grace*?

I know, I mean but I mean it's almost impossible because I was just keeping my toe, my one toe on it and I could just reach it with that, so.

So maybe we should the Department should consider changing the practical test to a clinical test on live patients

Uh but but, that's fine but the thing is uhm you have to practice on that thing first. If you practice if you are able to practice, whether it's a Frasaca head, whether it's just like that whether it's in a patient if you are able to practice first then you can go and do it. I mean obviously then you are expected to do but to just, personally working in there was like tense

And then Ok, the clinics in terms of the Dental Surgery Assistants, any challenges there

Uhm

Or non-existent

(Laughter) Ooh. Mostly you get up and you go get it yourself or you get up there and you go and ask them there for any materials that you need and sometimes it's in the middle of patient but you just

Uh

And uhm I mean you can't ask them to go and just fetch it for you obviously there're students or something

But does there there is an assistant per Rossette so technically there is one for every 5 students

Yeah, usually there's there's 1 that is actually where she's supposed to be and then you just go and beg her to give you whatever you need no matter where you are because usually they would be either on the phone or they'll be on the other side of the clinic which is fine but the thing is when you have a patient then you have to run and ask

When you're doing Cons or a surgical and with Fixed Pros

Yeah. It's uh well with the the surgical stuff in MaxFac generally it's Ok

Ok

But in Cons it's a bit of an issue. It is a concern. But this is a bit, but in Cons, the resources, I mean there isn't always the etchant will be done or the shade of composite that you need will be finished or something like that, I mean. We did all especially when we're doing our pract test and there's like 10 students doing it or 20 students doing it then there's not enough I mean yeah that's unrelated

But it is, it is in the sense that uhm the the way we teach or the way we're supposed to teach has to factor in the reality of the situation that we're in so if one is scheduling a practical test a clinical test it's technically, well ideally it's incumbent on the supervisor to make sure that the materials are there

Oh Ok

You see

Yeah, but. Yeah, well for a for a practical test in like Fixed Pros obviously that was the thought we had our materials but like for in the clinic it's a bit of a different thing, especially when there's a lot of patients

A lot of students taking the test

Yeah we I mean like with us we we're taking you have like 15 minutes literally you're supposed to be curing this composite and you would take like that curing light from one patient to the other patient running and you just

Yeah

Coz you don't have there's no time and there's 3 curing lights for 40 students and those type of things, so and I I mean you don't want to do it but when you're really pressed you kind of

Yeah

You just uh

Sha! What's coming for me what's coming out is is a little damning for the institution because we you know we've we've changed the curriculum to be more more aligned with the kind of graduate that we want and yet we're not supporting that with the resources that we know is needed are needed in order to make it a little bit more less stressed

Yeah like basically able to manage. I mean some days it's it feels like impossible. Sometimes I must be *honest* our whole class feels like this and especially in fourth year. I mean the other day me and a friend were having a discussion and we said uh there's so many things that that's just in your way it's like *everything* stops you and uh and the most positive we can, Ok we were in a negative space that day. But the most positive thing we could say about Wits Dental School is clearly they are too demanding, they should choose the students the right way

Or students who can who can

Handle it

Handle it.

Yeah

Hey, yeah and it's also, coz I was I was involved in the PBL side of the new curriculum when it started or the transformed curriculum when it started. So it's it's uh a bit disconcerting that we haven't yet changed, in how many years now?

5 - 7

7 years?

But I think it's getting better. I must say I think I mean if what I hear from the third years and from the second years in terms of their curriculum uhm I mean I think they're still there is still a lot of issues but I think in terms of the curriculum and in terms of the courses they have it's getting better every year

How?

Uhm well an example that I can think of is for us we had a very very big problem with our Endo course uhm we basically learnt Endo on patients first time, most of us in this year – final year we actually did Endo for the first time and our supervisors taught us – in the chair – so the Techniques course was basically for us it was almost a pointless one and uh we we wrote a letter, where everyone signed we said we have consensus this is not working and for the third year they did get a new course coordinator and they have a much more structured course and also uhm we couldn't scale and polish till this year but we saw patients from last year so we had to refer to Oral Hygiene and they had to come back and and I mean it's such a scale and polish! We could do amalgams and restorations

You could not

But we couldn't scale and polish we were never taught how to scale and polish and then at the beginning of that year our supervisors once again in the clinic we were taught. So a lot of things we were taught by the supervisors in the clinic where we were supposed to be taught actually beforehand what what you're supposed to know what's happening before you get to the patient and uhm

When does Oral Med and Perio programme start – fourth year?

Yeah it starts in fourth year but that also has changed now

Ok

Now it starts in third year

Ok

Uh or at least the basics that you need starts in third year

Coz you start your clinical Restorative when – towards the end of second year?

Yeah, and that's another thing. I mean some courses you start in third year and you have time to kind of build it up and then some courses uhm it's kind of like they're all still stuck in the old curriculum and you only start them in fifth year or middle of fourth year but you have clinical knowledge but but it's kind of just gets worse towards the end type of thing. Like I think by the time you get to fifth year you're kind of like have to catch up what you were supposed to be doing in the last two years and everything just gets pushed into half of fourth end of fourth and fifth year. And then you just yeah kind of have to handle everything and something's got to give

Uhm

Usually something gives even students' that's are really hard workers they try and do everything one subject will kill them because you can't handle everything it's just I mean in our class every

student every student at least had one sup or one subject that they they didn't make because if you're writing those I mean if you're writing three a day 'what do you focus on?' which one do you chose

Three a week

Yeah well we were happy with 3 a week, I mean we were doing 5 and 8 or whatever and so we uhm it's like what do you choose to fail you have to decide now, which subject is the supervisor more lenient or is it your last test or which subject can you afford to fail this time so you can make it up next time, so I mean people getting 70s and 80s usually failing

Getting 30s

Yeah failing at least one subject I mean I mean people like Kgomotso, who aces everything, now she has she has one sup and I mean I have 1 sup. Ok that's fine uhm you don't expect to pass everything

But you don't expect to to sup something when you are an exemption student

Yeah and also it's not that you don't work. I mean last year especially we worked till we felt we were going to die where for a week you would sleep three three hours every night for a week. Where psychologically it gets to the stage where you you really feel like you're going to die

You burn out

Yeah. You you burn out, especially in fourth year in the end of fourth year I know that fourth year is that tough yeah but I mean and all of us agree. Every single student experiences it like this even the exemption students. We were saying it's being described as a prison where you can't watch TV sometimes you don't have time to eat or have a bath or wash your hair because

Or go to the movies

I think that's not even part of our reference, movies it's not even it doesn't even enter your mind because you don't even have time for basic things. Uhm I understand that fourth year I mean everyone wants a piece of you or something but personally last year I felt like I know we're supposed to be strong but they pushed us to a level where it's not about hard work it's not about whether you can handle stress. It's about some divine intervention

And the the the scary part is is it seems as if it's been like that for the last 3 or 4 years with fourth year

Yeah, it has, I mean we were told but we were told by the fifth years fourth year is going to be the worse year

Ok at least in fifth year you can look forward to an easier year, hopefully

Yeah uhm I think fifth year has different challenges but they told us: fourth year is you just it's it's ridiculous they told us it's ridiculous that year

Coz fifth year you don't have any new components

Yeah I think fifth year is more about quota and kind of

Integrating things together

Where, if separate, it becomes kind of one thing in fifth year. Uhm, yeah, so it's always extra things that kind of hinder your learning and it's it really decreases your passion

And how has the supervision assisted that uhm lack of integration, or the stressfulness of the year?

Well my impression as a student was that they're also trying to do their best but at the beginning of the year they are told these students need to write 4, 5 8 or whatever tests and they have to get the time. They have to push it to that and every supervisor in every component does that and then when it's 12 components or whatever it feels like an end then it gets a lot but in general uhm Ok some have have been less understanding but in general they they try and they understand that it's it's not that we're just moaning or whatever it's that we're really don't have time

It's real

Yeah. In general they try and they try and accommodate you but at the end of the day you have to uhm you have to do certain things to pass. At the end of the day they can only cut you so much slack because you have to be able to do certain things to qualify to pass for the next year because you're working up patients, you kind just 'kind of know' it's uhm yeah so I get the impression that they also quite they know that they're trying to get blood out of a rock

But in a humane manner

Yeah

Sha! Yeah, it's interesting. Any component has a lot on its plate I think so to to at least make the curriculum a little workable and more student and supervisor friendly.

Uhm what I've seen well my personal experience up to fourth year is uhm it's it's disorganised sometimes where it's organisation and then that's what catches you in the end like we had 6 months of Oral Biology where we had a full course in third year, of Oral Biology where we wouldn't even go to next year's we were just waiting for the tests and then from June we had uhm because we'd had all the lectures the previous term and and from June we had Fixed Pros and we're expected to do this *huge* course in an impossible amount of time I mean there isn't time to learn how to do it, you have to know the first time you put that drill to the tooth you

have to know how to do it and it has to be perfect because you're already behind when you start it. And I mean if they could take away something like Oral Bio and move it down

To 3rd year

Third year and make Fixed Pros, I mean personally I think they should make Fixed Pros a whole year course

Oh no

I don't know why, I don't know why it's a 6 months course! I don't know why, because three quarters I mean at least our whole class had at least one or two things that had not been signed off because I mean you have to get it right and there's no time to do it and there just isn't time

I thought that I thought that they had uh reduced the number of procedures in Fixed Pros techniques because of the timing thing?

I don't know what I don't know what

You doing less provisionals isn't it or are you doing a provisional for each procedure that you're expected?

Except for veneers

Of course not

Yeah, yeah we are doing a provisional for each procedure. It's usually the provisionals that are not done because you do the prep and it gets signed off and the time you have for the provisional and the prep uhm you basically managed to master the art of doing the prep and

It's showing up now with the Practical Tests in fifth year year where it's normally the provisionals that are, that students struggle on

Uhm well a lot of students that I know of a lot did a provisional for the first time in their prac test because they didn't have time to do it beforehand because the schedule says you have to move on from ceramometal, to all ceramic, or whatever, or all gold, or something and you did the prep and you think Ok I need to do the next thing because I'm so behind already

You'll catch up with the provisionals

Yeah, a lot of my friends did a provisional for the first time in the test

Ok that then explains it

Yeah, I mean I felt like, I did the test I did it four times and I felt by the last one I actually started understanding how to do it just because with every time every time I failed the supervisor showed me and they said I mean 'hold the drill like this, and do it like this' and with every time

you learn a little bit more so that by the it's probably not perfect, but I felt like by the last time I actually started knowing what I'm doing

Ok

And and how to manipulate because we know how to hold a drill to tooth I mean

Cut a cavity

Yeah to cut a cavity because we have we did amalgams and everything. So you kind of have that skill. The provisional, it's a different skill because you only use those acrylic burs and things on patients which is obviously very different, uhm so that's it's a new a completely new skill that you have to learn and and you kind of wing it in a prac test

If you're doing it for the first time

Well even if you have done one before then you have done one

Then it's not enough practice

Yeah and you you haven't really practised it. And I think that's what most people suffer with provisionals

Uh that's interesting feedback

Yeah and also well my personal experience is I feel you need twice as much time for a provisional

No you do!

Than for a prep

You do need longer time for the provisional than the prep

Yeah and we were given an hour for the prep and an hour for the provisional. And I mean usually you finish five minutes before the prep because you're kind of adjusting and everything as you're still learning but you're kind of know what's happening and then the provisional is just a rush to try and get it done

And then the the supervisor to student ratio, do you guys find that a challenge or is it fine?

Uhm it's getting better than it used to be uhm last year in our techniques course last year the Supervisors usually there were some days where where there was only 1 or 2 but then usually someone else came a bit later uhm it is really frustrating when there is 1 supervisor and there is a queue of 20 people waiting and you can't get feedback because uhm yeah. In general this year in the clinic, in Pros in Pros especially it was it was Ok this year. It's getting better, I feel that I was getting to my experience in the previous years

Coz I'm just thinking say your BDS 2 techniques

Yeah

How was the supervisor student ratio then?

Well we had a bit of issue with our BDS 2 because we were supposed to uh be taught Cons in the 1st year we didn't

Uh

We didn't do Cons in 1st year then in 2nd year we did a little bit and then only in June someone came that actually handled the course. Uh and so we basically did everything in 6 months but we were taught

Both Cons and Prosthetics in 2nd year?

Yeah in 2nd year in 2nd year we did both Cons and Prosthetics but we were we were lucky we still our Cons uh Prosthetics course was very organised

Is it? But you only, was it Dr Lansky* then?

Yeah it was Dr Lansky so that was obviously very organised

Oh yeah then you had more you had the technicians assisting then more technicians assisting then that course

That course was fine. I mean it's now more of an issue. Well what I hear from last year and this year they were complaining a lot about that course. A lot of problems occurred and they are very unhappy the 2nd and 3rd

Shame, and they are going to have huge challenges in the clinics as well

Yeah, I hear that they apparently they do. I mean obviously it's an adjustment even us I mean it's very different doing it on a patient. Prosthetic patients are different, uhm every patient has some strange

Anatomy

Yeah oh yeah. So I hear that they're struggling with it but obviously we we couldn't complain about that course

Oh Ok . That's it. Thank you Priscilla. Anything else?

Uhm no not really.

Especially for for my the course that I'm interested in

Oh yeah, Pros

And hopefully we will we will act on some of the feedback that you've given

Yeah (ended @ 2:13:48)

APPENDIX 4.4

Fictitious names have been used throughout the interview

INTERVIEWS - STUDENT 4

(Fatima* et al) Started 2:13:48

OK, essentially what it is that I'm looking at is your comments regarding the curriculum, uhm the principles that underpin the curriculum referring it specifically say to Prosthodontics and those principles stemming mainly from the uhm philosophy of the problem based learning, you know, where it's supposed to be interactive; where the students are supposed to be empowered and taking responsibility for their own learning and resources and how that has translated to Prosthodontics and the rest of the curriculum and whether the the the principle of integration that PBL espouses is happening in your eyes with regard to everything. Who wants to start?

I I think PBL is a good idea. It is a good idea, but I just think maybe the way that we're doing it at the moment is not quite the correct way

How are we doing it?

Uhm for example, learning about it's not uhm that articulated properly or one of the jargon but for example last year we did a PBL on uh cancer and we hadn't actually done anything about cancer at the time when we did it and this year when we did it in Oral Path it would have made so much more sense

Ok

If we would have done it the same time as we did the course with your subject to do the PBL

Excuse me, let's go back (*some interference with the instrument making a shrilling noise*)

So yeah I just think if it was properly uh

Aligned

Aligned, yeah, with the curriculum then it would make much more sense coz last year we when we did it we probably would have researched but not yet really knowing what we're talking about and you know go into your head and come out, you know. But if you're learning it at the same time and you're seeing examples of it, then you'd get much more out of the PBL. That's what I think

And this year's cases, the PBL cases, how were they in terms of aligning with the rest of the curriculum?

This year I think the PBLs that we did were like the first one, the Diversity one, it was more in depth/it ??? you know the class

(some inaudible talking from the rest of the group)

We only did 2. We also did special needs

That was helpful

How helpful?

I think with regards ???

I hope so

Well we did it at the end of the year so, you know

Did it make sense and were you able to relate say the content of the the subject that you were dealing with in the PBL with what you had learnt in the other components?

I think I think with this year's ones – the Diversity and the Special Needs – we were able to relate it better because it applies across the board to all our components, rather than only a PBL on Oral cancer and epidemiology and things like that. But you were asking with the specifically about Pros, I can only think uhm it should have been integrated with all our PBLs but we hardly did anything relating to Pros. I can only remember what helped me in Pros is the PBL we did in 2nd year or 3rd year about our first patient, because our 1st patient is a Pros patient. So that PBL might have helped with Pros, but other than that we we haven't researched anything, there was very little Pros uh in the PBLs.

And even then when we did anything you know, we didn't uh like what Anura said we still didn't know what we were talking about; we were fuffing and you know; we didn't, like then you don't really know what to focus on. So you research and you just get a bunch of words and you talk about but still don't really know what you're talking about. You know.

So. Sorry to interrupt you – that kind, that experience where the cases that you do in PBL are supposed to say to pre-empt knowledge that you're going to get later on in your training, it, doesn't that help, kind, are you able to relate what you learn later to what you did initially and see the relevance of what you did earlier on in your training?

I think that's what the importance of your facilitator is, because especially if you're doing something before you've actually learnt anything about it, you need to be guided as to: this is what you must take out of it. You know. You didn't, you don't know what really are the important things...

Some of the ??? the process is so good

Yeah

So I think if you have guidance, with the PBL that you remember are the ones that your facilitator has guided you well told you at the beginning of the process: this is what you must concentrate on, but otherwise you know you don't remember really just you take, ?? and you listen to your classmates and you kind of absorb some of it but some of it you don't and at the end of it you feel you know this PBL is a waste

Like with the PBLs you all research your own topics so that early stage of not knowing really what it's all about the only thing you take out is what you research. So if I don't research the Pros bit I'm not gonna know about it you know, I'll just really know what I did

And then the benefit of uh different students reporting back on different aspects and being able to explain it such that you get something out of it

In all in all honesty if, in theory if if we do something that uh pre-empts our our direct enthusing ?? uh it seems to work well but in reality I think especially in third and fourth year we just have too many other things and if it's it's not our priority and you do what you need to research which is one tenth of what you discuss and you listen to your colleagues reports but what you take out of it is very little. Firstly you know nothing about that topic and uh and then when you report back maybe there are a few interesting things of very specific things, but

It's just student nature. If you not being tested on it you not gonna learn

Aren't there assessments?

Uh

This year were there any

This year there was, yes, tests

And if ?? not in the middle ??

Is it?

It's not only about tests I still feel if we had done our Oral cancer PBL in this year when we were doing it in Oral Path we would have taken out more and if we were reporting that and something I would have at least have been able to engage I would have remembered the

Tutorial that you had in the other department. And then the, I'm just thinking of the one in third year of uh Medical Emergencies, coz that had been timed in such a way that when you did the DLP you were doing the Emergency Medicine course. How was, how was that experienced relative to say this year's experience or other experiences?

Remember we were on 8th floor

We only did the presentations on 8th floor ??

I think that made some sense as well, but again this year we did a lot of emergency kind of

From 2nd year actually from even from phys. I mean emergency medicine is in we do it all the time, in almost all our courses at least one lecture is there, so. That's why we can definitely all relate to it and we all know something about anything

I don't know if it worked so well because it was aligned with the course

The challenge I think, when I used to do the PBL programme, talking from that, the challenge was because it's uh, it's not a fully PBL curricula, curriculum it's really difficult to align the cases with the other subjects so that when you're learning say when you're doing Oral Pathology that section relates, you have a case that relates to that section that you're doing in Oral Pathology, in Oral Med, say in Prostho because of the way the curriculum has been structured it's a hybrid. We're still based uh we still have lectures or tutorials however we call them and then we have the integrated portion and they don't tend / have to align even though the philosophy was to try and align them as much as we can within the limitations that the model, the curriculum model gives

Is it that possible, our classes are so small and every class has a very different class than each, I was just thinking if it's possible to maybe initially in our uh first PBL session if we have uh one or two even 3 options and for a PBL and then the class chooses what system they feel they specifically want to do at that time rather than just something that's not uh..

Not really interested in

Not interested in it but

On that note then comes the empowerment principle of the curriculum where there is student representation on the education committee EDUCOM, that's where maybe the student body can put those concerns and issues to the Education Committee to see how they can help one another. How has the class's uh uptake of representation on EDUCOM been?

I've been representing our class on EDUCOM and (audible sigh) uh and we have brought that up even with Integrated Learning, uh even with the Themes files we said you know what we've done Aesthetics and Occlusion for 30 of us to do that, let's do something that we don't do so much of in the lecture situation, but something we need to know uh maybe let us come up with options and our supervisors or, even if they come up with options, uh also as a class we felt that uh if we choose to do something, something that we're particularly interested in then we'd do much better rather than doing the same theme / two topics for 4 years. Uh but we brought that up but uh

Uh does EDUCOM work?

Ok because that's that's the comment that I'm getting from the the the students that I've interviewed here as well, that they feel that: OK the structure is there, however, when they raise issues in at EDUCOM they are just noted, and there is no

That's true

You know, there's, nothing happens after that

This year we've raised a lot of issues in EDUCOM and I I think we we,. For once we really had an issue then we just have to make a meeting with Professor Essop because EDUCOM wasn't wasn't there

What was, may I ask what that issue was?

Uh

Assessment; lack of assessment?

Assessment, or surgery or something

Because also EDUCOM, they they also tell us that: you know what, it's uh there's the protocol to follow, if you're having any problem with in a specific component and they're specifically for curriculum issues so if we. So really there's no way for students to say things like this. And I know I know PBL is a proper thing, but they would rather we take it up with our PBL coordinator and I don't know but we definitely have brought up PBL and Integrated Learning in EDUCOM. It's every time we ask for student input that's one of the things that come up. So

Ok, all right. Anything else whilst we're still on the PBL principles – integrated learning?

Well I think it's a good idea, it just needs to be worked

Refined

Refined yeah and, but I think the students also like, our attitudes towards PBL are not always that positive because as a student you always feel that certain things should just be taught to you in a lecture type situation and you know. Then you feel more comfortable, yeah

Ok I mean we are at University and we're studying Dentistry you know, some things you can't always just research on your own. I think everyone just feels more comfortable if someone is there, up there telling you this is what you need to know

That's also as well aligning the PBL

I also think lots of us thinks PBL works for the wrong reasons like: that you get to work in a team; which we hardly do, and you get to know your facilitators who are often your supervisors and if you feel comfortable with them then it's easier, yeah. So it might feel, for those reasons it's it works, that kind of learning situation works well.

And also in this age of knowledge explosion and uh the type of resources available, the type of tools available to source knowledge, you know, maybe PBL works in that way because you're exposed, you have to find, use those tools in order to find the knowledge and you cannot have concrete pockets of knowledge from the supervisors because half the time as well supervisors may not have the you know uh current information and because you have access and you have to do it you know it's easier. You come in with the what's the cutting edge ?? so that can also you know that also makes the teaching and learning more robust ,

Yeah

Coz I mean if you look at if you look at the landscape of the teaching staff, most of them are older than younger and you know I mean human nature is when you're older you tend to do the things that you're comfortable with and really not pay attention to what's coming up unless you're you actively keep in touch, whereas the younger ones will try and be on what's going on, on top of what's going on

That's true

That's a true ?? concept

But also we couldn't be such a wealth of information available to us if a student gives a 2 minute report on a topic. I don't know if that's what I'm meant to know for that topic

So that if it's something that interests you, hopefully it would trigger you to go and learn a little bit more

And it's nice as well coz then in the booklet that we get, there's always references there that they suggest that you go to

Yeah

And you also bring in your own references that you've looked at

Yeah, uh

Ok. Now with respect to the space that's available for you to do that it is that you need to do, how is that?

Terrible

Laughter

It is

I was I I did a timetable for those tests which is coordinating next year's BDS 4, of all our test dates and it was about 52 or something and I yeah it's about 23 weeks long and in in the first

block and the second block we only did about 20 of those tests, it was only Oral Bio, Path and Pharm. This last, the last 2 weeks of campus actually we wrote a test every single day!

Even on Saturdays I believe

Yeah, we came in on Saturday to write. That's all I would love to put effort into PBL but sometimes you just have to say

It's not your focus

Some subjects we don't do well 100% because there's no time. It's, and this is what we brought up in EDUCOM as well because we felt that Oral Bio this year a half course initially in 1st and 2nd block was a total repeat of last year's Oral Bio, there was nothing new it was the same course. And we said, you know what it's just a suggestion: the curriculum is so crammed can we do something, can we have Fixed Pros earlier. We even gave them all our suggestions, and they said uhm they'll look into it but they're trying to move Anatomy but it's so hard to move subjects and also the Anatomy department uh, there is a funding thing they get paid to run full courses

Oh

And uh it just it takes 2 years to move a course down, and they all insisted it has so many problems but I mean it's such a waste of time, we have so much time scheduled for Oral Bio and it's such a waste of time

Its half the year

I mean 6 months we could have, we did it in 6 months it was we could have it was so dry you know. And that's important

And one of one of the comments I got from some of the students was that pertaining to Fixed Pros, the techniques, was that some of you were doing the provisionals for the first time in the test because of the time issue

Yeah

Uh

Yeah

And I just feel that it's so much important to me than Oral Bio

Yeah

At least if it was uh elaborating on our 3rd year course or just some different like deeper topics more detail, but it was exactly the same.

Is it?

It was just that in a different way I think of articulating cases, but I feel that they could do that in 3rd year after we do our lectures, to give us the case and then ?? you know at the same time

It was nice it was nice because you took all your information that you learnt and they just gave you case studies kinda like PBL. So that was nice, but then I mean not 6 months for it! Yeah, so

And I hope that you gave this feedback to EDUCOM

We did

Coz I'm a great believer in thinking that even if nothing gets done timely there might come somebody who will take note of the issues that are raised to do something, to start doing something about them

I think they really have to coz I mean with the new curriculum and everything, these 2 years now and I'm including us and the year above us, we just being kind of caught in the middle of it you know and I think since I've been in 1st year every single 1st year course has been different

Ooh

We did..None of them have been the same you know and we are we're kinda like guinea pigs you know, every year something changes. If they ??

This didn't work last year let's do this again, differently, so we understand. On one side we understand that they need to, it's kind of trial and error, but I mean you know we kind of loose out in the long run as well, yeah, so

I wasn't aware that the it changes for every year, I'd thought by this stage that we've already graduated the first cohort in 2005, I thought after that, you know, it would be it would be getting a little bit more routine in terms of

And it's not slight changes, it's been ??? we've been doing things that I don't know, this is supposed to be a class that hasn't done wax ups, uh we're like always like doing something new. There was ? wax ups in first year

Ok

I mean some years sometimes do Perspex block cutting; some years don't?? class 2s without cutting, sometimes we don't, some years ..

Like for us like when we got into 2nd year in our Research and Techniques course, Prof Andressen was like so shocked that we'd never picked up our hand pieces before, you know. That having and this year's first years' have started drilling on ?? you know, so

And then your year, you've done the Michigan splint, last year we didn't do the Michigan splint

Yeah, so that's the thing. It just been different all the time, so

Ok

In the next few years I'm sure the course will be great

We'll still be evolving

Laughter

Curriculum you know is dynamic, that's another reality, things change, you know. We get uh staff limitations, or constraints coz people leave and they're not replaced, you know, the budgets' get cut, and the spaces get crammed, so it will still be evolving. But as long as it's, for me, as long as it's positive and it's not disadvantaging the students nor the patients. Coz at the end the the basic level of information that you need to come up with, come out with and if if the School can ascertain that at least that is given, and give you the skills to be able to add that which is not there, you know

It was what I'm saying is while the curriculum is still new and trying to evolve in that direction I feel that personally, that a lot of the times what the students' concerns might be irrelevant or petty or something like that but, I don't think they they take it seriously and that's a big problem we've had this year when when we had meetings with the various class reps, when we brought the problem we've discussed it, we've discussed it in EDUCOM and, we've even spoken about having a proper student-liaison on 8th floor, anyway. Sometime EDUCOM doesn't want to deal with issues like materials in the clinics, they will tell you straight: it's not an EDUCOM issue. We did clinical, restorative clinical exams and there were 40 of us in the clinic and there were

No materials

There were 10 curing lights and you're not allowed to leave your patient, you have to wait for someone to come and

They're not dealing with it and there is no other

We've raised it at almost every meeting. We've spoken to we've spoken to EDUCOM, we've spoken to Prof Essop about having someone just dealing with the student issues. That was that was ?? some things are a non issue, but sometimes there're real issues and like I think, I think the students can help and we're even, some of the input can be positive in helping staff with the curriculum because I mean we are we're living this curriculum and we will have something positive

Doesn't the DSC have regular meetings with the Head of School?

Only when there is a problem and and

And to get hold of him!

For a meeting

It's so hard! And like for example if you go to Prof Patel for example and it's a curriculum problem, he'll tell you go to EDUCOM. If there is, he was very helpful when we went to him for our problems, but the thing is just trying to get an interview with him an appointment with him, when we come and we want to speak with him with specific things he'll do something about it with, as much as he can, but we saw him twice this year

Only?

Yeah. Once in the beginning of the year just to say we were the DSC and uh towards the end of the year, yeah

And and what has been the experience of other DSCs with respect to having regular meetings with the Head of School?

Last year they didn't have a meeting with him, they didn't have a single meeting. When the HPCSA came, they asked us: How often do you meet with him and why don't you meet with him? If you don't meet with him, who is the student liaison? And uh yeah, so that's another problem

That's huge, especially when it comes to resources in the clinics

Yeah.

Since it it impacts on your learning in time

I, when we really need to speak with him, he always tries to be available for us, it's just

Then we, that's when we have the problems with ???

Worry about us making time because we have such a hectic day as well, and trying to fit that in with his hectic schedule, it's not always him it's also us trying to make time

One way to circumvent that is to agree on a regular set schedule, like every month on a say Friday afternoon or whenever the DSC meets with the HoDs or CEO and that is, you know, that is timetabled so that there is time and space created specifically for that because that's one of the principles of the new, the curriculum; that there is constant interaction and there are structures set so that students are able to talk with management and issues resolved or issues put on the table

Yeah, definitely, we need to have them. Coz just being part of the DSC this year I realised that if students have problems they will come to you and there are many problems

Mmm

And you don't realise that usually everyone just keeps quiet. I mean we need an avenue to go to

Coz I'm just thinking that

And they are tired of lecturers and supervisors telling them just follow the protocol ??? because the protocol is breaking down and even at EDUCOM they keep saying they need to revise it but they don't do that.

And in the interim you know we're losing out - we only have 5 years here and you don't want to feel robbed of your time and robbed of your money and, you know. At the end of it, even if, you want to feel like you left this place knowing what you need to know

And gaining as much as you can out of it

Actually this year the 2nd years had a problem and it was so difficult, I mean they presented it at EDUCOM; we backed them up as the DSC. They wrote a letter to the Head of Department, we tried to make a meeting with Prof Essop we didn't get to see him. It just became such a big problem and finally we went to Prof Evans and said you know what, coz he's really approachable and he always is there

And we said we don't know what to do now, we're stuck, please help us and he then he took us to Prof Patel's office and he said you know what we need to see him and we need to do something about it and he spoke to Dr Boitumelo. And that's all well because in the end it was sorted out but I mean that's not his job unless he is the proper student liaison.

He did that's how it used to be in the old

Yeah

The mentor, where each class used to have a mentor who wasn't part of the curriculum or

Or course, OK

Like in Anatomy or something, where we could just go to them

Ok, I didn't know that. You don't stop learning

Yeah, it was an outside person coz then they were worried about victimisation

If you were not in the clinics yet then it was a clinical person, but if you are in the clinics it's not

Yeah, that's a good thing because the coordinators are too intimate with the programmes. So the, a essence of objectivity might be lost

Yeah and the students would feel they couldn't tell you coz you might victimise

But is there a lot of victimisation feeling amongst the student body though?

I don't think so

I think it used to be a big problem in the past but you know recently

But let's say in your 4 years, has there been that feeling?

No

I find, what I find is that sometimes like uh a supervisor will treat you differently when you're in EDUCOM or else ?? I suppose that's natural I mean, obviously you will get along better or like people better than you like someone else. Look, that's just something I find

Especially in our class coz it's so small. You get to know each other really well

I wouldn't call it victimisation as such, it's just a preference towards some people and maybe they get treated a little bit better, maybe, you know. That's what find

It does seem exaggerated, I think ???

But the university rule, or unwritten rule, I suppose it's written somewhere, is that lecturers have to be aware of the power relations between lecturers and students all the time. One has to be conscious of that, so that we don't disadvantage or advantage students because of that. Because it is easy, like you said: it's easy, you know. If you take a certain, if that liking for somebody you will tend to gravitate towards them and if you're not aware that you really should not be doing that because of the rules, you know. The others that, you'll be spending more time with the ones that you prefer to spend time with

Yeah

And not pay attention to those that you possibly need to pay attention to more. It's just that Staff also need to be aware and consciously so, so that we are not disadvantaging anyone in the process

But it's not clearly victimisation though

Mmm

But ???

When we were on the DSC, I mean the students the complaints we heard – the students were not scared of victimisation

OK

I don't know if it was just because things had reached such a stage, that they just gone to ??? sort the problems out. But uh and on we just told them over and over again: we don't think that's fair. We were worried about that, but uh

Ok

But I really don't feel that happens anymore

We haven't experienced it at all

There is slight bias really that's human nature, but victimisation I don't think so

That's good. I think, yeah, in a situation where students say don't feel listened to it's easy to get to eventually get a feeling that could be victimisation because if you keep on bringing the issues and they're not being listened to you might feel that you know if I keep on bringing them up they'll just you know step on me and really not take note of what, or pretty dismiss ?? because I keep on bringing these issues up

Yeah, But we hear stories of earlier years that and you think that oh I'm just gonna lay low

That's uh I'm sure all of us have heard from other students: don't say anything; stay out of it

Laughter

The space. Lab space, both Labs? How has that facilitated or impeded your learning?

There is not enough space

We spoke about Lab space also. The thing we told them in the HPCSA recommendations it says clearly because of the space in the clinics that these are the recommendations when we came last year, this year we came to check. It says that we mustn't accept more than 40 students, and we even asked Prof Essop: why are we doing it? And then he said: no it's about funding, everything is on funding and we don't get subsidised enough by the government, and we have to. But first ??? this year in the Pros Lab we had to split the class and one, half the class had to come in on one day – on Monday - and one had to come in on a Friday, whereas in our class we were there Monday and Friday to everyone. They have the same work to do that. It's just too much now

Especially I mean, at Wits we're paying the most ??? fee that anyone else and yet, like in our 2nd year, in our Prosthodontic, in our Pros course, yeah, there was student that was accepted, one more student was accepted into our class and there was no space for her

And she had already started late

Yeah, and she had to sit in the Resto Lab,

Separated from all of us

Away from all of us, and I just think: why would they accept another student into 2nd year when the student.

No, that's not

And if she's a new student and yet she has to sit away from the rest of us?

And every year they just accept more and more and the classes are just growing and the facilities are not being developed and it's just I can't see the logic in it. I mean clearly it doesn't work if a half a class, if a whole class can't even fit in the Lab. I mean they're not together for their Pros lectures, they're not together for the demos or anything and 2nd year that's your foundation of your Pros

Well, it seems I'm learning more

So many students we now, the Pros has looked into it there's less uh demonstrators, so that's really doesn't work for those guys. They are ?? I think coz we feel we had a really solid good Pros course. We had all our demonstrators, they were there Monday and Friday. And that really helped, because when you go to the clinics you already feel like you know nothing. You're learning so much in the clinic and that was with our strong background. But if you don't have that background as is, you know nothing, you know, it's

And Pros can afford to accommodate them and not split the class because they have 2 full days available but Resto just has a morning session and they can't – just the ??? of them have to be in that Lab and

??? They're doing the same amount of work in half the time that we did in a whole year

Mmm

That's not really, there's lots of pressure, you just. You're forced to do the work and not learn as much. You know

You're going through the motions

Yeah, but we brought this in EDUCOM and the results back it up, because, I mean a whole class trying to fail set-up there's something wrong. They probably don't know what to do or not practising enough for it. I mean it's a whole class and, you can't blame the Technicians for that

Yeah. Actually that's what we experienced with the Fixed Pros tests because last year we cut down on the number of provisionals that needed to be done because of the time issue and we had challenges with students passing the provisional section. And similarly with the 4th year class, you know because of the time – more students are having to re-do provisionals more. So, just adding on to what you've just said, that the same amount of work that you need to do in a shorter time or less resources.

But we're not just whinning, I mean

No, no no

As students we definitely, we can see say, we can see how everyone is I mean, none of our lectures are not doing everything to try and give us the best course but and we can see clearly that there are staffing issues and. But we want to help as well and if we think we can make valid suggestions and we just need to be listened to.

Then in terms of availability of patients – how has that impacted? Are there enough patients with the right kind of work?

There are patients ??? Like Prof Patel told us: I have a waiting, don't tell me that patients don't come, because I have a waiting list with 2000 patients and I can call any one of them. But that's not the reality

Because I mean if a patient misses one appointment and says to you – I couldn't get a bus or I don't have money to pay, you can't just say that's it

You also have to give ??? from an institution, you know. These guys are obviously, you know of a lower income bracket and stuff and they come from far, they don't have money, they're supporting people, they have kids at home. We have to take all of this into consideration when we make our appointments for them and if they can't come every Tuesday from 4 to 6

They can't come every Tuesday from 4 till 6

We have 1 session a week, you know

And we have to try and be understanding but it seems that we also need to get our work done. So it's like a fine balance

It's really difficult, but I think..

We would love to be able to do this multi – disciplinary thing and treat the patient from start – from Perio, Resto and the rest of it, but you do what you need to do and now because the time is so short and you need the quota and

You don't always, we're all guilty of it. Not that I think, you don't always put what's best for the patient first. You do what you need for yourself, you know. Which is not

Which is the wrong way to

And you know, you know at the back of your mind this is actually not the best treatment choice

At the back of your mind

???

But you need to get your quota

It's quota driven

You need to get your quota, so you need to do what you have to.

Honestly I've done some, sometimes I'll do something and it will rile me like at night it will rile me and I think, you know this was not the best thing to do

Laughter

For our clinical exams for example you have to do class 1 amalgams, you have to ?? find a patient, if you've booked a patient that's not there on that day you cancel that patient and you find a patient with a class 1 amalgam

Now, Ok if you had ??? that's difficult in itself ??? you find a patient with that and you do the class 1 amalgam for the test. They don't ?? you can't just tell ??? You've got other patients. this year we've been in contact with other students in Pretoria and MEDUNSA

OK

So that was great, we just check and see what's happening and because they haven't done that in the past and we didn't know why, because I mean we really interested in knowing how other things are going

That interesting

And ???

And the stories?

Yeah, the challenges. Well in MEDUNSA there's great challenges with patients

They don't have patients?

Yeah ??? They don't ever have Pros patients. And yet ??

They get Full / Full patients It's ridiculous

Yeah. In Pretoria they have a points system so because they understand that you can't do five class 1 amalgams ?? so they do whatever restorative work they need to do on the patient and for a different procedure it's point ?? and you have to have so many points at the end of the year

Maybe I should consider that for 5th year

It's something like that

That's what Pretoria was like ??

You can't always get a patient who needs a class 2 amalgam so that you know

I think that works pretty well ??

And our quota is like 20 amalgams or something and if you don't get 20 amalgams it's a big problem ??

Laughter

Because the thing about Restorative is the staff in Restorative like to do resins so I was thinking that therefore amalgam quota is much reduced; there would be more resin quota than amalgam

But they are forgetting that fact that patients don't want amalgams, like patients would come and say take out all the metal fillings for me, you know

But also that I mean to just to make sure that you don't give up to see resins you only doing class 1s, they have to have done one of every procedure that's prescribed in the year or to have assisted. And the Pretoria students say that they have no say in their course as well I mean they don't meet with Exco, they are old school. The student body is there in name to organise the braai once in a year and

Is it? No feedback to management?

No. Nothing else

But for me ?? it's not **(laughter)**

But they still think their course works quite well. They know exactly what they have to do and how it's done.

But I mean, I like it here coz you can talk to your lecturers. You don't have really that fear, you know it's nice like that I think

You see the other problem with patients is this year we put in so many requests for partial patients or full / full patients and I had about 4 appointments this year where I go and meet my full / full patient and she'll have 4 teeth.

Laughter

'Ok I can't treat you now, next appointment' and it kind of stinks

And that's the ???

I think a few people in our class had that problem

It's the front office issue because they need, Oh Ok it starts before the front office. It starts with the Emergency section where when the patients are referred to the different waiting lists they are referred appropriately. And the next check would be the front office people, when they book the appointments just to verify with the patients what it is that they need. But then the other thing is patients would say: Ooh yeah I need that!

Yeah, and they don't end up getting treated any way

Coz what we've tried with the Fixed Pros side is to sift through the general waiting list and have a specific Fixed Pros list where the patients get allocated to students from. So those, the students then get those patients that have been seen by the Fixed Pros staff and it's easier, you don't have to sift through patients

Yeah that's a good idea

Yeah, coz I was just thinking since we've been doing Fixed Pros like I've been looking at the patients and I've been trying to see you know 'what can I do here?' and it's hard to find somebody that you can cut that crown on, you know

But that's another way to look at it as well. You need to be identifying your fixed pros patients from the Restorative clinic in 3rd year you know - 3rd and 4th year. Ok 3rd year you really don't have much room, but 4th year you begin to get an idea, so you work them up so when you need them in final year they are ready. You don't have to still do restorations, you know, you can just go in

I haven't actually done we haven't actually done that

???

We have an actual idea of what's going on ??

Even if the technical part of it is not brought down, just to be made aware at the beginning of the year that you know, this is what you'll be needing to be look at towards the end of the year, so in your clinical practice start looking at these kind of things. So that when you start the technical part of it in the latter half of the year you know why you're doing it for the clinical part, so that when you're in the clinics already, you know, you're preparing your patients for the following year to start on

That also then allows you to treat the patients as a whole

Yeah, that would be nice to get the kind of patient where you do all the work, everything we need, you know

We don't ever do that!

Maybe we should introduce the comprehensive care patient or case presentation

Yeah, that would be wonderful. We have these multi – disciplinary clinics and the other thing that was different in Pretoria is that they have set clinics – Pros clinic, Rest clinic, but yet they do comprehensive care and so they'll take their one patient to everything and they have to give a write – up scenario, they have to do the costing for the entire treatment

??

We don't think about costing. The only time we ever do that is in Perio

Oh no! You are going to think about costing in Fixed Pros

That's good, that's good.

Coz it allows?? And your patients ask you: what is the price? And you don't know, you really don't know

I don't know still, when patients ask me I don't know

Laughter

But seriously, coz for me Ok where I'm at it's not important but I mean for a practitioner – private practitioner - it is important. But even for me it should be, but because it's not one of those priorities

And it makes them more aware and they and the costs are a huge part ?? they are able to say this patient, rather let's do this treatment it's big enough ??

But I know Dr Tollman, he always asks us to fill in the codes and the treatment and everything coz he says 'you should know that' you know. And that's, no one else asks us to do that

Dr Matlala asks that

We'll find out next ...

We haven't had her

And in Perio we also do that

I don't do that, coz I'm from a different school, so. Even though I know that costing is important because to get informed consent, especially for the non-H0, even for the H0 patients we do, because it's a cost to the Institution and it's our taxes. But you'll get to do that with the Fixed Pros patients where you source quotes, treatment quotes, from the Labs and the clinical part is added by Accounts and the patient gets given a global fee as to what that particular procedure will cost. Obviously it doesn't include incidentals, you know like infection control and other treatment from other departments. So you're in for that next year. You can't run away from it. I see you'll be geared for that

Well it would be nice to have an idea, you know

And then the supervisors, how has that panned out?

I haven't had any complaints with supervisors

But the rest of the class when you talk amongst yourselves?

But just that they'll say I'd ideally like this supervisor because she always helps or he always helps me and teaches me. Someone else would say that supervisor never teaches me

Yeah

Ok

I think. Like I've said before, when you have such a small little community of students or whatever you call it, you do tend to know each other better and you do tend to fall once and it's like we said, it is human nature you kind help but be nice to that person and want to help that person for. And I think that could be a problem but

But I don't think the supervisors who don't teach. No

Or have bad hair days,

Yeah

Or they really don't feel like engaging

I mean like I feel comfortable with, or I feel uncomfortable with a supervisor then I'm sacred and I don't want to do anything wrong and nothing should go wrong and you know it's just if you're comfortable with someone that's half your battle won. You know, you can explain your treatment plan, you can breathe it's Ok to make mistakes, you know you learn from that I think

And also you also can tell when a supervisor wants to be there and wants to teach you and you can tell that the supervisor really doesn't want to be there

Oh is that right?

Yes you know, well I can

Well I think you can, yeah

*You can tell and then and but the ones that want to be there and want to help you and want to teach them and obviously we all have bad hair days and all but like you just feel so safe with them. Like with some supervisors I just feel, I can do wrong and I can make a mistake and I have that person there to help me, you know. Other supervisors you feel just like I've got so much pressure on, I can't do this you know

But then that's not your problem because we can have lectures and nauseum on restorative fillings and things like that, but I think every thing you have learnt is in clinic. I've learnt everything from my supervisors.

That's good I think if you have that rapport with the supervisors and the majority are willing then, like you said, it's half the battle won. And this is the only place like Dr Manana keeps on saying, it's the only place that you can afford to make mistakes. Coz once you're out there the mistakes are costly

And everything I've learnt is because I've made a mistake, you know

That's when you remember it

Yeah, and that's how you gain confidence coz you know, I was really nervous in the beginning such that I didn't want to do anything coz I was so nervous and I was I just thought: I don't have enough knowledge and

You can never

And then you get

Too scared

That's why PBL came in! But you've overcome that?

I have. And it's because of my supervisors because they said: you know what, let's just start at the beginning and let's just go slowly and you can do this, you know and if you make a mistake I'm here it's fine

I'll see you on Saturday!

No, but I can vouch for ?? you have something

And how have you guys managed the work – the test load - for the year?

Not very well

Almost everyone in our class had an issue with 1 course, even the hard workers and the straight A students. Everyone had a problem with at least 1 subject and it's not because

They don't know

They don't know, it's just that you don't have time to give everything your all! You then have to divide yourself so that you can pass everything, you know. If you don't ..

We were writing our final test and we were still here from 8 till 6. Some days you will have

We don't call them exams now (attempt at humour)

No, but I mean for Surgery –

Oh yeah, they are called exams

Their final exam

And those are once off ??

The only time we get time off is when we have exams. Like we had 1 day off coz we had a Medicine exam in the morning and another day off coz we had Surgery again the whole day ???

And then the rest of the day is in-between those ??? in patient exam, clinics, whatever you do, just do it!

And we even brought that up, we said is there anything, if the numbers are decreased maybe we can have, not have that 4 to 6 session because it kills us and we're the only institution that has that still. And to go home at 6 but firstly by the time you get home and you have to study for a test at 7 the next morning coz if we're writing at 7 often now just because we didn't have time. It's either at 7 o'clock or lunch and

With the test we wrote we came at quarter to, half past 6 or quarter to 7 early in the year

Coz there is no scheduled time

Yeah, and then when you sleep, you know it feels like honestly like we're working, it feels like that because

And ?? people like you know 4th years, Pharmacology and Oral Path, she'll concentrate on those subjects and then like, OK fine I'm writing a Restorative test you know, whatever, it's Restorative, so you'll get like 50 in the Restorative test when you should be getting higher – it's Restorative that you actually do every day! And you won't concentrate on it, it's just Restorative! And that's not the attitude we should be having, so, yeah

The time off is a real big issue I think

Do you get the test schedules at the beginning of the course?

In our yearbook it says that all the test dates have to be in 6 weeks from the time we get our yearbook in the beginning, but our supervisors in September were coming in and saying we really need to do a Paeds test, so just fit it in. We didn't even know for ?? component what we needed and

?? at least for the Oral Health Science components

*All our other components ?? Pharm we all know exactly what we're writing, what kind of test. Oral Health Sciences is just everywhere. And the supervisors complain that ?? we keep moving it, but we got to our last week we need to write a test I mean we have to just ?? and fit them.

We asked at EDUCOM if from next year at least that a basic, a skeleton test schedule can be put, or at least ?? what we need

Coz I know for Pros I mean, in our department, what we've done, or what the department has done consistently is put down the types of assessments that you're going to do and when they need to be in, to be done by. They won't, stuff, Ok this year we haven't really given specific dates, but we'll say a particular assessment in the first teaching block, you know, this kind of assessment by the second teaching block and and and. So at least the students would know that in the year they will have say 4 assessments and 4 different types of assessments

*And even with that this year we had at the end of the year we needed to do for Pros, we had only done, we needed to do about 3 more and an OSCE and it was like the last 2 weeks of the year and ???

There's an OSCE you need to do – do it!

I suppose the challenge with 4th year - the 4th year Pros programme is it's still fragmented – it's removable and fixed and you start with the removable part and the fixed later on and technically the fixed part doesn't really need to give you the programme until two weeks is it 2 weeks into the start of the programme? And because they start in July they have all that time. So you won't necessarily have it in the year book, you know

We rarely had a problem with the fixed, it's

Yeah

As you said the removable in the yearbook it has scheduled things for the 2nd block, the 3rd and 4th block and we don't have the scheduled removable session and so now we must make our own time

You don't?

No we don't have a Removable Pros. For 3rd and 4th block there's nothing. It's only clinics, and yet there's 2 writtens, there's an OSCE

The time table has changed in a year!

Yeah

That there's no Removable Pros

?? We're having a test during break, so we literally have 8 to 6 days every day. It's ridiculous!

Coz last year they had a Pros session Tuesday afternoon and Wednesday afternoon for the whole year

We had that in the 1st block on a Tuesday, but in the 2nd block that fell away for Perio or something

We still have to write our tests but we ??

And that's why this addition of Oral Bio just irritates us

Yeah

Coz we can see the time being wasted

And another thing with PBL, what happened this year is that we have like the whole Wednesday afternoon scheduled for PBL, which is fine when we had our first PBL that was OK and again if you'?? you have PBL and then you waste the next session, the next week coz that's the research week, you know but I mean I say that's wasted – I could be in the clinic

But at the end of the year we really struggled and you think back Ok I had all that free time and it was great but

I mean in our next PBL we didn't have PBL in that session and that was more opportunities wasted coz it was a repeat of what we'd done in the previous year ??

Like this year. Like they've just picked another PBL and we'll do this, it's like they didn't research and say: Oh these guys did it last year let's do something else; coz it was the exact same scenario we had done

Same scenario??

Or before or something

The PBL I think

We realise that Ok ???

And we were like Ok we can't do the same PBL, I mean honestly, how do you guys expect us to take it seriously

Because all they had to do was to pick a case really, and you know what that was a mistake??

It was our cancer case

So we thought Ok cool maybe now we're going to do something different in the PBL or then it was exactly the same

Oooh, challenges. Year book are they helpful?

Do you read them?

I only read it because I try to get some idea of the tests and what's required, but very little is provided. Lots of the components say that more information will be provided during the course

And is more information provided during the course time?

Uhm, no

You get it a week before and you have ?? test

At least schedule a test when ???

Oh

They need to have a little bit more stuff; there need to be more definites and they need to tell us: this is when you're writing, this is what you're doing!

And I suppose this is what needs to be done and look at that

Ok. Because the University does give, they've actually given the final draft of the almanac for next year, so where we're at we know when the dates when we can't schedule tests because that's decided by University. So when we're supposed to be doing the year plan for the following year, we have to use that as a guide.

The thing is, for uh like Oral Path and Pharm, we're given the dates and what time we're tested and everything, in the beginning of the year, even if that is in the, it's really a hectic week for us, we hardly ever change those dates because those are dates you plan for and our own year plan is that it's on there and we've just, everything is structured we hardly move the dates that are set

No we didn't move any of the Path tests

Just the 1 Pharm

Oh but that was ??? work

Ok, coz you must give me your dates for next year now (I'm scheduling tests for next year now) – if we're writing the first week, that means one has to get a concrete schedule

I think that's really fair

I'm like telling the 4th years please really and think about where you're gonna put your tests

The past two weeks for us was really hectic, writing every day is no joke!

No it isn't

And it's not, and your clinic work is sitting on your head! You need to get that quota and then you have to book patients for the 4 to 6 session the day before you're writing like the final test, you know. It's like really hectic!

And then the booking of patients, is it problematic or is it Ok, in terms of having access to phones, having access to patients?

You wait forever for switchboard

Eventually it comes through?

Yeah

I think that's Ok actually

Yeah that's not a problem

Patient files?

There's apparently a 'file – monster' here

Files also ?? I don't understand what happens to them

And what's the advice that you get given from the department with regard to

That we're trying to computerise the system

But uh

And generally we tend to photocopy our work

We told Prof Essop that and we told Resto uh get lost ?? from Prof Francois because he keeps his own files??

Yeah and

No we can't ever keep the files

No we're not supposed to coz there are notices in the hospital that they belong to the hospital so nobody –I've got a file that I need to write a report on them

They need to go to accounts, they need ??

And uh do you have with, with respect to the photocopying of the records do you have access

We only have 1 photocopying machine –

In the Lab

Yeah, that's the only one and we have to provide our own paper for. That's the only one

If it's not broken half the time ???

Because all

Photocopying is our big problem because most of our lecturers will give us 1 copy of something and just say circulate it

*And I've looked, I've actually just got a print out of my fees and it charges you it charges you for notes and like I should not have to be paying for something that I'm already paying for. And besides that if you give a class, 4 copies of something for us to actually getting a hold of that, it's so slim

Is it?

Yeah, it's not that anyone is being selfish it's ??

And you make a note to yourself, you know what I get the set of notes from this person ?? you've forgotten about it and suddenly the test comes and you think Oh my word I didn't get those notes, you know

Ok. And then the arrangements in the departments – Ok I can't talk for the Medical departments – but for the Dental departments isn't there an arrangement that the departmental secretaries to to

No, we came here to do that, and they told us we're not allowed to. Then we asked our supervisors uh for those because if we're not allowed to make the copies if they can give us their code we'll I mean we'll make the time and we'll come and do it and that wasn't possible. So

You can't use their codes

But I mean it's ridiculous, sometimes you pay R50, for a set of notes and like all of us we live away from home. That's a lot of money for us, you know so yeah

Especially when you've paid for it already and it's supposed to be provided

Oh no globally the the ?? your PBL notes coz I remember towards the end of my tenure as the PBL person I just got so tired of making copies for the whole class and I'd just make a copy per group

That's generally how it works. You get 4 copies, the chair of each group gets a copy and you have to circulate it and you have to make sure that everyone gets it

And you have 20 sets of notes

You have to go to the library and you have to wait in the queue

We live there ???

?? It's like a photocopying shop, which is so

And even then we're running ???

So these are the kind of issues that then if the DSC meets regularly with management to bring up, because they are, it's not like hearsay and it's not like hairy-fairy issues, its issues that are happening where you pay for the resources on your own account and yet you have to use extra money to make copies for yourselves and the University is not providing that

We brought this up at EDUCOM and yet, OK fair enough they said it was not a curriculum issue so..We met with Prof Ibrahim once and we told him: Prof look ??

Maybe the way forward then for the DSC is when they bring the issue up, have thought of the possible solutions for them so when the issue is presented to management possible solutions are given so that they don't have to think out, because sometimes they are also bogged down

Sometimes ??

Like now we would come in and say this is what we think ??

Even with the photocopying, that's why we said can the secretaries, can we get a code, can we use the lab, we've tried everything ??

I guess it's the role of the DSC it's a bit underplayed now and we can make it much, and we can be a creative force than what we are. That's what we really did try to do this year, because usually people, even the students even the DSC OK it's for the Pub crawl, grad Ball, that's all we do. I even thought ??

I don't know! There's a lot of things that we do ??

The powers don't recognise that we do exist, they just

Yeah they don't

They just

Ideally I would like to meet with all the student representatives monthly, I would like to take that feedback and go to someone else on 8th floor monthly. That's ideally how it should work and everyone should recognise that the DSC is your method or your way to get

It's not like that

Because amongst the students it works. I mean we've met regularly with the class reps, we know exactly what's happening in every class, we know their problems, we know how their clinics are working

We know what they want everything working

We know what's working well and what's not working. Regularly we speak to the class reps and it works really well amongst the students and then ??

And then something like we wanted a room for students coz we don't have that. If you want something to eat you go up to Med School and we don't have time for that you know, so. And we told Prof Essop about that and he made time and he came down and he was looking at all the possible areas that we could have that. Now if he can spend so much time for something like that, you know, our bigger issues like the curriculum issues and our material issues those should have emphasis placed on them as well

Maybe also go back to the DSC constitution and see what powers you have as the DSC and use that avenue. Maybe management has forgotten that it is a properly constituted University required body

I think we actually need to rethink the constitution because we know the constitution it doesn't...

No, but under the SRC constitution it is properly

Yeah

And then just refresh management's memory that it is a formally constituted body that needs to be heard, that comes with valid issues that need to be addressed

?? We tell, we try and do that and when I'm sitting in your office right now, you're taking me seriously and you're listening to what I say, but as soon as I step out of the office it's over! It's just students, they'll be out of here in 5 years! That's how I feel some of them they just don't take us serious

No, but, even if you particularly will be out of here in a years time, there's another group of that's going to come, and it's still going to be there

Yes??

We'd like to think that we all have the same issues again and again and again. But they say we're sorry about that

You know when we met with the SRC we were speaking to the different reps on other faculties like Law and Commerce, their classes are like 250 and things, and they said you know what we have an office that's set up with a computer and everything with the lecturers. We meet the

lecturers we meet them regularly, we have so much input, we can talk about the assessments the type of assessments, we so well incorporated into the department and the running of the faculty. And they are huge, I mean they don't have to take them seriously and there's 250 of them and yet we're such a small department we can come up and see you regularly and talk about things and deal with things when they come up. And yet

And what's the Faculty Student Dean say?

We actually

Yeah

The Dean has

Twice

Yeah, twice. We had a problem with our DSC this year, he was very helpful with that

We had a problem and we came to Prof Essop first and he said

He said it's not his problem ??

Ok, so you took it to the Assistant Dean?

Yeah, Prof Munday and he met with us and he was very helpful

And we met with him again. That was

He was very helpful, yeah. But the thing is we don't think that it was appropriate to go and tell him: we don't have resources

But maybe the challenge would be if you've brought it up with the Institution's management and you got a sense that they're not listening to you or not taking you seriously and there is record of that's what you did and you tell them that you know, give them time – give the Institution's management a time frame that could they please look into giving you these kind of, addressing the issues by a certain date, if not you'll take it to Faculty, you know. And not bring it up in an antagonistic manner, just to say that maybe they don't have the resources to deal with the issues and Faculty might be able to assist

I think we've just been, and we haven't been able to ?? this year, because when we did have an issue Prof Patel made a meeting with us ??

And that was, he told us ?? and that was because Prof Munday had sent an email ?? Oh no that was ?? And then he told us 'You know Prof Munday has sent me this email, it's my own School and I don't know why you didn't come to me, what's happening' So we're just trying to keep things as internal as possible, but I think that

But I think that it's the wrong way to deal with this.

The thing which to do then is start off with getting a commitment from the office, from his office, that the DSC will meet with his office regularly and that the office honours that and it should not be changed unless there is an emergency, you know, but even if it's changed for an emergency an alternate should be given

Yeah, coz we really they need to make time for us coz we are just as

Very important

Yeah

We're a training institution??

But it's in the HPCSA's recommendations that and they're not taking it seriously

They don't..the other kind of evidence that you'd bring forth to say look we need this scheduled time because the HPCSA mandates it, Faculty mandates it, University requires it and you as a student body need it, you know. I mean it's not antagonistic, you're not fighting anybody, you're merely stating what needs to happen and if it doesn't happen you still have that avenue to go to Faculty and say look: this is what we did, this is what we tried it really hasn't worked, please come and assist

I think next year we must speak to the DSC because what's happening is every year it's a completely new DSC and so like this year they told us a few things and we tried to do it properly and then we tried to meet properly. Then it took the whole year

By the time you find it's like half the year gone

Yeah we do need to

And talking of 4th year with so many assessments and such a heavy work load it is too much

But I mean we started this year, we can carry it on and coz ??

And because it's an ongoing thing

So, uh you are a more committed bunch than last fifth years'

No, no the current fourth and fifth year classes have been very cooperative, you know. They haven't been an there hasn't been an antagonistic class, they have portrayed a more cohesive body, and willing to work and find solutions to the issues

Yeah, I can speak for our class and definitely we've been

Yeah

And the bottom line is we want to be doing this and we all want to be doing this

Which is a huge thing

And that's why we want to sort things out ??

But the challenges are big

And many of them

Uh and when one looks at them you know, it's easy to think that it can easily be rectified but if people don't have the energy, if the other parties don't have the energy to come to the table it's difficult

Also something can look very good on paper and really it can but putting it into practice then it sometimes doesn't translate as well

Uh

But there is a plan, I mean we know that the classes are big (chances are vague??) but even if we it's like we cant see anything being done not only that we cant see a plan of action or something , no one it seems, seems to be even be thinking about what we said last week and that's the problem. I mean we know that you can't just suddenly staff a department and. But I mean we need to see that you take us seriously, this is an important issue and this is the plan

Well I'm taking points on my own course.

Fourth year??

No seriously. And thinking how best to refine it and make it more student and staff friendly, coz it's the two parties that I mean, if the staff is unhappy you know the students are going to be unhappy. (Pause) Anyway, anything else?

I think we've covered everything

Share it, share it

What else ??

But the interesting part though is, the students that I have talked with have come up with really good things, issues you know and how to go about reforming and what's happening. Coz half the time

We keep thinking about them all the time coz we're living them

Yeah, you know

Yeah, I mean one case in point is the yearbooks you know, I think, or I thought that the yearbooks were being utilised by the students you know the information needs to be there and you need to have it. Now you telling me that some of it is not there you know, you don't get it until very late you know and I'm asking myself then what is the point if the staff, if the School is not coming to the table with providing that information and yet the curriculum stipulates that that needs to be given, why are we not doing it?

Having the class reps read the yearbook towards the end of the year to check you know, but it's in the, you have to do this and sorry about ???

Coz I know that what Prof Green does with her course is that she reads through the requirements when she first meets with the class she reads through the requirements of that particular course with the students so that she knows that everybody who was there knows that this is what is required of them

With certain subjects you know exactly what you have to do, and in others then you don't know. Especially if you compare different subjects and you say you know what, in this subject we really are clueless we don't know anything. Some courses are really great and you know exactly what

And to be clueless at this stage it's not on

At this stage

Yeah

It should be easy, it should be easy. I mean the difficulty here should be in 2nd year where you're starting your techniques programmes, you're starting seeing patients and you're starting real dentistry, you know. Coz all that heavy work load but by 4th year, I mean 5th year should be a cruise coz there should not be anything new

That's what it's like in MEDUNSA, 5th year is a purely clinical year

But we do

But they start, they start Orthies like they started Orthies in 3rd year

Yeah

They start all their clinical subjects

We started half-way through this year

We started Orthies, was it half way through this year?

But still there's just observing we start Orthies properly next year,

Max Fac

We start Oral Med, Anaesthetics, and it's all like suddenly

Suddenly, the clinical load is so much

And the quota

Yeah

Next year we get a tough year

Ok. I need to change my mindset coz I've kept on thinking that 5th year there's nothing new

No. no

4th year is just that it's all everything new

Everything new

I think that 2nd and 3rd year, normally like for removable pros like full / full like in 2nd year we were like every Monday every Friday we were in the Lab doing it. In 3rd year you do 3 cases. In 4th year you do 2 cases. That's a lot. I mean in 5th year you're going to be doing more of full / fulls. That's a lot of full / fulls. Then it comes to partial dentures, you really don't know anything you know and suddenly you have to be doing partial dentures, how do you do a rest prep – we don't know

Is it?

So, yeah. Like I can do full / fulls in my sleep with my eyes closed without even thinking about it, and that's how confident I am about it and yet I think about something like Orthies which I'm only going to be starting next year, Oral Med I'm only going to be it next year, you know. So, yeah, I'm a bit ..

And then you still have to contend with Pros next year with the tongue and the lips there

Yeah

But I thought that was nice, our course it was nice, yeah, yeah

Coz also like Pretoria was telling us they did it in 5th, well someone we know who's graduated, they did it 5th year and it wasn't nice

That's Ok so then it's concentrated

No, but I like doing it in 4th year. I particularly liked that uh Dr Matlala really did, or you guys didn't have to give us that extra week of your time and you guys made that sacrifice but at the same time the class didn't have to agree either you know and we also said Ok let's do this for our own sakes and together we did that extra week and it worked. And I thought that's cool, we're all together, we did it

I think that we're giving you too much time for techniques and that's just my own personal coz I think because some of you guys demonstrate that after about 3 procedures you were able to cut a prep in less than an hour, less than a session, you know

It gets easier

The provisionals take longer

Oh no the provisionals do take long, but I just did a provisional now in 30 minutes??

(laughter)

No No ?? It's not experience even with prosthodontists it still provisionals are our bane, so

??We got the Cerec machine

Yeah, I guess

But that's 900 000

You don't feel that that's what you're doing you don't feel that it's prosthodontics, I don't get a sense

I don't get a sense that it's prosthodontics ??

?? Not just scan it

Ok Thanks guys. Hopefully... What happens now is once my interviews are over I'll analyse the data and I have, I do give feedback to the department or those colleagues that I talk with with respect to what I'm finding, you know. So I hope that the data holds so that something concrete comes out of it.

(Ended at 3:35:29)

APPENDIX 4.5

Fictitious names have been used throughout the interview

INTERVIEWS – STUDENTS 5

Kgomotso; Patel; Naidoo, Xavier

Started 3:35:27

Sorry, I'm starting to record. The philosophy of PBL – Problem based learning – where you it fosters integration of learning across disciplines and across the years, along years, whether you feel that that you are achieving that say with respect to the prosthodontic curriculum whether you are achieving that or not achieving that, you know. Any comments that you might have around that, coz I'm looking at the Prosthodontic curriculum, prosthodontic curriculum feeding into the main School curriculum because remember we don't have PBL in Prosthodontics as such it's a School it's a broad School initiative. Am I clear? ?? things like, Say the PBL that you did last year and how that went. Am I putting you on the spot?

Uh I just

Or even the techniques programme actually let's start there. The techniques programme and how that has helped or has proved challenging or invigorating, where the loopholes are, where the gaps are?

Well our techniques coz I started enjoying it, I had fun ??? you started with certain things, ???

The actual procedure

Overall I've enjoyed it

It's pretty much the same. I think it's frustrating when it comes to materials, you're supposed to ?? you struggle and then some people get left behind because people are busy with the material and it gets finished or you're waiting in line so you know, you get left behind and then once you get left behind with one thing it's just ?? you're behind then coz then things start piling up and I think that's when it becomes stressful

Just to, just to expand on that.. does having the schedule at the beginning of the programme, say the techniques programme, did that help or did you think about it as you were going through?

Yeah, I think ?? that helped knowing things to do ?? And I just think ??? and obviously you can't ??? you know like some students get it straight away ?? and other students repeat the procedure like the situation ?? you get left behind, so it's nice ??

Now in terms of being left behind did you find time, extra time, in your own time to catch up or is that also a challenge?

I think that's also a challenge

Yeah I remember last week ??? a lot of us were coming in at around 7am ?? before we started and on Saturday because you just there wasn't enough time because you'd have like a clinic from 8 till 11 and you'd have another clinic ??

Once we ??? a week

And then at that time we usually ???

Lunchtimes, afterhours, or before hours?

Yeah that's pretty much when we used to come in

And how how did that impact on your life?

I think that towards the end of the year we were getting really tired

We were stressed

Like we were like more studying to do ??

And also another thing with many of us doing it at that time was there's no supervision, you're doing it yourself and you kept thinking you're doing it right and actually you're not doing it a hundred percent, you know what I mean? So,

And the the e-book, the provision of the e-book, did that help?

?? That had lots of pictures and stuff

But in terms of doing it on your own weren't those helpful or did you ever refer to them when you were doing it alone, for the pictures?

?? We don't have computers ??? like you can't get the pictures out ??

But those pictures really helped us ??

If you probably know that OK tomorrow I'm going to do this, you might go through it to see exactly how the procedure is being done and in that way it helps you the following day if you have any hiccups or whatever

Ok and in in terms of the lack of computers or the provision of of computers to view the modules, did it ever occur to any of you to maybe talk with the course coordinator to provide a departmental or school computer?

Well ?? like they will put it in the the ??? for people who, but I think its ??

If the class had more like more visual access to the computers ??

No, but that was during the ?? session, but when you had to do it yourselves

If you have a computer next to you like this, it is fantastic

Did you think of maybe engaging the the coordinator for things like that or you were just too stressed to think on your feet?

Laughter

And another thing about the techniques ?? I take it that the time, that's the time that is very critical for ?? a lot of work and most of the time you try by all means to find time to do ?? like if you are ?? to do whatever you have to do on your own but most of the time you probably have to do thirty minutes because you need to go and study and then you're here till seven up to six. From six you definitely can't think of sitting there and trying to concentrate, you know

Oh yeah

You think, and you just rush home to try and eat and probably ??study and stuff like that, so if they make ??? it's quite hectic

Interesting. Now, with uhm regard to materials when we take it to the clinics how has that been?

It's better

Is it?

I guess coz uhm, coz everyone is doing something different most of the time and working at different times and at different paces so it's more available and coz also uhm the nursing staff in the clinics really helps

OK, so the DSA's are quite helpful, the dental surgery assistants

They are

Ok. I suppose for what you've done so far where you generally don't, but I suppose in Restorative you do, don't you need Dental Assistants?

Yeah, we do, but in Restorative like the materials just become I don't know

Critical

Yeah because ?? you deal with the patients ?? the person next to you is using it and there's no help ??? sometimes there is no ?? you've got to look for it among the cupboards and you don't know where anything is so that becomes a bit of a piss but, it's just a bit of a rush to get your material, you know what I mean?? including our tests, our clinical tests – it was mayhem and everyone was fighting with each other because now we want this, now we want that

And I think it depends on what time you have your sessions as well. I found that when we had our sessions in the late afternoon it's quieter and a lot of the materials that are usually on the desks are packed away and there's no one around, so we're scurrying around looking for things often you can't find them

But given that you've had Restorative from 2nd year, uhm and the organisation of the materials in the clinics hasn't, you as a class or as a group tried to find a way to work the availability of materials in the clinics, one, like finding out from the assistants where the materials are and what materials are there with what it is you need to do for the clinics

Is it

Individually

Ok. How regularly does the does the, what is it called? The Dental Council, the Students Council meet to discuss the issues that come from the students

I'm not sure

They meet quite often??

Last year they met ??

Your, Ok maybe not the Student Council, but the class, your class concerns and feeding it through to the Council. I forget that the Council is the whole School, feeding it through to the Council and then feeding that to the School

Hardly ever

Coz maybe, I'm just thinking on the top of my head that maybe one of the challenges with the scheduling of the Techniques programme and the lack of time that you say you don't have extra to catch up, maybe that's something that the class as a whole could have sat down and used the Council, the Student Council to feed through to the Department and try find some workable solution there – you know, things like you know, maybe asking for the School to be opened longer or for the materials to, I don't know how, I'm just

?? Materials just weren't available, you know

Afterhours, it's locked then

Yeah. And also when you've got your free time, and it's not on day we've got Fixed Pros and you've got to find someone to open the cabinets to get the materials, it's also frustrating

Uhm, uhm

But I mean I understand, we can't leave the cupboards open for materials, so

But then during the day, there's somebody allocated as a assistant allocated to Techniques, so maybe find a way, finding a way to to you know, to get them to make the stuff available. I'm just thinking for the couple of years, whether you've given them that feedback or whether the Department will get that kind of feedback so that the Programme is made less frustrating. Anything else with respect to resources – both Techniques or Clinics? And Didactic – copies of notes

They are a necessity?? Copy of notes

Are they really helpful?

They are

?? I think ?? you've got your textbook but you do ?? and the notes they guide – what is relevant

What direction to take

They make a huge

You don't know what to take out of the textbook, especially in Fixed Pros where you've got the BDJ Series, your whole Shillingburg, it's a lot of paperwork to get through. When we've got notes like we did get a few powerpoint presentations, a few lecture notes, it helps, it gives you direction – where to focus

If you don't understand from that uhm slide, you know that OK you've got the Shillingburg to refer to anyway, ?? that area on bridges now, what they say on bridges and everything and in a way it helps you to like expand. But if there are no notes, I find it quite difficult

Like Prof said, Prof said yesterday in a lecture, that it gives us it gives us that sense of security. If you've got those notes you're not in the deep end.

?? So so like if you've got an arrangement like you go into the section on bridges there's a whole different arrangement like you're not sure where do I focus, what do I where do I start where do I end, what's the scale, what do I need to know exactly

?? So are you suggesting that a skeleton of, or an objective, or a list of objectives of the tutorial or a skeleton of the tutorial would be helpful?

Ok. Does it..

I mean when we get a full presentation and we've had say we've sat for 2 hours in a tutorial or when we've had a powerpoint presentation for 2 hours, when we get those notes a whole eighty double sided pages of notes. I mean it's a lot of notes, you know what I mean, it's not like yeah we've got so many notes. We'll obviously try and summarise that to make it easier for ourselves. It's like when you get little notes maybe like just ten pages or twenty pages it's a better guideline. We're not asking for everything

Now, for the PBL programme, where there's a lot of there are a lot of resources to have copies of how has the class managed that or how has the PBL programme managed that

Usually with PBL we like divide ourselves ?? and the with that get resources what we need and from whatever you get you make a kind of a summary for the whole group and you make copies for the whole group

And how do you make the copies – do you go to the Library, do you come up here, do you ask

We do it on our own

This is quicker, coz you go to the Library with your card and uh

Yeah, do you have access to the School photocopying machine ?? and uh coz I think if I remember right at some point the students had access to the photocopying machine. Have you ever during your training ??

That I think is one of the complaints that we had from last year. We had to photocopies for ourselves

Yeah

Now, now in our accounts it says if there is so much

Exactly that's where I'm going towards

?? we we're like complaining because in our accounts

It's not only with the Dental School

The whole programme, for the whole programme. But did you bring it to the attention of the School's management?

We did moan about it quite a lot

And, what was the outcome

Not sure

Is it

I don't think I don't think my recorder is picking you up Mr Naidoo

I'm not sure if I heard correctly I think but at one time I think I heard you could take, if you have 1 copy for the class, the class could take it up to Prof Green to make copies I think

I also have heard something like that, that there are certain staff members that do allow students to use their codes to copy and I've seen quite a few students up here making copies on the machine, so I just figured that maybe student do have access to the copying machine

By a staff member? Ok, but I think the 2005 class had

Is it?

The last six months when we were at Coronation doing Paeds they gave us 4 copies and we'd have to sort out you know the rest for each group ?? but from the beginning of the year, they used to give us like one set of notes between 40 people

Now still on that topic, pertaining to the patients and how to book patients or how to contact patients what resources do you use?

??? you write the request to the Reception to get you a patient and then it's up to you to follow up and also most of the time you end up using your phone because you'd be like in the queue hearing that music from the switchboard

??switchboard

??If you are willing to wait long enough, if you wait long enough you may eventually get a line ??

How long is long enough?

??sometimes fifteen, twenty minutes ?? you can be on hold for ?? before you get to someone

Most of the time you usually give up

Yeah

I use my cell phone

??Eventually something comes up or it's the end of the session and ??

Yeah, coz that's what I was thinking, that if it's between sessions, by the time you get an answer it will eat into the next session

?? Sometimes it is quick, sometimes it is immediate and sometimes you just wait for ever

?? My patients the night before

?? That's the easiest

So those students that don't have access to outside phones are in trouble?

Yeah, ?? you get to your session and then ??

Yeah

Yeah

?? you lose out

And has the student council taken it up at EDUCOM? Or let me put it differently – how have your concerns been taken up, your study, your learning concerns up in EDUCOM, coz there is student representation at EDUCOM?

?? It's through the Council, but the thing is we never like get feedback from them what they have taken up or

?? We ask them, and we ask them: what is wrong; ?? do you have any problems, can you write down a list of what you'd like us to complain about

The only time was at the end of last year when we were arguing about ??

Yeah

That was, that was the one time where we had a proper discussion

Ok, so there is no mechanism whereby the students sit with the Student Council to address the issues? So how then do does the Dental Student Council come up with issues to discuss with the School's management?

Probably what they think or get at the individual complaint ??

Ok

You know

So if you don't if you're not in with the or if you don't talk with a member of the council

??Your concerns are not taken

Ooh, OK. Uhm, with respect to the teaching, how are the teachers and how is the teaching?

In Prosthodontic s?

And others, just expand it, but focus on Pros though. Because, uh now the the emphasis is going to be on how you apply what you've learnt and do you think that you're prepared somewhat or is there ?? feelings of trepidation or, you know

Uh with Removable Pros you get uh good grounds for Removable Pros, with Fixed Pros we've done half a year so far what I've got is like most of it I'm Ok with but some of it I'm not sure about

Yeah, I feel a bit anxious ??

?? so quickly and I just feel ?? just moving up to the next thing just to get it like with regards ??
so uh (laughter ? nervous?)

Seriously! This sounds horrible but that's what some of us try and do, you know.

Yeah

So

Like even now this week it's

Is it?

Yeah

?? Removable Pros

Now how do you think you could help yourself with that feeling given that now you have to get into the Clinics and apply what you've just learnt? Comparing..

?? Definitely the numbers ?? we're all gonna have to cope. Seriously.. No matter what we did

Once you've done, or gone over?? maybe you've done it maybe once or twice maybe we'll feel a bit different ??

?? Depending what changes or you get into it in the clinic ?? Maybe the feeling will change

Yeah, I think it's the initial breaking the ice that's all you can do I'm afraid

I try, I try

With Restorative Dentistry I mean when we were into Third year we didn't know how to give a local anaesthetic injection, I mean we were all very ???

?? Eventually you get used to it and it just comes

Coz that's where I was taking it that you've had, you've had, you've been in similar uhm situations before where you've done it in Techniques and then you have to make that jump into the clinics and wouldn't you think of using the tools that you used back then to help you now?

?? the transition ??

?? In Restorative you've done it so often that you can't ?? eventually you so used to

No, but then what I'm trying say is cast your mind back to that time of your transition, transitioning. Yeah, no just so that just so that it doesn't become too overwhelming because essentially the principles are the same

You tend to make ?? as well when you are, which is not good ?? I mean you wouldn't make those kinds of errors now

Exactly

?? Class 2 amalgam. You know what I mean

Whereas 2 years ago you ?? you got an exposure I mean during a Class 2 amalgam. ??

Ok

I know but I'm saying it wasn't a case where we had to get ?? we were just very nervous, we didn't how ?? down ?? one moment

The support of the Supervisors also helps in that point like when you're beginning like the support that they are there and they're always there to help us, they always help that much as well

It does make you feel better

Yeah

OK. And unfortunately for this, for the Pros side you're not going to be working in pairs. So you have to process that and handle that.

Yeah

I think that's where like ?? a kind of fear ?? OK fine, I ought to ?? Am I gonna do it right for the patient, you know those things are, those questions are coming into your mind you know, OK you probably just ?? you know. But usually ?? like he's saying again if the Supervisor or ?? you know. Having that Supervisor who's willing to direct you and everything you know. Not who would work for you, you know – direct you, direct

Just to calm you down, whereas ??

Calm you down ?? and then you tell yourself that: Ooh, OK I can do this. Because at one point ??

And sometimes you get Supervisors that don't have necessarily have the patience and they do get ?? shout at you and then ??

Is it? I thought Supervisors don't shout (laughter)

No, I'm just saying, sometimes

Also in Removable Pros you know the Demo Cases before we started also helped out

That helped a heck of a lot

OK

Yeah, that did help a lot

We were like OK what's the procedure to follow, we were like ?? to the Lab straight to the clinic. ?? the procedure this the procedure ?? put it together ?? OK ??

?? made a difference

Ok, interesting.

?? It made you calm and collected

And also, at this stage also uhm just to reinforce onto yourself that you've had the experience before and that you are experienced to be at that level you know just using the lessons from previously to feed into that so that it's not as overwhelming now as it was back then you know, because you you I suspect that you do interact, interacted with other senior students who have given you feedback as to how they managed or how they coped and hopefully use some of those suggestions to just ease it for yourselves.

Yeah

And uh, Ok we've talked about the scheduling and the tightness of the schedule. SPACE: the availability of space; the organisation of the space for clinics, for the tutorials, or Techniques and for self study?

Clinics I think it's OK ??

Clinics and tutorials are fine. ?? When it came to the Techniques Lab that's when we had a big complaint with our ??

Lots of heads that do not work

Model availability

Yeah

And then uh one of the concerns I suppose from the Department would be that students 1) don't look after the models

Yeah, and don't look after the instruments. So if, I think for the past year what the Department did what I've observed they did is that they gave much of the responsibility to the students – to you guys to be able to look after those things. Now when I observed at the end of the year that whoa! You know the state in, much of the state of in which the instruments are in, leaves a lot to be desired. For instance the previous years the Department took responsibility to look after and Ok they treated the students I guess like children, however at

the end of year you know, the state wasn't as bad. So the thing is maybe finding a balance between those two extremes

Find out what works and ??

What works?

They don't have to treat us like children to get us to respect the equipment ?? do, you know

But at this at this level

I know what you're saying but, yeah true

But at this level where you, why do they have to ?? the professional (laughter)

With Pros they give us when we were in Pros they give us

The sets

Yeah, our sets and stuff and we own those for the year and then we've got to give them at the end of the year. Obviously that stuff needs to be looked after. So that's like our responsibility, and I don't know, I wouldn't, I don't want to think that those those sets or those instruments are being badly used or badly treated. So I think that maybe when one of you guys gave us the law ?? sets of instruments you know, then say in June sign it out this is yours you have to hand it back in and anything damaged or lost needs to be replaced that kind of thing. And then people will start to look after those things

?? you have more of an ownership when you know that this is yours, this is what you have now, so take care of it now coz you not just going to get another set

Just like for example

?? and you need it so

?? an amalgam set for techniques for restorative and they must look after the amalgam set and hand it back in. I think that might be helpful

I think so

But in terms of now the cost of replacing it from the you know the student perspective, the the the informing principle is that they will not be lost or damaged but then if the odd one gets lost damaged stolen? But on that note with respect to the bur kits how has that been for you guys – no broken, no lost thing?

No, no ??

Laughter

And how has that informed how you look after the kits?

?? that ?? expect it stolen you get more cautious you start ?? like

?? take everything ??

I've had ?? stolen from my you know ? bur kit during the week we started. That infuriates you and then you've gotta replace the bur yourself, you know

Uh, and they are not cheap

No, not at all

But you've you've been given kits before not necessarily but kits but instruments before since second, from second year and didn't didn't you have similar experiences back then that could have helped now or informed how you view safety

Laughter

Well the bur kits that we got given I mean when we got our burs for Restorative no one ever stole our Restorative burs

That's good

I think it was we were new to it and we were working in pairs we got like a kit for a pair so that 2 people to like you know sort of like you know

Take responsibility

And so like we when we were in you know ?? it was normal for me to go up to my supervisor to check what I'm doing to leave my burs on my table

??that makes ??

I'm asking myself that why would it then be different from for from before?

You have to go and put your stuff in your pocket to go and ask a supervisor

Yeah

How your cavity looks and then come back and

Yeah, coz when I asked this question I was thinking I was thinking that: OK, it probably happened with the Restorative instruments

Yeah, because like the same thing with the Restorative and Pros as well like you take your set-up you leave it and someone is there you take your set up you go you come back it's there, that never was the issue.

Yeah, that's interesting. Interesting, yeah!

?? techniques for restorative we got given 3 burs or something so you know. We also had it once a week two sessions it was on a Tuesday morning so half the Tuesday morning my burs went back into my bedroom at home, you know – that kind of thing. It's not exposed everyday

But is every week the same you know the same group that basically you are now so the majority of you have come in from second year, so uh. Anything else? Yearbook? Coz that's where it's supposed to outline the programme

I think that maybe the problem with the year book with our class in that we we didn't take the yearbook seriously enough

Yeah

Is it?

Personally I think we were at fault last year, I think definitely, with quota, with tests and everything coz I mean half of us did not know we had to do for Removable Pros, I mean we threw so many tests into the last uh 2 or 3 weeks coz we didn't even know we had to do them just because we didn't look in our yearbook. So now I think this year we can pretty much ?? yearbooks and we know what's going on so that's you've got to learn the hard way you know what I mean?

That was that's very hard!

Laughter

??Since last year when everything was

Now everyone is asking we want our yearbook, we want our fifth year yearbook!

Do we like any issues that we wanna change or like I mean discuss them through now instead of like you know at the last minute. At the last minute nothing can be done

And that's that's why it's important to have uh component reps

Yeah, because the yearbook's got everything in it I mean we just want to read it and it was huge I mean you asked me personally once or twice last year – when are your test dates, it's in the yearbook? And I couldn't answer you because I hadn't looked in my yearbook!

Uh

So you know, we have to be honest and say we were at fault.

Yeah, no. I think my advice for this year would be to, but

The yearbook

Yeah it's very informative and

It's also ??

?? when you do go in there it's always there, you find it, but it's like whether we look at it thoroughly enough. I don't think so

That's the thing

****I just want you to note especially for this year, try and you know engage the yearbook and the component reps because I think one thing that lacks though in the yearbook is the actual scheduling of tests and that needs to be done early on, you know. I thought Pros was quite good with that but having heard your views and having talked with some of your colleagues I realise that that doesn't always happen, you know. There are some years where uhm the Pros Department has not put the schedule in or made it available right at the beginning within the early start of the programmes. Ok have you seen the one for this year?**

Yes

Yeah good!

Laughter

Yeah because the other the other thing is to make sure that uh when you start engaging the other components you have that information to help so that you don't get double or triple booked coz there's only one

Reserved session, you know what I mean. Like we got one week when we wrote something like 8 tests – it was just far too much for the mind and the body

Yeah, just the general well being. So my advice would be to engage the component coordinator, not coordinator - reps once you've read through the yearbook and try get a system where you know as a class you can meet on a regular basis to discuss what's going on. So that you don't feel alone

Yes that's true. We don't normally do that. Someone to back you up and they are like tell you everything is going to be alright. We did that for the last two months

And that helped and it made such a big difference

It's like you walk in you see that thing there, it's like. Like you know that next week it's this, you're like you remember it's there

With so much to do you tend to forget, you just as you walk pass

We are learning as we go

No, that's good, that's good

We have it for the whole year

Yeah. And engage the coordinators, you know the component coordinators as well as the year coordinator and the Departments, to just make it easier you know. I guess the majority of the staff members are really there to assist and help you know. Not to spoon feed but to ease, they won't give the test paper and the marking memo (laughter). Because that's the feeling that we sometimes get that: students just want the marking memo before so that they just reproduce it and there is no thinking. Anything else, any comments or suggestions? With respect to the teaching? Or any burning issues – how unempowered you may feel or empowered?

****One last thing it's just with regards to the techniques between like I did find it a little myself not so major but, I mean some people were really from talking you hear things – some people were very disappointed, were not but they didn't like it. Some sup, you go to one supervisor obviously we should stick to one supervisor with your techniques so if I show you my onlay prep, if you look at it and you correct it every time you know, but if, we had to go from one supervisor say the next session that supervisor wasn't there you go to another one like just confusion, conflict and then we were confused. But I mean there is no real way**

There is, theoretically, because the e-books are supposed to inform how the Department is going to teach so the criteria for each procedure is supposed to be in there. So both the staff and the students should be engaging the e-books to see that that the teaching is uniform. Coz we have different ways of doing things and there are different things of doing things but the teaching needs to be, IS not needs to be, IS uniform, and you are fortunate that this is the first time that they've come out so maybe engaging with the e-books a little bit more and just expose to the sup, coz I know I haven't read the e-book so, different from what the e-book says, but you know that's one way to make it less frustrating for yourselves.

Maybe with the this year's book it will be much better coz for us we have the i-book. If you go to one supervisor that one tells you to do the thing this one way and then if you go to the other one with the same thing that one will say something different. So uh we ended up saying that: OK fine, if I'm starting on the thing with you, I'm just going to stick with the book and 1 supervisor till I finish to stop confusing myself.

That's the best

And at the end of the day most people could not finish because of that. You go through one supervisor

Is it?

Yes

****That's what I found**

Ooh

You go to one supervisor and they tell you: this is not right after all. But meanwhile maybe you went to another one and they said: Its fine!

And I think in that way

So

When you get confused in like eventually like you're falling behind and we start something new you're not ready to start on the next thing without having finished that because you're confused

Were there a lot of supervisors per session – or change, the change?

I think the least that we had was like 2.

But the change with the sessions? Wasn't it consistent? I can't seem to remember.

It wasn't quite consistent

Let's say from first to second session was it the same set of supervisors or different supervisors?

No.

Normally in the same day we got the same supervisor but when we got to stay the extra time everything changed. That's when the change came about

One different thing

OK, I'll make a note of that. But I think that the you know, you also really should try and find means, yeah some tools to make it a little less frustrating, coz we do things differently and don't take it as an offence

Yeah

When a supervisor tells you to go back to the first supervisor to get it checked if there is a difference there you know

No but you find that within ourselves as well with uh like you may do something different from the way the i-book but at the end it's the same. So it's acceptable, so it's normal that someone does different from you

But just to make the frustration less, the process, because it's the process that's the frustrating part.

Maybe for like in the future, students coming up now, you can tell them say: listen guys when you have had your work corrected by one supervisor just stick to that supervisor

What we did previously was uh specific supervisors were like in the clinics, specific supervisors were allocated specific groups so for a specific procedure

That would help, that's how it started

So that procedure was finished with one supervisor and then the change over to the next procedure a different supervisor, so that, that way you'd be exposed to different perspectives but then that was before the e-books, you'd be exposed to different perspectives of how to do different things because the principles are the same.

In the beginning we had that, remember

But the the programme wasn't done that way you see so it was just that particular group but the rest of the groups were not, yeah

Yeah

You see, so but you know, different coordinators do it differently, so the challenge is as we meet them hopefully we'll try and address them. Anything else? Nothing? OK thank you

Thank you

Ended: 4:15:40

(3:42:28-3:55:20-3:58:20-4:02:32-4:07:19)

APPENDIX 4.6

Fictitious names have been used throughout the interviews

INTERVIEWS – STUDENTS 6

Margaret; Shelly; Leah; John

Started: 4:15:50

The recording is just so that I have a back up for when I start analysing the comments that you give me and when I start writing up. Names will be changed. (laughter) OK. Your identities will be protected. Ok does anybody want to start?

Well I think that the equipment in the Techniques lab we were ??given insufficient phantom heads for each student, they don't function or they are not there and then there is a problem with some of have to work on the bench and some have to work the head and then you have to swop around. So that's a bit of a problem, I find

What kind of problem?

Just with the heads

How then how does that proof a problem to your training?

I think because you obviously you don't get that training of working in the phantom head and obviously you have to swop all the time you don't get a constant you know, constantly get taught on the phantom head. Not that it's the actual clinical patient, but the way in which you sit and you handle all the instrumentation and look at the teeth you prepare. It's very easy to do it on the desk

Uhm

But when you do it in the mouth it's difficult

Especially given that the Techniques course is supposed to be training you towards - a simulation of the clinical setting –therefore training you towards being able to handle similarly in the clinic. Anything else?

****No, just that generally like ?? I've got to say that uh the Fixed Prosthodontic Course is most definitely the most challenging course that I've ever done. I think it's almost a credit to the way that it is run uh in that it is so thorough. They make sure that every student gets a uh everything thoroughly, completed and all the requirements ?? You know, it's very frustrating you know, throwing your toys out of the cot like everyday**

But with respect to how the Techniques course has been structured and how you're taught in the Techniques course how has, what challenges or good things have come out that?

****Uhm, I think, I think there is a problem in that uhm a lot of the stuff you invariably teach yourself. I Think that Pros or Dentistry as a whole you know and uh I think the supervisor will show you once and then we're sort of expected to go back and do it. But in saying that the supervisor still give you step wise sort of uhm uh instructions and uh they still want you to do things so in a way it's good that you kind of end it on your own, you know, that you, the way that things are, solve them for yourself, you know so no one is sort of holding your hand for you and anything, you know**

But, would, just on that point have you experienced different super supervisory skills where you have certain supervisors that hold your hand through the procedure like show you what it is that they want and compared to those that uh they show you once and then expect you to do the procedure thereafter?

?? one of them in particular uh he always seems, he shows you how to use the handpiece which was something that we really haven't been you know, ?? one other person who directs you, you're supposed to do simple things like that you know which I think our supervisors just take it for granted that we already know

Yeah like we were taught how the chair actually functions. That there was actually two lights, that you could actually switch the lights overhead to change to a different intensity

Yeah

Which light?

On the actual dental chair

Ok

Yeah, and uh we weren't actually taught that, we were only actually told that in the 4th year. We didn't know till then and the bracket table actually can actually go according to the level or the height can be adjusted and that's in our 4th year

But then you started clinics in second year, third year?

Third year

Ok

Yeah

Interesting (shows duplication of teaching soft stuff that is subsumed by all departments – has not been centralised to one component. ? resource wastage)

And and uh Perio was actually quite good in showing you how to sit and you know encourage the patients to come sit down so they don't sit on the where the feet you know lie and that kind of stuff

And break the chair

Yeah, yeah

(Laughter) Yeah. Anything else with regard to the Techniques: the space; the schedule?

The schedule was fine, we were given enough time

Is it?

All talking at once

You know some of us aren't exactly the fastest, you know

Yeah

I'm thinking

I'm not

The ?? thing is like if you get it the first time like right then you're like on par and everything is fine. But the minute you get

You lag behind

You lag behind then you just

It gets frustrating and it became worried, you panic and nothing works

And once you're behind then it's hard to catch up because like the even the supervisors aren't there all the time like you to see whatever you haven't completed behind like to catch up so

And then in terms in terms of trying to catch up in your spare time how has that panned out?

When we have spare time even if we come then we do our work and we try to do it but then there's no like guidance also then and then when you go back and you ask for guidance like you'll ask if its right and then there's something wrong then ?? free time will stop and not like we have much of free time

No no free time

And then even like, I don't know I feel like Fixed Pros should have started in the beginning of the year last year. Like it would have been much more easier and much more like like now we're just so stressed out like. It's not like any ??

At at the beginning of the year, did you have time in your in your School schedule to allow for the

Oh yeah, with regards ???. I think ??

?? Endo was like, Pros

?? Oral Bio

What I'm trying to ask is in the first half of the year, your time table could there have been time to put it in?

?? towards the end of the year our schedule became very stressful and then we started getting much more tests coming through

?? to worry about

?? It was almost like every week. So our kind of ?? we do in our theory and our practical and that's where a lot of people actually fell behind in Fixed Pros because we were constantly worried we have an exam after this. And I think that if the Fixed Pros Lab schedule was issued at the beginning of the year, and something like Oral Bio was the second half of the year people would be able to concentrate much more on Fixed Pros at the beginning of the year because they would be more fresh and less stressed

Than at the end of the year

Because ??

That goes to the yearbook, remember that one of inclusions in the yearbook is that the assessment dates need to be sorted out at the beginning of the programme. Did you have that or was that not there

We tried last year to do have it ?? confirmed dates with our respective lecturers right. Towards the end we were just told that: no, we need another assessment and things were just added here

We had 3 more Pros assessments

?? the last 4 months we didn't know what was going on ??

?? during the week was like something new ??

There was a week that within the year planner there were 5 tests scheduled every single day we wrote ?? by Thursday you were so finished that people were like on Friday we couldn't write

Following on that when you look at the role of the student reps and the Dental Council for that was did you take it up with the Student Reps or the Council to make the Departments aware of the strain you were under, if it was not included in the yearbook?

We tried

We did

******Say for example we had one subject where ??one department to write any more tests and seemingly they said: No, we are not writing anymore tests and then at the end of the year it came up: no we had to write 3 more and we were told that, that was already early in December we were not, and then started writing ?? the we had ?? coz we had our own little time table on the board, and it was so you know to try and find space. We just reached a stage where ??

It was difficult then coz people had set dates and they didn't wanna change and it was very difficult to set it to fit it in

Because I'm thinking as well on with the programme this year with the dates already being set for the tests

So now we can plan around what has been set, you know

This year already concerning like seeing what happened last year we said that this year the same thing will not happen. We've just had an EDUCOM meeting today where we raised the issue

OK

******By the end of February we would like ALL the tests or anything that we need to be assessed on has to be confirmed, the dates need to be confirmed, not only for the 5th years, but for the 4th years and 3rd years so that we can plan around it and be prepared well in advance and everyone agreed on that and it was said that by the end of February everything needs to be done

The recourse if it doesn't get done? What was the recourse from EDUCOM?

Oh ?? they just said for now they're gonna try and make sure that everything gets

So from the Council side or from the Student Reps' side, what would you like to happen to see happen if that doesn't happen?

If it doesn't happen obviously what happened last year cannot be repeated. It was very hectic

That's where I'm coming from. It could happen, so knowing what you went through last year and you've already pre-empted that not happening, but if it was to happen with that hindsight what would you do this year? What would you like to see happen this year, if by February that is not done?

If by February if everything is not confirmed I would think that any further dates that any lecturer wants to schedule needs to be done then with the entire class. In order ??

What's suitable for us because they haven't

Yeah

Whichever date we set because it can't ?? another test. It needs to be

But then they are considering Pharmacology for example and all the others because we never have a meeting and schedule on the ?? 9th it's gonna be Pharmacist it's gonna be a

Dentistry

A Health Sciences and then the Health Sciences department they are all on the 9th because they have a separate ?? and then we have a clash and then it's already set, we're not moving any more tests, anymore than we do

Obviously they must ?? read the year planner ?? it's gotta be fair because we already have ?? the year planner is there for everyone to see this is where

What we're going to ?? Pharmacology for example before you ?? obviously you can even Pharmacology is a bit of a department which is ??

The challenge is between the Dental components and the non Dental components. I think that's where Ms Wilson is coming in that the issue is that there is that clash

?? Actually I credit the Medical Components because by the end of January all the Medical Components have finalised their dates

Ok

And by the end of January last year we knew when our November exam was – Pharmacology,

Oh, so the challenge is mainly from the Dental side

The Dental side

Ok, but then technically then it should be easier to manage that coz it's within the School

Uhm

But I guess the reality is different (laughter) or has been different. There was something that I needed to, that I thought of, I should have made myself ?? when we were going on about the scheduling.. No, the EDUCOM: how has the representation of, by students on EDUCOM penned out, with respect to making it easier for the students or that interaction between students and School and the Lecturers?

Well, so far like uhm for as long as I've been on EDUCOM any uh matter that has risen we've really discussed on EDUCOM, like they allowed us to completely express ourselves, and they just don't put you down

Uh

And they listened to it. And with lot of the things they did naturally like, there was some kind of ?? forwarding that took place. With some of the matters they couldn't be but, say for example

with uh Clinics when we complained that there weren't enough supervisors and that uhm, a month or two afterwards there were one or two ?? there was supervisors in the clinics. So it wasn't that we were ignored we were listened to and ?? EDUCOM does, it allows us to ?? ourselves, not biased, fair and it really does help as compared to when you like you go to individual

Yeah

Departments or Lecturers?

Uhm, I think Lecturers ?? yeah

OK. And then with regard to uhm the interaction between the class and the council, the Student Council, how, does the class meet regularly to put their concerns and views to the Council? Or is it on an adhoc basis?

From experience last year with the 4th year class because the council is predominantly from the 4th year class, I'd say that's the easiest one, but uhm with 5th years last year we had very little ?? communication uhm but with the 3rd and 2nd years we had a lot of communication throughout the year.?? Uhm I'd say that every few weeks or every month we like we call the class and ask: are there any issues that you that you're experiencing? And with the 2nd and 3rd years we were able to help them. We found the 5th years were very removed from us last year

Ok. And now, now that you you've just clarified the the interaction between the students and the class, how was the interaction between the Council and School Management, in terms of addressing, meeting: meeting with the Council, listening to the issues and addressing those issues and achieving the desired outcomes?

Uhm, well, last year with the Council we had to intercede for one of the classes. Uhm we were listened to on 8th floor. Uhm we were given like a plan of action, how we could proceed ? what could be the best outcome and it was concerning a specific department. And within that department they told us that: this is the Head of Department, you need to speak to him, he will then investigate the matter to see what you said is true. And that did happen, and I personally, I'm not sure what happened at the end of the year. Uhm Lukshana then forwarded it as the President of the Council.

Ok, so the interaction between the Council and the the School's management, the School management is fine?

Yeah, it was successful

It works?

Yeah

Ok. Any comment from anyone on that? (long pause). The yearbooks: are they helping you or you just get them, sign for them and just leave them on the top of your desks (laughter)?

I think I think they're good. It's just that last year it wasn't very user-friendly

Yeah

Because compared to like the years before. Uh it was like all crammed up and some of the Departments wasn't even in that yearbook. So if we have a full like a full, a yearbook with all the things given one time, then we also know what's happening and what our requirements in that. But we, it definitely helps to know what's the requirements, and the objectives of all courses and I do use it

Because that could also take out the stress of getting extra assessments because in the yearbook there is a map of how many assessments are needed for that particular programme. What's not there normally is the schedule because the schedule has to be, technically they want it uh uh arranged before the start of programmes by all by the year coordinator, that's why we have year coordinators. So that by the time the students get get say two weeks into the course or the first month into the course they have the plan of all the assessments of ALL the components including the non Med, the non Dental, coz that's one of the things that need, that we need to do as a School yeah as the coordinators. Supervisors: how's the relationship between supervisors or the interaction with supervisors: approachability, motivation, the motivation, uhm

Uh on a personal level I've I'm very easily de-motivated by some

Is it?

Yeah, so you know, some supervisors will say something that can easily get you down you know. You sort of have to pick yourself up you know

Yeah

Uhm, but generally I think uh I think most of them are quite uh approachable, you know

And do you do you even though you know that they're staff members, do you also look at them as being human as well – having off days and not try to take what they say to you personally?

Uh, yeah, I want to think that uh you know they understand that we have off days as well, so, because we have a lot of assessments throughout the year and a lot of clinical time as well and you could be quite good in the clinic you know. You could be quite decent and then out comes the assessments and you get a bit nervous, things go ?? terribly wrong uh so obviously it doesn't reflect your overall ability, you know

What quality do you think uh is good from the supervisors perspective in terms of encouraging you to learn?

Uhm, I think tolerance and to sort of uh, you know, I know that some supervisors what's clinically acceptable to them is not acceptable to another, you know and uh that's uh in Prosthodontics especially where there's like a sort of like a very subjective opinion about things, you know. So, one supervisor will say something is good and the other will say something is bad. Sometimes you're kind of in a sort of a lost, you don't know where to go, you don't know what's required of you, you know. It's written down in the requirements but even so, you know, a supervisor will have a different opinion about one particular point that's written in the criteria, so there's not much you can really do about it. ?? but so long as the supervisor can listen to the students and the student says: but uh, like Dr so and so says, you know, there is an advantage here - the other supervisor can look at it and Ok, I see your point of view, that's OK, you know

I'm just thinking that in Pros, the criteria are supposed to inform the supervisors and the students as to what is required of each procedure, so the e-books and the manuals are supposed to – even if the supervisors may have a different idea, or perspective of doing that – we have to go by what the manuals and e-books say. Have you been in a situation where, you know, the manuals and the e-books say different to what the supervisor says, how has that been handled?

Uh, I don't know, I think, I think everything is written. We all know what is expected of us, what we have to do. And we know what it's supposed to look like, but then say you've got something that you think does not have an overhang and in your opinion

OK

It's not an overhang, and then one supervisor says it's fine, the other supervisor says: you know you have an overhang here. And you can take it to two different supervisors and you could get different comments, even though everyone knows what's in writing and what is expected of us. So well I think, no matter how much you put in writing, no matter how much everybody knows the standard that is expected, there will always be slight differences in opinion as to the quality of the work. As much as I think the School tries to get it in writing and everything and to get the standards and everything, I think that's just the nature of the subject, you know

The quality that you started with was: tolerance – any other qualities? (laughter) – supervisory quality that eases the learning and

I think in a way there's some supervisors really make you feel relaxed. And if you're relaxed that brings out the lesson ?? in you, especially in the clinic, coz you've got a patient and the supervisor. You don't know who you're more scared of sometimes

Oh

You know, you've just got to like, if you could just be relaxed and then things could turn out that positive, you know. A lot of times you go into these things kind of negative about it and you think: Oh no, what am I going to do if I fail uh?

How then do you prepare for the clinics, to help it ?

Uh

Especially in the clinics, our clinic supervisors, their tone says a lot to us, because when we work, we're already like hypersensitive and anything will affect our mood and our own performance and supervisors like, those who like talk in a softer tone, they still demand, they demand perfection, but they're more understanding in how you do it. The thing with them we're actually

?? We're becoming too lenient, they're more easy to converse with ?? this is the problem, and you wouldn't approach someone who's you know, then you wouldn't wanna ask questions

You'd rather

You'd rather you know

?? if they're shouting

Yeah, and then you'd just like, you know

Ok, so: TOLERANCE; TONE; what else?

Uh sometimes a bit of motivation, you know

Like?

Just like uh: Alright, that's OK, alright, I'll give you the quota, that's ok, you know

Supervisors say that?

Yeah, and they do you know coz, sometimes, I mean to be honest, you sometimes, you just want the signature

?? the motivation is like ??

You just say well, you see this is the problem, uh but don't worry, you just do this, you'll get it right. You know a bit of that and you just think OK I, they actually think I can do it. And then you got that, it's almost like a mental thing and then you go say: right, now I know how to do it

?? you're almost confident in things

And then you feel they care for you, like they want to teach you

Yeah

?? (all talking at once and inaudible)

Like sometimes maybe supervisors will say: it's not good work, but OK we'll give it to you. It's not, I haven't got one that done and says: OK your work is ?? we'll give you a . They will say, you know uh: fix it here, you're getting... I've had a supervisor ?? but next time, improve on this over here to go up a step and they will show you what's the problem and then next time they give you full marks and you eventually get your E because it is getting better you know ??

Yeah

That's interesting

And then ?? because sometimes you'll come and ?? coz you're not really learning what they're saying; they're like Oh no, you know. Then you're actually afraid of asking a question anymore and then ??

Yeah.

OK

But I know it's a bit it's difficult in the environment to have patients who sometimes will ?? students ?? like patients because you also like you know I wanna get this done, supervisor will say: no, it's not right and you'll go back.?? Useful to chat to you, you know uh

Is there a lot of preparation that happens before - hand from your side for the clinics?

****I think it depends on the supervisor**

Is it?

I really think so because what happens with uh well I actually so that view with uh Rem Pros for example if like as we said if you have positive feedback ?? build your interest and next time you'll want to ?? oh but you know I uh ?? whereas if the lecturer or supervisor was negative about it you gonna be as quiet as you can in that session.

You're not gonna ask questions

Yeah, you're just gonna like you know uh ?? do what you need to do, but you'll be as quiet as possible, you won't ask any questions and you'll just want make sure that your work, hoping that they're gonna say: OK it's fine, you know and get finished as quick as possible. Whereas with the positive feedback even if it's wrong, they'll tell you that you need you to correct this and you'll be like: Ok you go back, go correct it and then you take it back to them, and when it's correct at the end of the session right you'll still discuss it with them. Think OK yeah, that was more, this is what I did right, why didn't it work, whereas if they're negative about it, the minute they say it's right: that's it; you pack up, dismiss the patient and gone!

You learn more in the other way

You learn more

You're more interested

And then

You're not so scared you're gonna stuff up

And everything works better

I find, if I'm relaxed and if the supervisor is relaxed then I'm not saying that they must become you know easy on you and let standards drop, but it's just the way in which we interact. Because students in themselves probably have a, you know they don't think they're doing well and just that bit of motivation will improve their work

Now in terms of the techniques preparing you for the clinics, doesn't that help – that transitioning from techniques to clinic?

I think it's kinda scary to think now you're going to finish your techniques course in Fixed Pros and now you're going to do the REAL patients where there's real gingival and real interproximal areas that are really tight and you know just you pass the turbine its BRRRR??? and now you can't pop any teeth out because it's now life and and that is a bit scary because you know, you're

And you don't

You try to practise, I mean you could only do so many because there are only so many teeth available to get out to practice. You don't ?? the one that really needs ?? to try and get that angulation correct or whatever and again time issue, you try and come on a Saturday once before to try and practice or that test or whatever and you know when you're in a relaxed environment, it's Ok it goes nice and then the next time you come in and you're writing a test everybody is stressed and then, you know, it's terrible! But now when you think you're going to do it on a real patient it's scary

It's actually easier on patients

Yeah

Like you said you can't pop the tooth out to check where the undercut is; but Ok then if it's severe the undercut will show up on the casting because it won't fit, but it's much easier on patients

Oh is it?

The only challenge that you need to work with is the tongue and the cheeks and having an assistant there to do it for you. I mean to assist you, not do it for you. Ok, any comments? Anything you want me to take note of with regard to the programme for my research? Coz

what's going to happen is the finding that I get I'm going to feed, even though it's for my Education Masters, I'm going to feed them to the department and that will help in uh modifying the prog or modifying the programme coz it's always a work in progress so the good points that come out as to the quality of the programme the Head of Department will choose to implement so it's not all in vain, even though I'm doing it for my own personal benefit, the School also benefits coz I'm part of the School. Ok, thank you.

Ended: 4:43:29

(4:16:30-4:21:55-4:25:53-4:32:57)

APPENDIX 4.7

Fictitious names have been used throughout the interviews

INTERVIEWS – STUDENTS 7

Start: 4:43:27

Pansy; Tshepo; James

We'll start with the Techniques programme and how that has helped to move to the clinics. But starting with the Techniques, how is it? Is the space properly, is it adequately equipped, planned,

****Ok, I've personally seen that the materials aren't sufficient there. We always having a problem sharing and then there aren't spatulas and you're busy like you know running around and then,**

Uh at the same time you're busy

Because of that we start using different you know, like for example you need to use a certain spat, plastic spatula to mix you use something else and you end up using other instruments and improvising, you know because there's a shortage of materials

Yeah. And then how has that frustrated your progress?

You start doing things haphazardly and just start taking things

Doing things not properly

Yeah

Then you start taking material from this person then that person and it's different colours and different consistencies and you it's just, it becomes very frustrating

And the Frascasco Heads also, all of them are not working. So we've had a problem with that. Uh I personally feel like the demos should be given in smaller groups coz sometimes I feel that we're too many standing there, and you can't see what's happening

Is it the demos that have been given?

Not, not for everything

The things is with the demos, because some students are slower than others I find that usually the, with the students that are faster and are ahead of the class, always get the first demo and then we lag, people that are behind

We end up learning from the students

We start learning from the students, you know, because then we don't get to see the demos because we're a bit behind

And then with the supervisory input, do the supervisors then assist you in walking you through the procedure if you're left behind?

They do, yeah if you go to them. If you go to them for help then they do help

Ok. But uh do you also get supervisors who don't, who expect that because the demo has been given therefore you need to know how to do it and they don't hold your hand through the procedure, or don't show you how to do a particular aspect that they're requiring of you – of the procedure?

Uh, not really. I think if we go to the supervisor, especially with me uh personally, if I went to a supervisor and asked for help, they have always given me the help and then shown how to do it. Uh, yeah

So you haven't had problems with supervision where you feel that you need that extra help and when you go to a supervisor you don't really get it or you feel short changed?

I don't ??

Ok. So you're a good group, good lot! Or the supervisors are a good lot (laughter). How do the supervisors, on that note, how do the supervisors motivate you to do it?

Well, according to me well whenever I go to the supervisor really they sought of like take me through to, they take me through on what we're supposed to do, having shown me what I get wrong about the particular procedures. So we end up, again they give you, they give you another chance to be able to practice by yourself and re-do it if you done it wrong again and again until you get it right. So I, supervisors I think are quite Ok

Uh also, an experience with doing things again and again. I know there was a problem with having shortage of teeth and because we were given just a certain amount of teeth, we are now pressed, you know what I mean we are a bit stressed because we wannna get it right the first time coz we know we don't have other teeth

Uh

So, we're a bit afraid to make mistakes because we know we're not going to have enough teeth to practice on, so I feel if we're given more teeth and then we're not afraid you know to try and see what works for us or doesn't.

Anything else?

The good thing I think is that they tell you do step work and then come back to me and go back and come back. It really does help you rather than doing the whole thing and then going there

and their like: ooh, Ok. But they are, they have been once or twice when a supervisor has said: Ok go and finish this whole thing and then come back to me. But I felt that the other method is much better where there is

Ok. And how do supervisors as well motivate you? In what ways do you find motivation from the supervisors?

?? them to encourage you when you do do it right finally, I think. So that, I don't know. And

Coz that's the question that I was going to come to after Tshepo's comment, that: is the feedback that you get more negative, focusing on the things that you get wrong, or is it also focusing on the things that you're getting right? So that there is a balance between what you're doing right and what you're need to correct

No, it's more on what you did wrong

It's more, yeah

It's not

There's not much

More on what you did wrong

So the 'right' only comes at the end? (Laughter)

Yeah

Right

Well there has to be, there has to be quota to be signed off. Ok, so where I'm sitting, I'm thinking that it therefore means that the supervisors then need to give a balanced view, where there is, they point out what's good about it and what needs to be corrected so that it is not

Yeah

Always what is wrong, uh, to keep you engaged and motivated

And you think after a while you keep going to a supervisor and you keep and they keep telling you: this is wrong, that is wrong, you know you sort of like you want to give up, coz it's like, nothing is right, everything is just wrong! So maybe if they do point out the positives that would be much better.

And then the presence of e-books, and the presence of the demo on the computer, does that help?

Yeah

Yeah, I think it is a big help

But this whole week I haven't seen that

Yeah

Yeah, but then that helps. We do have it there, coz you usually end up reading it – sometimes you get this you get that ?? it certainly helps.

And when you see pictures it helps more than the article, so

Any comments on that – any more comments? In the clinics now, how is Pros in the clinics – the learning, the supervision, the set-up, the patients?

Coz we've only done Removable, but I I feel that like the different supervisors they've got. I don't know, they're very varied with their opinions and what's right and what's wrong and different methods that they use they're very different. You maybe you're maybe using one method and then they're like: who taught you that? You're supposed to be doing it this way and you feel like

The change of supervisors like from one block to the next, say one block you're working with the patient and you're doing things according to that supervisor and the way the supervisor has shown you, and then the next block you have a different supervisor and then suddenly everything is wrong coz: how you're supposed, why are you doing this, who taught you that and then you know it bothers us

But having the manuals to help with that, or to lay down how it needs to be done, hasn't that helped you? Or doesn't that help the situation where you then refer, or the supervisor and the student refer to the manual? Coz I know there is a standing rule in the Department that students need to have the manual on them

Yes

Uh.

For the normal ?? form there isn't uh, I mean for partials I don't think

Isn't there?

No, there's a manual

Is it?

??last year ??

And

I got my ?? and the rest of the class

The Department did not give everybody

No

We had ours so, but then we had to get it from

I had to, I went, they said, the secretary, you personally need to.

And this was .. You know why I'm flabbergasted because I'm in the Department and I know that manuals are supposed to be distributed to students and if they run out, then the Department needs to know and the secretary needs to make more copies. So if students had to make other students copies it's a bit scary

Yeah

I made a copy

And I got a new copy, there was a new uh copy for the Removable, for the Full/Full

That we all got

Yeah. No, but the partial

Not the partial dentures one

Is it? And did you make the Head of Department or the year, the component coordinator aware of that?

No

UUUH! Why not? You see, that's the principle, one of the principles of PBL where you take ownership and you keep engaging with the management as to what's going on in the programme, so that there's less frustration. Ok. So please, this year do that, do that OK. In the clinics?

The Clinics, I think it's OK. It's just, it doesn't really happen often, but it happened during, uh more towards the end of the year where uh material, there was material shortage, you know then. It takes up time and you then, you don't do what you were supposed to do in that session coz you end up looking and searching for materials and going from this Poly Clinic to that Poly Clinic

And the Dental Surgery Assistants are they helpful in that regard, in terms of

Yeah, towards the end

Certain of the nurses are very good, but

And then do you take that up with the Poly Clinic, that particular Poly Clinic uh Controller?

Yeah, they know but then they say they can't do anything. It's just

Yeah, shoo! Interesting

That's also frustrating

Yeah

Then you can't find things and you, you know, especially towards the end of the year

And in the fourth block, the fourth session

Yeah, the fourth session it's usually, there's no nurses

You know for Perio at the end of last year coz we had it last session and sterilisation closes early and we never ever could get ?? from sterilisation

Now on that, on that note do you make the Dental Council aware of that to report to EDUCOM or the School Management on those things?

Our supervisor report it, so I we didn't take it up

I think it might be incumbent to just let the Dental Council or the student reps on EDUCOM take your concerns to those. Coz that's the body that you students have a forum on, so that the challenges that they experience during the training are addressed, coz it's easy enough for, you know, as a supervisor you might not be aware, you might know but not really be aware of the frustrations that you guys are suffering and not take it up in the Department, you know. And I'm one of, I greatly believe in bombarding with, even if it's the same issue, at some point something will get done. Anything else? Yearbooks – how have the provision, how has the provision of yearbooks impacted..

This year we haven't yet received it.

Every year we usually

Like usually we get, we'll be receiving them

And do they help?

Yeah they do help because they outline what is expected, what's the expectations and the objectives of whatever particular course we are doing, so. Well it's, it's dependent on you that you do as students whether you made it ?? but if you've read it you'll know what is required of you

Has there ever been a situation where say the yearbook that the component, the course says that you have to do 5 assessments and you end up doing 2 and that's fine?

No, there has been situations like that

Is it?

Yeah

Ok, coz what's coming through is uh there has been, there is more of the other situation where you end up doing extra assessments

Yeah

That's true

Uh. Oh, OK. And uhm, how has the the provision, how has having yearbooks helped you particularly, you as an individual to plan your year?

It outlines exactly what you need to have, exactly what, it has the requirements so you uh sort of you know what direction, it leads you to the right direction, You, I sort of plan: Ok I need to do this, I need to have done ?? See if there were no yearbooks then we'd be a bit lost, you know, not knowing what to do

And do you work to the yearbook or do you set your aim higher or at the yearbook's level?

I think at the yearbook's level

Just because (laughter)

Because if you look at it in Pros, if you look at Removable, you sort of want to get that minimum quota that they have ?? because you find out that sometimes to even just do one patient alone can take you even more sessions, maybe about 8 or 9 sessions on a patient

Why?

Sometimes there are certain procedures, steps in dentures where you just have to redo like jaw registrations in Removable Pros and so like calculating what the yearbook has outlined you might sometimes feel as if you know maybe the quota, the minimum quota that you have to do is even too much for you so most of us try to aim to just get the minimum quota and that's it.

But then you get students who get much more than the minimum quota. How do you think they manage that?

I think also it's a lot to do with your patient.

Some patients

Yeah

With certain patients things just don't go right – the Lab, I know lots of times the Lab has confused or lost your, you know they haven't done things properly and then it, you waste a lot

of time with that and also patients, some patients they don't come for their appointments, they don't pitch up

And do you outline to the patients at the beginning what you require of them?

Yes

Is it!

Yeah, always tell my patients

And is there, what process have you then taken, what recourse have you taken if a patient, you've outlined what it is that you need out of them and they don't deliver? What do you do?

We usually just, you record it in their files, and then we, I mean we always finish them. I always finish the procedures coz I've had lots of problems with patients, always had difficult patients, but I always finish the case but uh make a record in the file and

Coz with the Fixed Pros side one of the things we do is screen the patients and the ones that you get to see are the ones that we think are suitable for your level. So you don't have to do the screening yourselves whereas I know that with the other sections, you know the patients are just from the general, say Removable waiting list, There hasn't been a Prosthodontist screening

I think that helps

Yeah

That would really help us

It happened to me

They come back one session

And then they have to go for an extraction, I mean

?? I had a really difficult case and it wasn't, I couldn't do that, and the week after I had a patient with teeth in her mouth. I think I wasted like 4 weeks coz I had different, I couldn't do any of the patients coz they had teeth, I had difficult cases,

And how do you get uh the patients allocated to you?

We hand the patient request form in the Receptionist and the Receptionist would just scroll the book

It's just the Pros book – it doesn't say they need partial; they need removable

I don't think they're screened from the, I think the front they should be a Prosthodontist that screens Pros patients initially. That can say they are suitable for 3rd, years, 4th years, 5th years and that should be written down, because sometimes they give you like I don't know, the very difficult cases that you can't do. Like you have to give one to one of the Post Grads to do it

Is it?

Yeah, yeah

Look I know with me all of my patients that I did last year for Pros, I had to screen them myself at emergencies, like I got patients from emergencies, so which is somehow disadvantages patients who have come before and have been on the waiting list at some point in time

Uh

You find a patient, you see the patient and you say: Oh this one is suitable for what I want to do you know and then you take it from there like meanwhile there are hundreds of other patients who've been on the waiting list for a long period, but you know it's situations like that you end up you know

And has this kind of, have these kind of issues come up amongst you guys, discussion, discussions amongst you guys for the student reps to feed to EDUCOM and to feed to the School Management, those on the Council about such challenges so that there is a win win situation for everybody, because like Tshepo has just said there are patients who get disadvantaged and students also get disadvantaged because they get to screen their own patients and that takes, that makes the process a lot longer?

I think that may solve the problem. We don't have anybody ?? looking at our problems, that I think problem as students we don't take things up

Coz I'm thinking, you know, it's a recurring issue that keeps coming up in all the groups that have come, most of you that have come and interviewed you know, that there isn't that communication between the component, the course reps, the Council, EDUCOM and the School and it would just help for a body. But one of the concerns that come up is that students think that they are not being listened to when they do take issues up. Any burning issues with regard to Pros, the programme, the teaching?

?? Let me say to my personal experience, I look at all other departments I think Pros department is the one of the most organised department I know. Whichever course we did in Dentistry you know, because they outline whatever that you want you have to do especially as students and also they deliver as to maybe lectures, tutorials, whatever whereas maybe some other departments, you know, still have that lack ??. but in terms of organisation the department is generally well outlined

And the amount of assessments that they give – do you feel it's adequate or could be reduced or increased? And how could it be modified?

I think it's adequate

Coz on average you have – no, not on average, you have, yeah, on average, you have say 1 and a half assessments per teaching block

It's adequate because ?? it helps with the students as well to see whether the students is progressing or not progressing ?? In other courses where you have just have 1 exam only at the end of the year, you don't know really whether you are doing the right thing or the wrong thing or how are you studying, you know. So I think quite honestly

How many components are there this year – is it still 8?

?? OHSC

Or 10?

With regards to ?? I think it's 10

Now if you look at the number of components, right, and say with the continuous assessment strategy / principle if you have 1 assessment per teaching block from each, how would that impact on the overall number of assessments?

Yeah, it gets to you

Last year, I think by the end of the year I was

Everyone was

It was heavy

I think we wrote 2 or every week. It gets quite

Hectic

Tiring

So you're just learning for the short-term, it's not about for the long term

Yeah

And the thing is they won't spread out the assessments. Most of them are in the 3rd and 4th block. I don't think we wrote many in the 1st and 2nd block

So you only wrote Pros

Laughter

Remember Pros!

Yeah, that's true

Oh

Yeah and everything you know, started ?? we need to do this ?? they put everything into 3rd and 4th teaching block. You even got crammed ?? 3rd and 4th block

And was this fed through to EDUCOM

I think they had

No, I think they ?? because this year they will try and do, to set out and like fix the dates and you know everything

Shoaw! OK. Coz I mean in the Department we feel that 1 and ½ assessments per teaching block is adequate for the programme, however, personally I think that it might also be slightly too much especially given that the BEST system is supposed to be engaging and assisting you on a continual basis in the clinics and if you have, say you have 1 Fixed Pros session a week and 1 Removable Pros session a week, it therefore means that you have 2 assessments every week, you see. That's just counting the written and the WCTs and and ... So you guys have not looked at it that way, I can see

Laughter

?? Clinics are one particular

Yes

But if you go back to the objectives of the BEST system, you will realise that it is an assessment system and you, actually it is an assessment system because you get a mark – the clinical ranking mark – so maybe when you start engaging with uhm EDUCOM, the Council and EDUCOM, come from that angle when you're negotiating every, the re-alignment of the assessments. You see, because most of the clinical departments use some form of continuous assessment in the clinics – for the clinical ranking mark. And therefore it means that you need to engage more with your patients and what it is that you're doing and understand why to get a better clinical ranking. Not that it ever, people get you know students get low clinical ranking marks. Anything else? Or I've given you food for thought. Which I shouldn't have, you need to be giving me food for thought. Anyway thank you guys.

4:44:44-5:02:41- 5:06:00 – 5:08:28)

APPENDIX 4.8

Fictitious names have been used throughout the interview

INTERVIEWS – FACULTY

We're starting now

(FAC 1) Ok I think the first thing I'd like to say is that I think the principles of the new curriculum, of self-directed learning and facilitating learning and teaching have been taken on by the Department to varying degrees. Some colleagues have taken a lot of it and others not quite so much, but I think it has influenced the teaching and learning in the Department by and large. However, quite powerfully I think that the old fashioned lecture mode to a large class and then just simply expecting students to absorb the knowledge from that, I think that has changed a lot. I think there's a lot of sort of problem based small group teaching. Certainly, certainly in the areas where I deliver my teaching, very seldom I don't think I ever give a traditional lecture any more.

Ok that was going to be my next question. In terms of, you've just said that it has influenced the way we teach in the Department. Now do you see that more with the senior lecturers or the junior lecturers or across the board in terms of the positive influence?

It's difficult to say because I don't really know what people do in their classrooms. But from conversations with various people I think it's more experienced teachers that have taken the new principles on board more than the more junior teachers. Yeah.

And does the Department then address that in terms of trying to get the junior teachers?

Yeah, I think not enough, certainly not, no, no

Ok. And the role, your role as a facilitator?

I think that my role as a facilitator has I think I've always naturally been more of a facilitator than a dictator, but I since, since the new curriculum and all the reading and the problem based learning principles I have become more at ease and more validated in that kind of way of teaching in facilitating more and empowering the students more: to ask the questions, to try and find their own answers, to a more of a dialogue with students than just a one way bulimic

education where you feed it through a funnel into their heads and they vomit it back in the exams and you give them ticks.

And have you had any feedback from the students with respect to how you teach them? And what kind of feedback has it been?

Look that's very difficult because students will not give you negative feedback. But I've had lots of positive feedback, but you know, that's, uhm, one always treats that with caution. What's happened is that the present second year class whose teaching Dave and I took over have been telling the third year class what a good time they are having and how much they're learning and the third years have said 'why didn't you teach us last year?' You know. Yeah, I've always had lots of positive feedback.

Back to your comment about the third years asking why you haven't why you didn't teach them last year. But you did teach, even though it wasn't for what you're teaching the second years for this year, you did teach them – no, you did PBL

They wanted to know why I didn't teach them the mechanical course

Ok

Because the second years are having such a good time and they're learning so much

Ok

And I've had the same from the Technicians as well. The Technicians were a bit at sea. And that's because it was a more inexperienced teacher doing the course last year. You know, not because I'm better or so, but I'm very experienced

And then the difference between the junior years that you teach and the senior years that you teach, what have you found?

Uhm (*long pause about 9 seconds*)

In the teaching?

In the teaching...

Or the learning

My best – in the learning. Ok I find that the more junior years are terribly hungry and very keen about dentistry. And the more senior years tend to get a little bit more disenchanting, they are disenchanted. They are under pressure, they almost just want to pass the exams and get it behind them. Whereas the junior classes are much more open and they want to know just for the sake of knowing and not merely just for passing. My teaching I think – one kind of, I kind of stratify it with the junior ones. It's more general obviously. Just laying the ground work, a foundation. With the senior students it is more specific and I expect more out of them than the more junior students. As far as teaching methods go, I think I'm more of a facilitator again with both the junior and the senior students.

And do you see a change through the years that you've been doing teaching with the transformed curriculum principles?

Yes I see a change. One of the changes is that so many of our students come back and want to teach in the Institute. You know, when I was a student, we just wanted to flee because it was so awful and so authoritarian. And students, I get a feeling that students are more empowered, that they are more kind of grown up, they don't just regurgitate stuff and try to pass tests and exams. They think a little bit more. Hopefully...

Laughter from both

Yeah. In the clinics, how have you found them compared to the tutorials? Now concentrating on the senior years?

To the senior years

4 to 5

As compared to previous students?

Yes

I think they are more proficient, because they start clinical work earlier and their exposure to dentistry starts in the first year. So I think they are I mean if I compare third years with third years in the old curriculum, they did not even do any surgery work. They only got into the surgery work in the fourth year. So I find them more competent in removable pros.

Uhm

I find them more competent

And do they have the necessary background knowledge in order to handle the clinical cases now or back then?

I think more now. I really do, yeah

Now taking a different aspect. In terms of the resources, uhm concerns about, first of, concerns about patient management systems – have you had any issues with that or have you heard any comments or concerns from the students with respect to booking patients, availability of patients, management of patient records etc.

Huge issues. Everything is a total mess and it doesn't seem to be improving, it seems to be getting worse

How do you then manage that for say the group that you teach?

Management by crisis

Explain that

I really don't have the time or energy to sort out the systems

But for the group that you say

For the group that I teach, I just advise them to do things early – book patients early, even to keep their record cards which is against the rules, because otherwise they get lost at the front desk and I just tell them that they have to take a huge amount of responsibility for the booking, for phoning their patients and reminding them, for making sure that everything that they need is available, because it's not going to be done for them.

Ok

And if the files are lost I'm not prepared to cancel a patient I just carry on keeping file s illegally

Have you considered (*laughter*)

I do

Have you, no, the illegal part not the continuing

Yeah

Have you considered any other methods or ways of dealing with say files that go missing and how to support the students without them having to keep the files with them, the original files, that is?

I have raised this matter in meetings, various departmental and school meetings and no-see-um for years and nothing seems to happen, so I've actually given up on that route. I don't think it works. I don't think the administration is capable of sorting out our problems and I think we just have to live in the jungle and look out for ourselves.

Ok. And then, in terms of the support that the school and the department and say the lecturers, give to the students, for that particular issue and also for things like notes, what things spring to mind for you where students have to do a lot of their own photocopying, and though they have to pay for the photocopying; their fees include payment for notes and extra materials; how have you or the department or school tried to address that?

I don't know how the department or the school have tried to address it. I certainly do a lot of photocopying for the students. I in any case like to give them notes on whatever I do and that frees me up to have a freer discussion for the notes are very structured and all the information is there. Ok and then the actual so-called lecture often takes the form of a 'case of what is the main problem that we need to address today' and 'what do you feel' and 'Ok let's follow that up and discuss it' and 'what do you mean by that' and 'what do you think' and you know that kind of problem solving exercise to understand the central issues in a particular area, and then the details are the notes and I point them out to them, where the details are. And those kinds of things are always, I mean, every time I have a lecture I've always got a packet of stuff to give them, and I do that myself. It's so easy for me to do it.

And as, still on the notes issue, as chair, as a former chair of EDUCOM, was this issue raised by the student council reps in EDUCOM about having to make their own, having to copy their own notes say if a lecturer gives them one set of notes for the class of forty? Has it ever been raised?

Not as far as I remember, no

Ok. And the interaction between the student council reps and EDUCOM, how has that been through the years?

(*pause*) Lively. It's the only meeting that the students have attended regularly. Whenever I go to Faculty Board or any other meetings, committees, where students have designated representation, there's always a complaint that the students don't come. And I think the reason is that there is very good dialogue with the students on EDUCOM; that we did respect them, we took their issues seriously and we responded. Whereas in other school or Faculty meetings I have heard students being pooh poohed and put down and being told 'you don't have the experience to be able to judge us' None of the other committees do the students attend. They're attending EDUCOM.

Are there committees that the students have representation on apart from EDUCOM?

At all. All the school committees and Faculty, must have student representation.

And then

In their constitution, but the students don't come. And of course, the

Management

Uh members of the committee say 'ooh yes of course they are pathetic and they are not interested anyway

And the interaction between, I know it may be slightly off – the interaction between the DSC and the school management because they are supposed to have regular meetings with school management. Have you heard anything?

Uhm, not really, but the impression I get is that, I don't know if it's still like that, maybe it's changing but up till recently, it's always been the biggest shloops that were elected onto the Student Council and the ones that they felt would smooth their way and I don't know, they don't go to School Executive. I don't think they have interaction with them

Well I'm not sure

Head of school, I'm not sure about that

I think they, well my understanding is that they have regular meetings with the Head of school as the DSC, but I don't know. I'm also getting feedback that that has not been happening as regularly as it did previously

Also I don't think that they're very empowered and proactive

For that particular thing or

About student issues. The students are supposed to be

The students or management

No the students. Because surely that kind of interaction is supposed to be about bringing student issues and sorting them out

But then if they then do it with EDUCOM, you see, where you get student representation in EDUCOM, and most of the reps are part of the DSC

Yes, yes

There's a misalignment there

Yes, yes, definitely. Definitely

Ok the role of the yearbooks. What's your philosophy on that? And do you find it effective from a student perspective and from staff?

Yeah, we've reviewed this. We started off by putting in all the subjects then we decided we will only put in OHSC, in the year books and that made it slightly manageable. It's a lot of work. So clearly one doesn't want to do it if it's not so useful. So then it's now just OHSC and it's not that much work because everyone is now in the groove. Everyone sends their stuff along and it's quite easy for the coordinators to put it all together and issue it. It's going quite well now. We considered it at EDUCOM whether we should transform the yearbooks, make them shorter, whether some stuff should be excluded or other stuff included and I did sort of informal questioning of the students, one can't call it a survey, and most of them feel that it's very useful. You know, some of them say 'it's our bible'

Is it? Junior or senior or across the board – students?

(pause) More senior. I think more senior. I haven't spoken to the first or second years if that's what you mean by junior. But like third, fourth and fifth years. Most of them find it, they would feel lost without it. Yeah, they do read it. One of them asked 'Do you read it?' and she said 'No, but my friend does and she tells me everything'

A lot of the concerns from the students are with respect to the scheduling of assessments, and that they don't get that information and I know if I'm right, that the yearbook is supposed to have all that information but I know that the yearbooks though, don't have the schedule of assessments

Ok the third year yearbook does

Uhm hum

For three years now

Ok

It has had the schedule of assessments. The fourth year, I think also has. Second year yearbook has it now for the first time this year

For all the OHSC or just the Department?

All the OHSC

OK

I don't know if the second year yearbook has the OHSC and the Medical School subjects. The third year yearbook has all the Medical School subjects and the different components of the OHSC

OK

All of that is in the yearbook. And that is how the students know that they should be getting it because it's inside the yearbooks but I think fourth year has some of it and I don't know about the final year. I know last year the final year ran around like chickens trying to sort out clashes and this and that but the third years have definitely had it and they've had it for three years now

Oh, that's good

Yeah

Because they're some of the issues that came out during the student interviews: that they had extra assessments which were not scheduled in the yearbook come up and that they had to do and that some were scheduled and they never got to do. They didn't get to do all of them, they had three booked or scheduled and then the / a department would decide that particular department would decide to just do one and that would be OK. Or another department had nothing scheduled and then in the one week have like four, three or four assessments without engaging the students in agreement to doing the assessments

Yeah, you know I can't, I would be lying that it's, if I said it hasn't happened ever with the third years, but certainly we keep to the assessment schedule. We keep to it. Dr Boitumelo puts up the dates and everything and everything happens even the PBL, integrated tests, when they have to hand in projects, when they have to hand in their themes files. Everything is there. And we do keep to it. We keep to it and I tell the students that last year there was one case that the students wanted to change and I said 'No, we are not going to do that, we don't do that.' And that was the last time they ever approached me to change something.

That's good

So no, the third year is very tight, but I mean, you see, I'm coordinating it. I don't know. Dr Mistry is coordinating second year and I know that this year she, for the first time, has a schedule of all the assessments. It remains to be seen how well they keep to it. You know.

Uhm, because the challenge with the fifth year for the department was, there were individual schedules brought out within two to three weeks of the programme starting. You know the students asked for changes and that the deadlines, the due dates, were flexible and it caused a lot of tension because at the end you're rushing to get things done

Yes, yeah, I was aware of that. And then some members of staff suddenly decided to go to the game reserve for a week. And not only continuing assessments, but they've actually changed examination dates and brought them forward. Do you remember Tracy and Leslie? Their exam was brought forward by a whole week and they suddenly had a week less to study and they were too sacred to

Take it up

To take it up.

I remember that

Do you remember that?

Yeah, I remember that

It was last June, wasn't it?

Yeah

Yeah, last year June

And also the students did say that that one of the non-dental departments did that. I think Anatomy, no not Anatomy, Medicine or Surgery also did that

They did now, did they?

Yeah, students reported that in the interviews I did with them. And they said it was not a Dental subject, it's not an OHSC component, where because the lecturer was not there, the week that the exam was scheduled

You see, I think that this kind of thing has always existed at this school. We've never had year coordinators before the new curriculum and we never had things like schedules and the students were much disempowered and the lecturers, especially the Medical departments who tend to be a bit heavy handed, have just, it's been ad – hock you know, and the students just had to deal with it. This is one of the reasons that some departments don't like the new curriculum, because they want to remain in their comfort zones and they want to be able to change assessment dates and go to the game reserve and so as they please. They don't want to commit. And then they perceive that as being dictated to. You know, they are not team players

How has the Prosthodontic department been part of the transitioning of the curriculum in your view, and the support that the department gives to the students as a department?

They're two very separate questions. I think that the Pros Department has to a greater extent than any other department taken on the transformation in assessment, in facilitating – we are willing to facilitate PBLs, in adopting some of those kind of student centred learning facilitating

methods in their pedagogy much more than any other department as far as I can see. So there is your answer 'how has the Pros department taken it on'. The other question is 'support students' (*pause*). I find that difficult to evaluate. I think certainly in the third year where I've had my biggest input, I think students get a lot of support, but from myself and Dr Boitumelo. Second years, I have just started with them. There was unhappiness with the second year students, which I was aware of as many of them spoke to me about it.

What kind of support have the second and third years or the third years mainly had from the department with the curriculum – with the Pros curriculum?

Very clear programmes, very clear guidelines, very clear assessment criteria and I think that's made the students feel comfortable. And also the fact that both Pros coordinators – the year coordinator – are a Pros staff member. This is myself and Dr Boitumelo – who is the Pros coordinator. Both of us are very approachable. And they find this, their first clinical year, very very exciting. They really find it a real joy, you know, because 'at last, it's all coming together and they are treating patients, they're becoming real dentists'. And I think generally their teachers are very supportive, you know. The more experienced teachers have been put onto third year supervision

Ok

Which is a very good idea. Drs Bankowitz, Boitumelo and me

What about Prof Tamlin?

Yeah, Prof Tamlin as well. And that in itself is a huge support

It is

To have experienced teachers

Is then, and that the letter from the third years praising the coordinator for the programme

For what

The letter from the third years, remember? Praising the Pros coordinator for the programme and how supportive they've been

Yeah, for the first time in the history of the Wits Dental School, ever since I've been working here anyway

As a collective as well

As a collective. And one can actually take that seriously because it's not like trying to butter-up one particular person, you know

Any other comments from you, with respect to the curriculum for the department, and how we're handling it, from your side – how we could improve it? How we could alter it, what we are doing right?

We could do more developing of the academic staff, especially junior staff. I mean they're just thrown into it. And I'm not a hundred percent sure about the position on registrars as far as the work of the department goes. Should they get some development as teachers because they do some teaching, or should we just look upon them as 'well, they'll go anyway?' I'm not sure on the position of the registrars

Now. Because before they used to have to do the PBL staff development workshops

Uhm

Ok, any other issue that you'd want me to take note of? I think we've covered the broad topics

No I think that our department, I mean, we seriously review our teaching in terms of horizontal and vertical integration every single year, and we give it thought. I don't think any other department does that. I really don't think so. (*an eight second pause*) I don't think I want to say anything else, unless you want to ask me anything else

No I've covered most of it

You've covered...

And hopefully the audio has covered most of it, all the comments

Is it working?

It's working. What's interesting, just for your information,, what's interesting I think. One interesting piece of information that I got from the students is how they prepare for their sessions – whether clinical or the tutorials – that it depends on the teacher that they have. If it is a teacher who draws them out and shows that they are interested in the students' learning, they're more willing to go that extra mile and prepare before – hand. Whereas if it is somebody else that they can see doesn't really give a toss as to whether they are learning or not

Just wants to get through the lecture and bugger off

Yeah. They also don't

Did they name any names?

No

No

Well I don't encourage them to name names. I thought that was interesting because my

Of course

My logic would be that, as students they would need to prepare for whatever it is they're going to be doing or they're going to be engaged with. But if they would rather not...

Certainly. Certainly at second and third year, when they've got the time. They have a lot of time allocated to research in third year

Is it?

Yeah, and they could, they could be preparing in that time. And they've also got lots of manuals and the Pros book and all sorts of material in Pros. Maybe it's a good idea to give them some of the stuff that I give them, like the week before. You know, because they're still hungry, they might just read it. Certainly the better ones would read it. Yeah, that's a good idea. In fact, I'm giving them a revision thing on 'vertical jaw relationships' and I've got a very nice hand-out for them and I think I'll give it to them – before

Because they did say that they actually also like to be given notes because it shows them what is relevant and what's not relevant. Whereas if they are not (given notes) if they don't get a guideline, a written guideline, from the teacher, it just makes some, most of them it makes them more fidgety and anxious

It does yes. And also from the teacher's point of view, I find that they are so keen to take down every word that you say. Ok, certainly the second years. I've noticed this. That they're not thinking and they do not understand and that's why I like to give them notes and that frees them up to listen to me and to think and to understand. Because they take down every single word and then you ask them a question about what you've just said, and they don't know because they're rushing to take down every word. You know what I mean? So it's actually better to give them the notes, but same time I control very strictly attendance. Because the danger with giving stuff out is that they might not attend because they think 'oh well, I'll get it anyway' you know. So, I'm very strict about attendance – I point out that these are clinical tutorials and it's upped my responsibility to make sure that they attend otherwise I cannot allow them to work on patients. And I do a head count every time to check they're all there, then I ask who's missing and they must come and explain

And they do?

They do. They bring doctors certificates, and they come and explain, yes. Because I follow it up, you know. I don't just threaten them. Ok. And also I do trust that whoever is not there has got

A reason

Has a good reason, you know. I respect them enough and they know that

And then your engagement with them in the clinics in terms of the BEST system, how is that going?

Fine

Is it?

I find that a student's evaluation of their work or assessment of their own performance usually matches up 100% with mine

Ok

If that is what you are asking

No, oh that as well as assessing for yourself whether the student understands that which they are doing

I'm very experienced, very experienced you know

Well

You mean does the BEST help with that?

Uh

(pause) It kind of comes at the end of the session, you know. SO really my assessment of whether students are understanding what they do comes during the session and if they don't I explain. I mean I never just sit. I never for a moment sit during a session, or stand at the side looking out of the window. I'm continually circulating around watching what they're doing, to see if they understand. I also ask them questions so that I can confirm whether they understand and if there's a need for me to explain things that they are unclear with. I mean today some of the third year students didn't have patients because it's their first patient, it was a whole mess with bookings and they haven't got their instruments and you know. It was just a total mess. So I got one of the students to come up and fetch the skull and we revised muscles of mastication and I showed them how to examine muscles of mastication and they were examining each other and you know, I think that the chair-side or the clinic is the biggest teaching opportunity of the whole lot. And if I spot someone who doesn't, I mean some of them didn't know their muscles of mastication today. And I said to them 'if I ever spot you not knowing this, you are going to cancel your patient and you will go to the library and learn this because you need to know it.' So I do teach, and I check the next session whether they've learnt what I have told them to do. I tell them, like in today's session, I told them that 'now for your impression taking, you need to learn, look at your surface anatomy. You need to look at retention and stability and support and you need to read up about taking primary impressions and you need to know that for the next session. So, what was the question?

Whether the BEST system, and your engagement; your usage of that, with the students - to assess whether they understand that which they're doing clinically is working?

(Pause) I don't think the BEST has made a difference to me, because I've always done it this way, you know. I think it may be helpful to the students because if you give them an "S" you do discuss what it is that went wrong and you know that helps. You know, when I was a student, I used to do a piece of work and I'd get like, I mean, first of all, we weren't assessed in the clinics. We only had tests. Like we'd have tests half, mid-year and at the end of the year. Say a set – up: I would hand in a set – up and I'd get 72%. There was no criterion or reference assessment whatsoever. And I think most departments did not have criterion – referenced assessment before the new curriculum came in, you know. I think the BEST is a very good criterion – referenced assessment system. It's a good teaching tool. I think it teaches. I don't think it helps me to assess the students because I'm very experienced in that, but I think it's a very good teaching tool for the students to know where they've come short and to

To critically appraise

To critically appraise their own work and learn to have it critically appraised by their supervisor.

Ok, thank you.

Pleasure

(Length of interview: 38:29)

APPENDIX 5: INSTRUCTIONAL SYSTEM

APPENDIX 5.1

INSTRUCTIONAL SYSTEM – OHSC 501 COMPONENT 1: FIXED AND REMOVABLE PROSTHODONTICS

Clinical Assessment Document

As at December 2006

NB: This document supersedes all previous documents

1. Introduction

The clinical assessment system is based on two factors: the number of procedures satisfactorily completed, and the clinical grading marks.

There is a minimum requirement laid down for each of these assessments, as detailed below. It is the *student's sole responsibility* to ensure that (s)he obtains these minimum requirements, as failure to do so, will mean that a 50% clinical mark cannot be awarded. A 50% clinical mark is required for promotion.

2. Quantity requirements

2.1 Quotas to be achieved

It is a requirement that students perform a minimum number of procedures, which are accumulated each year. There are, of course, other procedures that can be performed, but the time constraints of the curriculum, as well as patient availability mitigate against all procedures being regarded as minimum requirements.

The procedures set out in Tables 1 and 2 have therefore been divided into those that ought to be performed, and additional procedures that may count in a student's favour if they have also been performed, or if they have been performed through force of circumstances instead of one or two of the minimum requirements. This will allow for some flexibility, but the skill requirements *must* match those of the minimum requirements for any discrepancy in quantities to be allowed.

If a student has fulfilled the minimum quota requirements, and has performed additional procedures, an award of up to an additional 5% may be added to the Clinical Year Mark.

Tables 1 and 2 will be modified from time to time to take into account changes to the curriculum, to the patient base, new developments, and so on. The term "follow-through" means that the student performs all laboratory procedures except packing, flasking and de-flasking. The term "non follow-through" means that all laboratory procedures are carried out by dental technicians, unless you wish to carry out some or all of the procedures yourself.

Table 1: Removable Prosthodontics: minimum clinical procedures

CODE	PROCEDURE	3 rd YEAR QUOTA	4 TH YEAR QUOTA [#]	5 TH YEAR QUOTA	CUMULATIVE QUOTA
<i>MINIMUM REQUIREMENTS :</i>					
FTDP	Follow-through denture, students in pairs*	2			2
FTCD	Follow-through complete denture	1			1
NFCD	Non follow-through complete denture	(1)**	2(1)	(1)	2
SACD	Non follow-through complete denture using semi-adjustable articulator and face-bow mounting~			1	1
TCCD	Test (Hossack) case complete denture [†]			1	1
IRCD	Immediate Replacement complete denture ^{††}		(1)	1	1
SICD	Single complete denture (non – follow through)			1	1
ABPD	Acrylic-based removable partial denture		1(2)	2 (2)	4
MBPD	Metal-based removable partial denture: Kennedy Class III or IV		1(1)	1	2
DEPD	Metal-based removable partial denture: Kennedy Class I or II		1(1)	2 (1)	2
REPF	Repair: Fracture [^]		1(1)	(1)	2
REPT	Addition of a tooth [^]		1(1)	(1)	2
RELB	Reline / rebase		1(1)	1	1
TICO	Tissue conditioner per denture			1	1
	Clinical sessions	18	24	30	72
<i>ADDITIONAL PROCEDURES:</i>					
IRPD	Immediate Replacement partial denture				1
FITR	Functional impression technique				1
TICM	Tissue conditioner with medication per denture				1
DUPD	Duplication				1
RFLA	Repair: Addition of a flange [^]				1

* Carried out in pairs, students swop lab procedures with second case

** If a student completes 4 or more dentures in 3rd year, 5% will be added to the Clinical Ranking Mark

~ Student must do the face-bow transfer and mounting onto articulator themselves

† Student carries out set-up for trial base: all other lab procedures can be sent out

†† Minimum 5 teeth, of which 2 must be adjacent

^ Students must do all the laboratory work themselves

The numbers in brackets mean that that procedure may be completed in that year or either year.

The cumulative quota is the absolute minimum required to complete the course. There will be no exceptions.

#The 4th year quota is a **minimum** of the following:

2 x complete dentures

2 x removable partial denture (any type)

1 x repair (any type) or reline/rebase

Table 2: Fixed Prosthodontics: minimum clinical procedures

TECHNIQUES COURSE

PROCEDURE	QUOTA
Inlay tooth 25: prep, imp, wax-up, cast*, fit*	1
Onlay tooth 36: prep, imp, wax-up, cast*, fit*	1
Veneer (incisal prep), indirect: tooth 22	1
Full gold crown, prep and temp: tooth 46	1
Ceramo-metal crown, anterior, prep and temp: tooth 21	1
Ceramo-metal crown, posterior, prep and temp: tooth 16 or 26	1
All ceramic crown, prep, temp: tooth 11	1
3-unit ceramo-metal bridge, preps and temp: central to canine: 21 to 23	1
Preformed post and core	1
Cast post and core: direct	1
Cast post and core: indirect: prep and impression.	1
Full gold crown, prep: tooth 37	1
Three quarter crown, prep: tooth 35	1
Michigan-type occlusal splint, made by a class colleague, to be worn for one week continuously	1

* If laboratory facilities available.

CLINICAL REQUIREMENTS		
CODE	PROCEDURE	QUOTA
GOIN	Gold inlay or onlay	2
POCR	Posterior crown, FGC or C-M	2
ANCM	Anterior ceramo-metal crown	1
ANAC	Anterior all ceramic crown	1
POCO	Post and core	2
BRDG	3-unit bridge	1
	Clinical sessions	60
	<i>ADDITIONAL PROCEDURES*</i>	
ACBR	3-unit bonded (Maryland type) bridge	1
3QCR	Three quarter crown	1
INVE	Veneer (indirect)	2
CDCM	CAD/CAM restoration	1

*Additional procedures over and above minimum will qualify the student for an addition 5% on the Clinical Ranking Mark

2.2 Quality requirements for quotas

Please refer to the separate publication on the BEST system for details of the Minimum Total Quality Score. Set out here, are the criteria to be used for the assessment of each of the stages for the procedures.

2.2.1. Assessment criteria for the clinical stages of complete denture construction

The following criteria will be used to aid the assessment of the clinical stages:

Primary impressions: common criteria

1. The sulcus has been recorded evenly
2. There are no voids in the impression which will affect the construction of special trays
3. In a lower impression, there is extension into the retro-mylohyoid area, and full extension of the buccal shelves
4. The extension of the special trays has been indicated correctly by the marking-pencil line
5. The line indicating the lingual extension of the lower special tray is to, and not beyond, the mylohyoid ridge

Primary impressions: criteria specific to the use of alginate in a stock tray

1. The stops are all showing, indicating that the tray has been fully seated
2. In a lower impression, there is support for the alginate (from periphery wax) in the retro-mylohyoid area.

Final impressions: common criteria

1. The tray has been seated symmetrically
2. The impression material is adequately supported
3. The functional sulcus has been recorded for both depth and width
4. There are no voids in the impression which will adversely affect the periphery or the fitting surface

Final impressions: criteria specific to the use of a special tray

1. If a spaced upper tray is used, stops should show through impression, or have less than 0.5mm impression material covering them
2. If a spaced lower tray is used, green stick should have been used to record the posterior lingual sulci and retro-mylohyoid areas
3. Close-fitting special trays must also have had greenstick added to the posterior palatal seal area

Final impressions: criteria specific to the use of compound and ZOE in one visit

1. There has been adequate relief of the compound for the paste
2. There is an even thickness of impression paste over the surface of the compound
3. In the lower, there is adequate support for the ZOE, particularly in the retro-mylohyoid area

Final impressions: criteria specific to the use of the double alginate technique

1. There must be adequate support for the alginate, as evidenced by modifications to the stock tray, particularly in the retro-mylohyoid area
2. There is an even thickness of the second alginate layer over the surface of the first layer

Jaw relation record

1. The mid-line must be recorded
2. The occlusal plane is acceptable
3. The vertical height of occlusion is acceptable
4. On closing there is no perceptible shift of either base in the mouth
5. If Alminax used, there should be **no** signs of it having been heated with a wax knife
6. The inter-occlusal recording material does not extend onto the untrimmed surface of the occlusal rim, when the posterior section of that rim has been prepared to receive the inter-occlusal material
7. The occlusal rims are well localised against each other by the inter-occlusal records, which correspond to the key-ways in the upper rim
8. The posterior flanges of the bases do not touch when articulated
9. Use of the occlusal rim to record the registration is not acceptable

Trial Base / Try-in

5. Models are articulated correctly and neatly
6. Teeth to be placed where original teeth were most likely to have been, so that the arch form should follow the original arch of the teeth
3. On average:
 - upper anteriors are 8-10mm anterior to the incisive papilla
 - incisal inclination is related to the anterior ridge inclination - it is helpful to imagine the roots of the teeth
 - a tangent to the labial surface of lower incisors passes through the sulcus
 - a perpendicular through the buccal cusp of the lower first molar meets the buccal side of the crest of the ridge

4. Generally only the lower premolars are set directly over the ridge, because of the pattern of resorption.
5. Teeth set according to compensating curves
6. External surfaces of the trial bases to be contoured correctly
7. Wax gingival margins correctly festooned around the necks of the teeth, no wax on teeth or occlusal surfaces, and wax smooth with no blackened areas.
8. Root effects and stippling may be used to enhance the appearance
9. Maximal intercuspatal contact in centric occlusion
10. Evidence of customisation of aesthetics, at least to the upper anteriors

Face bow record

1. When completed, bite fork should be symmetrical within the face bow, and all components tightened sufficiently
2. If a bite fork assembly is used it must be removed carefully and mounted using the correct mounting jig on the articulator
3. Students should mount the models themselves

Remounting and finishing

1. Occlusion adjusted correctly for maximal intercuspatal contact in centric and for balanced articulation
2. Dentures correctly trimmed and polished without damage to peripheries or teeth
3. External contour of denture surface retained: neither teeth nor flange contour polished away
4. Gingival contouring retained
5. Any root effects and stippling retained
6. Fitting surface to be clean and free of surface blebs, pimples, etc.

Delivery

1. The desired result from the laboratory remounting procedure is to have dentures with the correct vertical dimension of occlusion / inter-alveolar distance, and the occlusion properly adjusted for balanced articulation. Either the dentures are returned from the lab. with the upper mounted on the articulator (having been remounted and ground in), or if the models were destroyed, new models are available for clinical remounting
2. The external contours, height and width of periphery (including the post-dam) have been maintained after polishing
3. Pressure areas have been identified and corrected
4. Occlusal adjustments have been made on the articulator after clinical remounting
5. Final intra-oral occlusal adjustment has produced acceptable balanced articulation
6. Patient instructions to be given on care and maintenance such that patient understands what is required, and a recall visit to be scheduled

Recall

1. Complaints and problems reported by patient to be correctly diagnosed
2. Occlusal interferences to be investigated first unless obvious areas of over-extension are present
3. Pressure-indicating paste to be used to detect pressure areas
4. 'Dr Thomson' disposable applicators to be used for peripheral extensions
5. Patient instructions to be reinforced

2.2.2. Assessment criteria for the clinical stages of removable partial denture construction

Primary impressions

1. Tray does not show through the alginate, indicating correct placement and correct use of palatal or buccal shelf stops
2. There are no voids in the impression which will affect the construction of special trays
3. Occlusal surfaces of teeth are recorded without air bubbles
4. Support for alginate has been provided where necessary in edentulous areas, with compound or wax
5. Periphery allows for adequate extension of special tray

Tooth preparation

1. Occlusal rests should be of correct shape and depth, with no sharp edges
2. Cingulum rests should be sufficient to provide resistance to an instrument when pressed against them in an occlusal direction
3. No excessive damage to external contours when undercuts created by tooth reduction
4. Composite highly polished when used for undercut creation by addition

Final impressions

1. If special tray used, stops should not be on teeth that have been prepared
2. Special trays should have adequate relief holes
3. No sign of bubbles on occlusal surfaces and rest preparations
4. Adequate extension in edentulous areas
5. Distal extension areas to be treated as for a complete denture

Try-in: acrylic-based

1. Final models to be assessed for correct reproduction of detail and extension to edentulous areas
2. Final models to be assessed for correct path of insertion and block-out of undercuts
3. Aesthetics to be assessed for adequate tooth selection and placement

Try-in: metal framework

1. Framework to be assessed on model for correct placement of components and conformity to design
2. Framework to be assessed intra-orally for adequacy of fit and for occlusion

Distal extension frameworks

1. Special trays to have correct extensions
2. Altered cast impression assessed for correct extensions and for correct fit of framework.

Delivery

1. Fitting surfaces assessed and adjusted as necessary
2. Occlusal adjustments carried out
3. Patient instructions and immediate and future recall arrangements made.

Recall

1. Complaints and problems reported by patient to be correctly diagnosed
2. Occlusal interferences to be investigated first unless obvious areas of over-extension are present
3. Pressure-indicating paste to be used to detect pressure areas
4. 'Dr Thomson's' disposable applicators to be used for peripheral extensions
5. Patient instructions to be reinforced

2.2.3. Assessment criteria for the clinical stages of procedures used in fixed prosthodontics

History, examination, diagnosis, primary impression

1. Mouth is caries free and free of periodontal disease
2. Diagnosis to be arrived at after use of panoramic and periapical radiographs, after assessing occlusion and having done vitality tests if necessary.

3. Primary impressions should be free of voids so that diagnostic models can be articulated without interference.
4. Face-bow recording taken as necessary.

Face bow and jaw registration

1. When completed, bite fork should be symmetrical within the face bow, and all components tightened sufficiently
2. If a bite fork assembly jig is used it must be removed carefully and mounted using the correct mounting jig on the articulator
3. Students should mount the models themselves, using a two-stage technique with impression plaster first and then white plaster
4. Jaw registration should be at the correct pre-determined vertical and horizontal relationship and the material must record all occlusal surfaces of both arches, using Temp Bond if necessary, and be cut away through the buccal cusps to check accuracy of fit of the model

Impressions

1. The tray should have adequate rigidity and be symmetrically seated.
2. The impression material is adequately supported.
3. There are no voids or drags in critical areas of the impression.
4. The impression material has not pulled away from the tray.
5. All finish lines have been captured and are visible, with impression material clearly visibly beyond the finish line.
6. There is no step-formation between putty and wash with silicone impression materials.
7. There should be no un-set impression material on the surface of the impression.

Provisional Restoration

1. The provisional should provide positional stability not allowing the tooth to drift or extrude in any way and therefore be in occlusal function
2. The restoration should be well contoured and highly polished
3. Margins must be accurate and not impinge on the gingival tissues with absolutely no overhangs.
4. The restoration must provide a good cosmetic result (contour and appropriate shade selection).

Cementation, burnishing and finishing

1. Correct proximal contact of the restoration (neither too tight nor too light).
2. The restoration should be completely seated (proper marginal adaptation).
3. The margins should not be overextended nor under extended, too thick or open.
4. The restoration should be in occlusal function (not in hyper- or hypo occlusion).
5. Restoration should be highly polished.
6. All excess cement should have been removed.
7. Gold inlays and onlays must be finally burnished one week post-cementation

Gold Inlay/Onlay

Preparation

1. Gingival bevels, buccal bevel, lingual bevel and proximal flares must all be continuous with each other (i.e., bevels should be blended into the respective flares).
2. Presence of functional cusp bevel.
3. Onlay has a 1.0 mm wide occlusal shoulder with bevel on the functional cusp/s.
4. Occlusal reduction to follow contours of cusp (1.5 mm on functional cusp and 1.0 mm on non - functional cusp).
5. Pulpal floor should preferably be flat.
6. Proximal boxes should be extended buccally and lingually to break contact with the adjacent tooth. The gingival floor of the box should be perfectly flat. *There should be no undercuts on the walls. Students should not err in the opposite direction by over tapering the walls.*
7. Adjacent teeth should not be damaged by preparation.

Posterior Crowns

Preparation

Preparation features:		
	Occlusal reduction	Finish line depth and configuration
Full Gold Crown	1mm non - functional cusps	0 – 1.0 mm
	1.5 mm functional cusps	Chamfer knife edge
		Shoulder or shoulder with bevel
Ceramo-Metal crown	1.5 mm non - functional cusp	1.2 mm labial chamfer, or shoulder with bevel if metal margin aesthetically acceptable
	2.0 mm functional cusp	0.5 mm lingual chamfer
		1.5mm axial reduction

1. There should be no damage to the adjacent teeth during proximal reduction.
2. There should be no undercuts
3. There should be smooth transitional line angles.
4. Finish lines should be ideally placed supra-gingivally and on sound tooth tissue (aesthetics and retention sometimes dictate that margins be placed sub-gingivally but if so, they should extend no more than half the depth of the sulcus (epithelial attachment should not be violated))
5. No unsupported tooth structure should be left at the edge of finish lines.

Anterior crowns

Preparation

Preparation features:		
	Occlusal reduction	Finish line depth and configuration
All porcelain crown	2 mm incisally	0.8 – 1.0 mm shoulder
	1 mm lingual aspect	
Ceramometal crown	2 mm incisally	1.2 mm labial shoulder or heavily chamfer
	0.5 – 1.0 mm lingual aspect (porcelain guidance requires greater clearance)	0.5 mm lingual chamfer

1. Reduction should be in 2 planes labially
2. No damage to adjacent teeth
3. Presence of lingual/palatal wall for retention and resistance form
4. There should be clearance in lateral and protrusive movements

Post and core

Preparation

1. Some coronal dentine should be retained (ferrule effect).
2. Post length should be long enough to be retentive (± 9 mm). The length of the post should equal the crown length or two thirds the length of the root, whichever is greater.
3. The length of the remaining GP apical fill should be at least 4-5mm.
4. Unsupported tooth structure should be removed.
5. Anti-rotation slots or pins should be placed in circular or round preparations.
6. Post-diameter should be no more than one third the root diameter at the C-E junction. It should be at least 2.00 mm less than the crown diameter at mid-root.
7. Posts to be kept in the long axis of the root, the core can diverge.
8. Sharp line angles to be avoided.

Cementation

1. Post-core is properly seated.
2. No voids between apex of post and GP.

3-Unit Bridge

1. Abutment preparations as per criteria for relevant crown type.
2. Preparations must have no undercuts relative to each other unless design is fixed-movable.
3. Assessment and diagnosis of correct extent and shape of pontic.
4. Pontic should be made and adjusted to approved type.
5. Student should display knowledge of pontic designs (ridge lap, modified ridge lap, hygienic and ovate pontics).
6. Correct design of embrasure spaces between pontic and retainers.

Indirect Veneer

Preparation

1. Preparation has preferably been maintained within enamel.
2. Finish line should be defined to a slight chamfer at the level of the gingival crest, or slightly subgingival. Proximal finish lines should not extend beyond contact point with adjacent teeth.
3. Finish lines for incisally reduced veneers should be 1.0 mm from centric contacts.
4. There should be no sharp internal line angles.
5. There should be no undercuts especially in proximal wrap preparations.

Cementation

1. Isolation of abutment teeth with rubber dam.
2. Veneers should be properly seated.
3. No excess cement.
4. Veneers should be of an appropriate shade.
5. Veneers should be functional occlusally.

3 Unit resin bonded (Maryland type) bridge

Preparation

1. The tooth preparation should include axial reduction and guide planes on the proximal surfaces with slight extension onto the buccal surface to achieve a bucco-lingual lock.
2. The preparation should encompass at least 180 degrees of the tooth.
3. Presence of vertical stops (rests) on all preparations.
4. Presence of grooves for resistance.
5. Preparation should preferably be confined to enamel.
6. No undercuts should be present.

Bond and cementation

1. Isolation of abutment teeth with rubber dam.
2. No excess cement.
3. Proper seating of bonded bridge.
4. Light occlusal contact – no interference in centric and lateral and protrusive excursions.

Three quarter Crown

Preparation

1. Occlusal reduction to follow contour of tooth
2. Functional cusp bevel
3. Bevel onto buccal cusp for aesthetics
4. No damage to adjacent teeth
5. Presence of proximal boxes
6. Buccal, bevel, proximal flare and chamfer finish line to be continuous

CAD/CAM restoration

Preparation

1. All aspects of the relevant restoration as above to be covered.
2. Student will receive assistance with the other aspects of imaging, design, milling, and placement of the restoration.

2.3 Clinical stages and their Relative Value Unit

Each prosthesis has been designated as consisting of a variety of different clinical stages, as per the tables following. Occasionally, not all these stages may be used; in this case, the MTQS is calculated on only those stages actually carried out.

2.3.1. Removable prosthodontics

Table 3: Clinical stages and RVW: complete dentures (codes FTDP, FTCD, or NFCD)

STAGE	RVW
History, examination and diagnosis	1
Primary impressions	2
Secondary impressions	3
Jaw registration	2
Try-in	2
First re-try	1
Second re-try	1
Finish	1
Recall	2

Table 4: Clinical stages and RVW: complete dentures using a semi-adjustable articulator and face-bow mounting (code SACD)

STAGE	RVW
History, examination and diagnosis	1
Primary impressions	2
Secondary impressions	3
Jaw registration	2
Try-in, face-bow and protrusive bites	2
First re-try	1
Second re-try	1
Finish	1
Recall	2

Table 5: Clinical stages and RVW: test (Hossack) case complete denture (code TCCD)

STAGE	RVW
History, examination, and diagnosis	2
Try-in	3
Finish	3
Recall	1

Table 6: Clinical stages and RVW: immediate dentures (code IRCD)

STAGE	RVW
History, examination, diagnosis and treatment planning	2
Primary impressions	1
Secondary impressions	3
Jaw registration	1
Try-in	1
Set-up	3
Model trimming	2
Finish	1
Recall	2

Table 7: Clinical stages and RVW: acrylic-based partial dentures (code ABPD)

STAGE	RVW
History, examination and diagnosis	1
Primary impressions	1
Design	3
Secondary impressions	3
Jaw registration	1
Try-in	2
First re-try	1
Finish	1
Recall	2

Table 8: Clinical stages and RVW: metal-based partial dentures: Class III or IV (code MBPD)

STAGE	RVW
History, examination and diagnosis	1
Primary impressions	1
Design	3
Secondary impressions	3
Jaw registration	1
Try-in	2
First re-try	1
Finish	1
Recall	2

Table 9: Clinical stages and RVW: metal-based partial dentures: Class I or II (code DEPD)

STAGE	RVW
History, examination and diagnosis	1
Primary impressions	1
Design	3
Secondary impressions	3
Altered cast impression	3
Jaw registration	1
Try-in	2
First re-try	1
Finish	1
Recall	2

Table 10: Clinical stages and RVW: repair of a fracture (code REPF)

STAGE	RVW
Finish	procedure must be clinically acceptable at first presentation to obtain a credit

Table 11: Clinical stages and RVW: addition of tooth to denture (code REPT)

STAGE	RVW
Finish	procedure must be clinically acceptable at first presentation to obtain a credit

Table 12: Clinical stages and RVW: addition of flange to denture (code RFLA)

STAGE	RVW
Finish	procedure must be clinically acceptable at first presentation to obtain a credit

Table 13: Clinical stages and RVW: reline or rebase (code RELB)

STAGE	RVW
History, examination and diagnosis	1
Impression	3
Finish	2
Recall	2

Table 14: Clinical stages and RVW: tissue conditioner (code TICO)

STAGE	RVW
History, examination, diagnosis and treatment plan	2
Placement	3
Recall	1

Table 15: Clinical stages and RVW: immediate replacement partial dentures (code IRPD)

STAGE	RVW
History, examination, diagnosis and treatment planning	2
Primary impressions	1
Design	3
Secondary impressions	3
Jaw registration	1
Try-in	1
Set-up	3
Model trimming	2
Finish	1
Recall	2

Table 16: Clinical stages and RVW: functional impression technique (code FITR)

STAGE	RVW
Two-stage impression	procedure must be clinically acceptable at first presentation to obtain a credit

Table 17: Clinical stages and RVW: tissue conditioner with medication (code TICM)

STAGE	RVW
History, examination, diagnosis and treatment plan	2
Placement	3
Recall	1
Recall	1

Table 18: Clinical stages and RVW: duplication (code DUPD)

STAGE	RVW
History, examination and diagnosis	1
Mould creation for wax dentures	3
Try-in	2
Impressions	3
Finish	1
Recall	2

2.3.2. Fixed Prosthodontics

Table 19: Clinical stages and RVW: gold inlay or onlay (GOIN)

STAGE	RVW
History, examination, diagnosis, primary impressions, face-bow if indicated	1
Preparation	3
Impression	3
Face bow and jaw registration	2
Temporary restoration	2
Cementation	2
Burnish and finish	2

Table 20: Clinical stages and RVW: posterior crown, FGC or C-M (POCR)

STAGE	RVW
History, examination, diagnosis, primary impressions, face bow if indicated	1
Preparation	3
Impression	2
Face bow and jaw registration	2
Temporary restoration	2
Adjustment of occlusion	2
Cementation	2

Table 21: Clinical stages and RVW: anterior ceramo-metal crown (ANCM)

STAGE	RVW
History, examination, diagnosis, primary impressions, face bow if indicated	1
Shade selection	1
Preparation	3
Impression	2
Face bow and jaw registration	2
Temporary restoration	2
Assessment and adjustment of occlusion	1
Cementation	2

Table 22: Clinical stages and RVW: anterior all ceramic crown (ANAC)

STAGE	RVW
History, examination, diagnosis, primary impressions, face bow if indicated	1
Shade selection	1
Preparation	3
Impression	2
Face bow and jaw registration	2
Temporary restoration	2
Assessment and adjustment of occlusion	1
Cementation	2

Table 23: Clinical stages and RVW: post and core (POCO)

STAGE	RVW
History, examination and diagnosis	1
Preparation	3
Impression	3
Temporary restoration	2
Cementation	2

Table 24: Clinical stages and RVW: 3-unit bridge (BRDG)

STAGE	RVW
History, examination, diagnosis, primary impressions, face bow if indicated	1
Knowledge and diagnosis of pontic design	1
Preparations	3
Impression	3
Face bow and jaw registration	2
Temporary restoration	3
Assessment and adjustment of occlusion	1
Cementation	2

Table 25: Clinical stages and RVW: 3-unit resin bonded (Maryland type) bridge (ACBR)

STAGE	RVW
History, examination and diagnosis	1
Preparation	3
Impression	2
Temporary restoration	1
Bond and Cementation	3

Table 26: Clinical stages and RVW: three quarter crown (3QCR)

STAGE	RVW
History, examination, diagnosis, primary impressions	1
Preparation	3
Impression	2
Face bow and jaw registration	2
Temporary restoration	2
Occlusion	2
Cementation	2

Table 27: Clinical stages and RVW: indirect veneer (INVE)

STAGE	RVW
History, examination and diagnosis	1
Preparation	3
Impression	2
Temporary restoration	1
Cementation	3

3. Quality requirements: the Clinical Ranking Mark

Please refer to the publication on the BEST clinical assessment system for the derivation of the clinical mark: it is a combination of the average weighted mark received for sessions, and any clinical examinations taken in each term.

The minimum average weighted mark to be achieved to be the equivalent of a 50% Clinical Ranking Mark, is 3.0.

4. Summary

In order for a student to be granted approval on *clinical* grounds for promoting to the next year of study, the following requirements must be met:

1. Perform the minimum number of clinical procedures as set out in Tables 1 and 2, to the minimum quality required, as indicated by the Minimum Total Quality Score for each procedure.
2. Achieve a minimum Clinical Ranking Mark of 50%, as indicated by the average weighted mark received for all clinical sessions.

The Clinical Ranking Mark also contributes to the Year Mark, as set out in a separate publication of the Department.

5. The case of the disappearing patient

Disappearing patients are defined as those who are definitely not going to return by reason of death or having moved away, or other similar reason, which reason *must* be verified by the supervisor.

5.1 For complete dentures

§ If the student has reached the try-in stage with complete dentures then the student at that visit will be asked to do an aesthetic set up and best balance without grinding teeth.

§ Then the dentures are to be finished in our lab (not sent out) and the student must then remount the models, and produce a perfect balance on the articulator.

§ If the dentures have already been processed, the student must still remount the models, and produce a perfect balance on the articulator.

§ When presenting this to the Supervisor the student must demonstrate that (s)he knows and can describe precisely, the clinical procedures to be followed at delivery, and at recall.

§ THEN and only then can the student be given a quota credit.

5.2 For Immediate replacement dentures

- \$ The student must have reached the finish stage and completed all model trimming, etc.
- \$ Then the student must assist a colleague or member of staff at the delivery stage of their dentures, and for at least 3 recalls, in order to obtain a credit.

5.3 For partial dentures

Acrylic-based

- \$ The student must have reached the try-in stage, having performed all other procedures satisfactorily, especially the tooth preparations and the surveying and blocking-out of the master model.
- \$ Models, try-in, and design must all be present, with suitable and appropriate articulation.
- \$ As it is not possible to simulate any further stages, the n/a column must be completed for the remainder of the stages on the quota form, and this form must be retained by the student and will be worth a half credit only.
- \$ Details will not be entered into the system, but this half credit will only be considered at the end of the year if the student has a problem with the required quotas.

Kennedy Class III or IV metal-based

- \$ The student must have successfully tried in the framework, and have reached the waxed-up try-in, stage, in which case a half credit will be given, using the same principles as above for the acrylic partial.
- \$ If the waxed-up try-in has not been completed, the student must carry this out before being granted the half credit.

Kennedy Class I or II metal-based

- \$ If the student has reached the same stages as for a Class III or IV above without having carried out an altered-cast impression, the same criteria apply, to obtain a half credit.

§ If the student has successfully carried out an altered cast impression, and has reached the waxed try-in stage, then the student must proceed as for a complete denture, and then can receive a full credit.

APPENDIX 5.2

PROMOTION REQUIREMENTS

SATISFACTORY PERFORMANCE AND ASSESSMENT REQUIREMENTS FOR THE COMPONENT: PROSTHODONTICS, COURSE OHSC501

BDS 5 CLASS OF 2007.

January 2007

1. *This document supersedes all previous documents*
2. *Marking is carried out in 5% intervals. All aggregated marks are rounded to the nearest 5%.*
3. *The course coordinators are Dr Mokgadi and Prof Tamlin; the internal moderator is Dr Boitumelo; and the external examiner is Dr Moosa (University of Pretoria).*

1. Term and Year Marks

- 1.1 The minimum *clinical* criteria at the end of the year must be fulfilled before a year mark can be calculated, i.e.
 3. Perform the minimum number of clinical procedures and sessions as set out in the clinical assessment system, to the minimum quality required.
 4. Achieve a minimum Clinical Ranking Mark for the year of 50%.

Failure to obtain these clinical requirements will necessitate repeating the year.

- 1.2 The minimum *assessment* criteria must be fulfilled as set out below, before a year mark can be calculated. Assessments can include any topic previously covered, from 2nd year onwards, and can cover both fixed and removable prosthodontics. This is because the course cannot be seen as separate, discreet pockets of knowledge, but is a continuum of continuously acquired knowledge, building on, and sometimes modifying, knowledge previously acquired.

2. Year Mark

This will comprise the following:

Clinical Mark: Hossack case:

to be completed by the end of Teaching Block 2:	10%
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Fixed pros practical assessment:

to be completed by the end of Teaching Block 2:	15%
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Removable pros assignment

to be completed by the end of Teaching Block 3:	10%
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Written test Teaching block 1 (1 hour)	5%
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Written test Teaching block 2 (1.5 hours)	10%
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Written test Teaching block 3 (2 hours)	15%
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WCT test Teaching block 4 (2 hours)	15%
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Clinical Ranking Mark	20%
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If this Year Mark is 60% or more, the student will be exempted from the final assessment. If it is less than 40%, the student will have failed this Component and must repeat the year.

The “Hossack” case

This is named after a founding Head of the then Department of Prosthetic Dentistry here at Wits, and a respected teacher of removable prosthodontics. You are required to present a patient for whom you have made a complete set of dentures under limited clinical supervision. The case must first be approved by a Specialist member of the Department of Prosthodontics.

Clinical supervisors must be present when you see the patient at all times, but they will give no direct assistance. Laboratory work can be carried out by a dental technician, but you can, of course, do *all* the laboratory work if you wish, and you are encouraged to do so. The **final try-in stage** must be assessed by two internal assessors, before you may proceed further. A provisional mark (the average of the two) will be awarded at this stage. At **delivery**, another provisional mark will be awarded, again by two internal assessors. After sufficient recalls have been made and you and your patient are satisfied with the completed case, a **final mark** will be given after the case is fully presented to two internal assessors. Selected cases may be presented to the internal moderator or external examiner. If the patient fails to return, the final mark will become the mark given at delivery. If the try-in mark is less than 50%, then the maximum mark that can be obtained will be 50%. This case must be completed by the end of the second teaching block. See also section 3 below.

Fixed pros practical assessment

This will take place in the second teaching block. It will be a laboratory assessment in which students will be required to prepare abutment teeth for a 3-unit ceramo-metal bridge, and construct a provisional bridge on those preparations, within 3 hours. The criteria against which these will be assessed are as per the clinical assessment document.

Removable pros assignment

You are required to write up the case you carried out using a semi-adjustable articulator and face-bow recording. The report is to include patient selection and rationale, as well as your overall experience of the procedures, discussing those aspects of the case relating to the use of this type of articulator. The report should be no longer than the equivalent of four A4 pages single spaced, 12-point font, excluding illustrations. This is to be completed by the end of the third teaching block.

Written tests

A schedule for these (and all other assessments) will be drawn up in consultation with the School Education Committee (EduCom) for the year, and once determined, will only be changed under exceptional circumstances. This means that non attendance will mean receiving a mark of zero for the assessment. Only genuine cases of legitimate illness will be excused (but please note that a medical certificate *per se* is no guarantee), or other exceptional circumstance. The Department may then allow the student to sit another assessment: agreement on permission to write another assessment must be reached within 5 days of the missed assessment, otherwise

the mark of zero will stand. It is the student's responsibility in all cases to arrange for the deferred assessment.

WCT

Written Clinical Topics. These consist of short topics presented on screen (projected to the whole class) as a slide or diagram, to be answered by means of short notes. Generally, 5 minutes are allowed per answer, and there will usually be 24 questions covering both fixed and removable prosthodontics.

3. Minimum requirements

The practical assessment and assignment each carry a sub-minimum requirement of 50%. If this is not achieved, the relevant assessment will be repeated. If passed, a maximum mark of 50% will be given. If it is failed again, a *final* repeat will only be carried out during the last month of the course.

The Hossack clinical mark carries a sub-minimum requirement of 50%. If this is not achieved, a further case must be undertaken, and if satisfactory, a maximum mark of 50% will be given. If this is again not achieved, a third and final case must be attempted, to be completed by the end of the fourth teaching block.

The written tests carry a sub-minimum average requirement for the year, of 40%.

The written clinical topics test carries a sub-minimum requirement of 40%.

The Clinical Ranking Mark for the year carries a sub-minimum requirement of 50%.

Please note that failure to achieve any one of these sub-minimum requirements will mean that the Component is failed, and the student will repeat the year.

4. Year Mark

As the year mark is an aggregate of many marks, condonation will only be *considered* for an aggregate mark of 59%. If the Year Mark is 60% or more, the student will be exempt from the final assessment and the Year Mark will become the Component Mark.

5. Year Mark <60%

If the Component Year Mark is <60% (and $\geq 40\%$) then a final assessment will be taken. This will be a 2-hour clinically oriented written assessment for which the sub-minimum mark is 40%. Failure to achieve this will mean that no year mark will be allocated and the Prosthodontics Component has been failed.

The Final Mark is calculated as follows:

Component Year Mark 65%

Final Assessment Mark 35%

This mark must be at least 50% in order to pass this component. The mark awarded to this component will then be a *maximum* of 50%.

6. Component Year Mark >60%

Students may elect to improve their mark by taking the final assessment offered to students under 5 above, and the Final Mark is calculated in the same manner. If this final mark is higher than the Component Year Mark, then this final mark will become the Component Year Mark. If not, the original Component Year Mark will stand.

7. Supplementary assessment

If the student achieves a final mark of <50% (and $\geq 40\%$) a supplementary assessment will be offered. This takes the same form as the final assessment, and bears the same relationship to the Year Mark as did that assessment. Hence the supplementary mark comprises:

Year Mark	65%
Supplementary Assessment Mark	35%

If this Supplementary Mark is 50% or more, the student will pass with a Component Final Mark of a maximum of 50%. If it is less than 50%, the Component is failed.

8. Award of an 'A' symbol or first class mark for the Prosthodontic Component

An A symbol will be awarded to any student who obtains at least 65% for each assessment, and who is ranked within the top 10% of the class for each assessment.

APPENDIX 5.3

TOPICS TO BE COVERED

COURSE	TOPIC
PUBLIC ORAL HEALTH	<ol style="list-style-type: none">1. An awareness of the demographic composition of the community being served2. The principles involved in an assessment of the needs of the community being served, and methods of prioritizing treatment3. The socioeconomic factors involved in the provision of a partial denture service and the applicability of a partial denture service4. The ability to assess the socio-economic implications of the provision of a complete denture service especially for the underserved and disadvantaged5. The place of a complete denture service in the context of a national oral health policy6. The socioeconomic factors involved in the provision of advanced restorative dentistry and fixed Prosthodontics7. The place of such a service in the context of a national oral health policy
COMPLETE DENTURES	<ol style="list-style-type: none">1. Behavioural science<ol style="list-style-type: none">A) behaviour modificationB) behavioural aspects of denture wearing and associated habits2. Occlusion revision3. Primary impressions<ol style="list-style-type: none">a) alternative techniques4. Final impressions<ol style="list-style-type: none">a) alternative techniques5. Pre-prosthetic surgery6. Duplicate dentures7. Overdentures8. Implants9. Why dentures fail10. Management of problems and

	<p>correction of errors</p> <p>11. Techniques appropriate to general dental practice</p>
FIXED PROSTHODONTICS	<ol style="list-style-type: none"> 1. Occlusion <ol style="list-style-type: none"> a) choice of articulator b) wear of materials 2. Colour Science and dental art <ol style="list-style-type: none"> a) principles and definition b) shade selection procedures and methods 3. The perio-prosthodontic interface 4. restoration of the periodontally compromised tooth 5. Acid – etch retained prostheses <ol style="list-style-type: none"> a) history, types and indications b) Rochette bridges c) Maryland bridges d) All porcelain bridges 6. Precision attachments 7. Management of problems, causes of failure, and correction of errors 8. Techniques appropriate to general dental practice including treatment and financial planning
REMOVABLE PARTIAL DENTURES	<ol style="list-style-type: none"> 1. Techniques appropriate to general dental practice 2. Design exercises 3. Conventional dogma vs. evidence-based perspectives on partial dentures

APPENDIX 5.4

MARKING POLICY

MARKING POLICY IN THE DEPARTMENT OF PROSTHODONTICS

As a result of having to go practically word by word through papers with students who failed (and whose parents didn't believe it!), I raised the question of uniformity of marking and of marking memoranda at the last Departmental meeting. I was requested to put a few things down in a 'policy paper', which is what this is.

Marking

The principle here, is that the marks indicated on the paper and for each question, are calculated at the rate of a mark a minute, in order to guide the students into knowing how long they are expected to spend on the question, and therefore how much depth is required of that answer.

BUT, when marking a question, the principle to be followed is not to give marks according to that time determined mark, but to give a *percentage* mark. The era of computers is now old enough for there to be no excuse as to how to work out, say, 45% of an 18-mark question, because the computer will do it for us!

Quite apart from that, though, is the related and far more important question of the degree of discrimination with which it is possible to mark in the first place. If you mark to a 1% discrimination level, ask yourself this: do you honestly think you can get close to that if you re-mark one week later, not knowing what mark you gave in the first place? No, of course you can't. But if you mark at 5% intervals, your own intra-rater reliability will be far greater. Can you really tell the difference between 52% and 50%? No, of course you can't. But you definitely know the difference between 50% and 55%, don't you?

So, the principle to be followed is this: ***Only give a percentage mark and only mark at 5% intervals.***

Feedback

All questions other than those for a final examination are for both summative *and* formative assessment. They are both as important as the other, in fact it could be said that the formative nature of the assessment is often *more* important. This means that you should annotate the questions liberally with your comments, and the students should be told just where they have gone wrong (or right!). It is in our own best interests to do this, because as you know, marking a good answer is always easier than marking a bad answer.

Now this annotation does mean a greater commitment to marking, but can be made easier, again by having computers come to the rescue. If you find after marking a few questions that there are some common errors, and you are making the same or similar comments, type these into your computer (with a very small font of about 8 or 9 point) and print them out, cut them up and paste them on to the student answers! Saves an awful lot of time, and, more importantly, gives you a very good indication of what to concentrate on when you give the feedback, *and* when next you teach that topic!

Final exams are a little different. Now, you do not want to unduly influence an independent, external marker, and so you should only give a mark, and NOT annotate the paper in ANY way at all. In other words, NO TICKS! If a student asks to see the paper, it is possible for them to add up the ticks, and ask why the mark is less than the ticks. Try explaining *that* to an irate parent.

Moderation

A word about moderation. All courses should be moderated, and some should be externally examined. In the past, we have referred to an 'internal external' and an 'external external'. Current parlance is that someone from within the School or University (the 'internal external') can act as an *internal moderator*, and should be moderating at least 50% of the assessments, including approving the questions asked. An *external examiner* is normally used for the final stages in a course, for integrated assessments, and for any other assessments a Department may deem necessary.

An internal moderator and an external examiner should examine a representative proportion of answers, from the bottom, middle, and top of the range of all answers.

Memoranda

Some marking memoranda are in fact full and perfect answers. This is nice, but not necessary, and very time consuming. It is also difficult to know at what level to give the mark, if there is no indication (as there generally is not), of just what constitutes an acceptable pass mark and what constitutes a perfect mark. Such memoranda, wonderful as they are, are not a lot of help for marking.

Instead, it is better to list a series of points which you feel ought to be covered by a student answering a question at that particular level. Some of these points can then be identified as the minimum required to obtain a passing mark (50%). The degree of conformity of the answer to the remaining points will then give an indication of the actual mark to be awarded between 50% and 100%. And yes, it should be possible to obtain 100%. If a student returns everything on your list, why not give 100%?

Similarly, if the minimum points are not present in the answer, then the maximum mark that can be obtained is 45%, and the actual mark will be between 0% and 45%, depending on the presence or absence of any other points.

Another alternative works quite well for such things as partial denture designs. Here, it is often best to assume that 100% is the starting point, and then *deduct* marks (again, 5% at a time) for errors identified in the design. Certain errors might be considered cardinal sins, and if present, cause the maximum mark permissible to be 45%. Some errors, or combinations of errors may be specified as requiring a mark of 0%. For example, for a design that can be drawn, but simply cannot be made!

Setting questions

No question or series of questions should ever be set by one person, without the advantage and advice of an independent group. That is why we have established an assessment committee. Preferably, all questions to be asked during a term should be determined at the start of that term, and all these questions put to that committee at one time. Then you will have an independent view on the suitability of those questions, and their relation to the competencies to be tested.

As a matter of principle, all questions should be tested for the appropriateness of the learning domain to be tested, as well as for their relationship to the relevant competency. Once again, a collective opinion on these matters is important, and there are several examples available for the types of questions in Prosthodontics and their relation to learning domains which will guide you in asking, and marking, questions.

APPENDIX 5.5

BEST SYSTEM

GUIDELINES FOR THE ALLOCATION OF CLINICAL MARKS

These guidelines are related to the procedure(s) or stage(s) of a procedure carried out during a clinical session, and they serve as modifiers to the mark given for the session code.

Students are expected to present a procedure or a required stage of a procedure when they are of the opinion that it is satisfactory. Students may enquire of their supervisor if unsure as to the satisfactory nature of what they are presenting, but this enquiry may be taken into account depending on the student's experience with the procedure, and year of study.

YEAR	MARK			
	B	E	S	
5	<p>No fault is found.</p>	<p>A correction is required, which is then carried out without any difficulties or assistance.</p> <p>Also, student readily knows and understands what is required, even if the fault was not initially recognised.</p>	<p>A correction (or more than one) is required but is not carried out satisfactorily the first time. Also, or alternatively, the student has insufficient knowledge of the correct procedure.</p> <p>Also, or alternatively, the fault (or faults) was, or were not, recognised or understood.</p> <p>One enquiry is made as to any correction required</p>	<p>S</p> <p>su</p> <p>ca</p> <p>w</p> <p>T</p> <p>an</p> <p>T</p> <p>in</p> <p>W</p> <p>in</p>
4	<p>No fault is found.</p> <p><i>If procedure has not been carried out before:</i> a correction is required which is then carried out without any difficulties or assistance, and student readily knows and understands what is required, and knows the procedure to be carried out.</p>	<p>A correction is required which is then carried out satisfactorily, and the student recognises the problem, and understands what is required.</p> <p>Some procedures or stages may have to be demonstrated beforehand.</p> <p>One enquiry may be made as to any correction required</p>	<p>A correction (or more than one) is required but is not carried out satisfactorily the first time, even though the student knows and understands what is required.</p> <p>More than one enquiry is made as to any correction required</p> <p>The fault/problem is not solved without assistance.</p>	<p>S</p> <p>su</p> <p>ca</p> <p>T</p> <p>an</p> <p>T</p> <p>in</p> <p>W</p> <p>in</p>

<p>3</p>	<p>No fault is found, or a correction is required, which the student obviously knows and understands, and carries out satisfactorily the first time.</p> <p>One enquiry may be made as to any correction required</p> <p>Student carries out procedure satisfactorily even if procedure is demonstrated beforehand.</p> <p>Laboratory work where applicable is satisfactory</p>	<p>A correction (or more than one) is required but is not carried out satisfactorily the first time, even though student knows and understands what is required.</p> <p>More than one enquiry may be made as to any correction required</p> <p>Procedure or stage may be demonstrated beforehand.</p> <p>Laboratory work where applicable is satisfactory</p>	<p>A correction (or more than one) is required but is not carried out satisfactorily the first time. Student has insufficient knowledge of the procedure.</p> <p>The fault/problem is not solved without assistance.</p> <p>Laboratory work where applicable is not satisfactory but can be corrected in time to carry out the clinical procedure</p>
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APPENDIX 6: DLP CASES



UNIVERSITY OF THE WITWATERSRAND SCHOOL OF ORAL HEALTH SCIENCES

Dental Learning Package IV.6

How do we help Mark?

(Treatment alternatives)

Session 1	27.07.07	2pm	DGA / CHSE
Session 2	24.08.14	2pm	CHSE
Session 3 (Plenary)	31.08.07	DGA	
Test	21.09.07	DGA	

INTRODUCTION

This DLP has been designed to allow you to consider treatment alternatives using an actual patient being treated in our clinics

RESOURCE MATERIALS

Prescribed texts / manuals / lecture notes from all your clinical disciplines

Personal communication: consult any of your tutors in the various departments.

ASSESSMENT

1. Assessment of facilitators by students: in the plenary session
2. Affective Assessment of students by facilitators: throughout the DLP
3. Cognitive Assessment of learning outcomes: TEST.

Session 1

Follow the normal routine for PBL, ie: elect chair, scribe & timekeeper

Scenario:

Mark is a patient in the School of Dentistry, University of the Witwatersrand. He is 17 years old, an only child, who came for the appointment with his mother. Both parents are professionals, and the family lives in an upper class suburb.

Mark has congenitally missing teeth, and has been receiving treatment at our School since 1993.

A diastema between the 11 & 21 was closed orthodontically, and a partial upper denture was constructed in chrome cobalt to replace missing 12 & 22. The deciduous lower anterior teeth were extracted at age 12, and a partial lower chrome cobalt denture was constructed. However Mark never managed to adapt, and has been unable to wear the lower denture.

Mark and his mother are now concerned about his appearance, and also the difficulty in chewing. He is now in matric, and although he is performing well at school, has become rather withdrawn socially.

They are keen to have treatment that will be more definitive, as he is now fully grown, and may not be on his parent's medical aid for much longer.

Marks mother says that she wants the "best" for him, and that money is no objection.

- (i) Examine the photographs, models and radiographs
- (ii) Form a diagnosis and consider what treatment alternatives are available
- (iii) Consider which alternatives may be most appropriate for Mark, and the time-frame for these
- (iv) .Discuss the benefits, risks, advantages and disadvantages of the various treatment modalities

Now draw up alternate treatment plans for the following hypothetical cases:

1. The patient is poor, attends a rural clinic, having no access to specialist care, or a Dental School.
2. The patient attends a family practice. The father has a moderate income, mother is a housewife, and there are 4 more children in the family.

Session 2

1. All learning issues will be covered during the report back.
Members of the group will report back on their research findings.
Each group member should provide copies of their report to the rest of the group, so they can prepare for the TEST based on this DLP.
2. The learning issues will be elaborated during group discussion.
Please note that this session should **not** be a “reading back” of the research material, active discussion should take place. One way to encourage this is for the reporter to give a brief overview of the topic, and then engage the rest of the group via questions and provide assistance in understanding of the learning objectives.
3. The group will then make plans for preparing a presentation for the plenary session.

Session 3

Plenary Session

- Students will fill in facilitator evaluation forms.
- Groups will give presentations to the class.
- Students are advised to take notes of anything not covered in their own group.
- Discussions will follow.
- All students should be prepared to contribute / participate during the plenary.
- Facilitator assessment continues during this session.

Test:

Friday, 21st September, 2007 in the DGA, 2-3pm.



UNIVERSITY OF THE WITWATERSRAND SCHOOL OF ORAL HEALTH SCIENCES

Dental Learning Package IV.6

How do we help Mark?

(Treatment alternatives)

FACILITATOR GUIDE

Briefing	23.07.07	1pm	Room12, 8 th floor
Session 1	27.07.07	2pm	DGA / CHSE
Session 2	24.08.14	2pm	CHSE
Session 3 (Plenary)	31.08.07	2pm	DGA
Debrief	31.08.07	4pm	DGA
Test	21.09.07	2pm	DGA

INTRODUCTION

This DLP has been designed to allow students to consider treatment alternatives using an actual patient being treated in our clinics.

RESOURCE MATERIALS

Prescribed texts / manuals / lecture notes from all clinical disciplines

Personal communication: consultation with any tutors in the various departments.

ASSESSMENT

1. Assessment of facilitators by students: in the plenary session
2. Affective Assessment of students by facilitators: throughout the DLP
3. Cognitive Assessment of learning outcomes: TEST.

Session 1

Introductions

As these are senior dental students, introductions are no more necessary.

Clearing

At the beginning of any and each small group session, go round the group, and each person (including the facilitator), should tell the group what is presently occupying their head space. Only after unloading current preoccupations, can a group member truly focus on the task of the group.

Preliminaries

Elect officials, set ground rules (norms).

The Problem

Read trigger individually, or preferably, as a group.

Mark is a patient in the School of Dentistry, University of the Witwatersrand. He is 17 years old, an only child, who came for the appointment with his mother. Both parents are professionals, and the family lives in an upper class suburb.

Mark has congenitally missing teeth, and has been receiving treatment at our School since 1993.

A diastema between the 11& 21 was closed orthodontically, and a partial upper denture was constructed in chrome cobalt to replace missing 12 & 22. The deciduous lower anterior teeth were extracted at age 12 and a partial lower chrome cobalt denture was constructed. However Mark never managed to adapt and has been unable to wear the lower denture.

Mark and his mother are now concerned about his appearance, and also the difficulty in chewing. He is now in matric, and although he is performing well at school, has become rather withdrawn socially.

They are keen to have treatment that will be more definitive as he is now fully grown, and may not be on his parent's medical aid for much longer.

Marks mother says that she wants the "best" for him, and that money is no objection.

- (i) Examine the photographs, models and radiographs.
- (ii) Form a diagnosis and consider what treatment alternatives are available
- (iii) Consider which alternatives may be most appropriate for Mark, and the time-frame for these
- (iv) Discuss the benefits, risks, advantages and disadvantages of the various treatment modalities.

Now draw up alternate treatment plans for the following hypothetical cases:

- 1 The patient is poor, attends a rural clinic, having no access to specialist care, or a Dental School.
- 2 The patient attends a family practice. The father has a moderate income, mother is a housewife, and there are 4 more children in the family.

Clarification

Ask the group whether there are any words or concepts, which need to be clarified for a full understanding of the problem.

Buzz Groups

Put the students into pairs or triads, and let them discuss the problem.

Brainstorm

This is a group activity.

The goal here is to record key words representing the main concepts in a non-threatening way. All suggestions must be treated seriously. The scribe records the main key words from the group (one or two words only). You may sometimes need to prompt them into the issues that need to be considered.

Organise

The students can now try to group some of the words to develop learning objectives.

Finalising of Issues

The main ideas can be grouped and listed. Some of these can be identified as topics that can be discussed immediately. Others will be identified as learning objectives, which will

require the gathering of more information before they can be meaningfully discussed at the next session. Everyone must agree on these issues.

Session 2

Report back (small groups)

1. All learning issues will be covered during the report back.
Members of the group will report back on their research findings.

Each group member should provide copies of their report to the rest of the group, so they can prepare for the TEST based on this DLP.
2. The learning issues will be elaborated during group discussion.

Please note that this session should *not* be a “reading back” of the research material, active discussion should take place. One way to encourage this is for the reporter to give a brief overview of the topic, and then engage the rest of the group via questions and provide assistance in understanding of the learning objectives.
3. The group will then make plans for preparing a presentation for the plenary session.

NB. Remember to fill in assessment forms as each student presents.

Session 3

Plenary Session (whole class)

- Students will fill in facilitator evaluation forms.
- Groups will give presentations to the class.
- Students are advised to take notes of anything not covered in their own group.
- Discussions will follow.
- All students should be prepared to contribute / participate during the plenary.
- Assessment of students by facilitators continues during this session.

Debriefing

Facilitators will meet immediately after the plenary to discuss the DLP.

Test

Friday, 21st September, 2007 in the DGA, 2-3pm



**UNIVERSITY OF THE WITWATERSRAND
SCHOOL OF ORAL HEALTH SCIENCES**

Dental Learning Package IV.2

The Patient with Special Needs

Contents

- Introduction
- Resource Materials
- Session 1 20.09.07 2.00 – 4.00 CHSE
- Session 2 04.10.07 2.00 – 4.00 CHSE
- Plenary Session 18.10.07 2.00 – 4.00 DGA

Facilitators: Dr Mistry*/ Dr Dave Bankowitz* / Prof Green*

Introduction

This DLP is designed to start broadening your concepts governing treatment of your patients, and start modifying your approach to suit different kinds of patients with special needs. The knowledge gained from this DLP will form the basis for your more detailed studies of these classes of patients in the different CORE COMPONENTS.

Resource Materials

Mitchell D. A & Mitchell L: Oxford Handbook of Clinical Dentistry – Latest edition

McDonald RE and Avery D (2000): Dentistry for the Child and Adolescent; 7th Edition, Mosby, Inc.

SOHS - Manual of Paediatric Dentistry

Wilkins Esther M: Clinical Practice of the Dental Hygienist Chapter VI. 8th Ed. Williams & Wilkins

Barnes (1944): Gerodontology; Oxford Publications

Journals in the FHS library:
Special Care in Dentistry

Session 1

Activation of prior knowledge

You are now senior dental students in the School of Oral Health Sciences. You have had training in the basic sciences, basic medical sciences, general medicine and surgery, and some clinical experience in delivering treatment. Until now you have been following exactly the techniques presented in your lectures and manuals. It is now time to begin to realise, that one size does not fit all, and people have special needs at different times of their lives, or in different states of health, as well as different socio-economic or cultural situations.

The challenge of this DLP is for you to develop a mind map of those special life situations which may require that you adapt your approach to treatment. Once you have your mind map, research the guiding principles according to which you will modify your way of treating people in the various categories, and discuss how the approach and treatment will vary for each group, and why.

Suggested approach

1. Analyse the problem carefully.
2. What issues need to be considered here? (brainstorm)
3. Organise the types of Special Patient in a mind map
4. Suggest some special principles guiding treatment for each type
5. Define the learning objectives
6. Decide how the group will tackle researching and presenting these issues

Please bring with you a copy of the report of your research for each member of the group, to enable them to prepare for the TEST to follow the plenary.

Session 2

Elaboration of knowledge

Report on your research findings. Please note that this session should ***not*** be a “reading back” of the research material. Prepare a report on your research, with copies for each member of the group. Your presentation should be a summary and explanation of your written report. Make sure that you have a thorough understanding of your topic, so you can answer any questions. Active discussion should take place. One way to encourage this is for the reporter to give a brief overview of the topic, and then engage the rest of the group via questions and provide assistance in understanding of the learning objective.

Each student’s report back should not be too long, so that enough time is available for discussion. Each reporter should obtain feedback from the facilitator and the other students.

You should also allocate time to discuss the form and content of the presentation for the plenary. Plan a meeting to prepare your material for presentation. Each group will present! Marks will be allocated for good presentation and discussion.

Session 3

Plenary Session

Presentation

All groups will give a presentation to the whole class. All students should be prepared to contribute / participate during the plenary. Facilitator assessment continues during this session.

Facilitator Assessment

You are given the opportunity to give feedback on your facilitators anonymously. This will assist us in improving any matters of facilitation, which may need attention.

Test

A 1 hour test will be scheduled to follow this DLP. The date will be arranged by consultation.



UNIVERSITY OF THE WITWATERSRAND SCHOOL OF ORAL HEALTH SCIENCES

Dental Learning Package IV.2

The Patient with Special Needs

FACILITATOR GUIDE

Contents

Introduction

Resource Materials

Objectives

Briefing	14.09.07	10.00	Room 12, 8th floor
Session 1	20.09.07	2 – 4	CHSE
Session 2	04.10.07	2 – 4	CHSE
Plenary Session	18.10.07	2 – 4	DGA
Debriefing	18.10.07	4 – 4.30	DGA

Introduction

This DLP was designed to start broadening students' concepts governing treatment of patients, and to make them aware, that we need to modify our approach to suit different kinds of patients with special needs. The knowledge gained from this DLP will form the basis for more detailed studies of these classes of "special patients" in the different CORE COMPONENTS.

Objectives

- Develop a mind map illustrating the different groups of patients with special needs
- Investigate in depth the special needs and their implications for the management of each group

Resource Materials

Mitchell D. A & Mitchell L: Oxford Handbook of Clinical Dentistry – Latest edition

McDonald RE and Avery D (2000): Dentistry for the Child and Adolescent; 7th Edition, Mosby, Inc.

SOHS - Manual of Paediatric Dentistry

Wilkins Esther M: Clinical Practice of the Dental Hygienist Chapter VI. 8th Ed. Williams & Wilkins

Barnes (1944): Gerodontology; Oxford Publications

Journals in the FHS Library:
Special Care in Dentistry

Session 1

Activation of prior knowledge

The format of this DLP will follow that of the previous ones.

Introductions

As these are senior dental students, and know each other well, introductions are not necessary. However at the beginning of any and all small group sessions it is necessary to do clearing. PLEASE DO NOT SKIP ON THIS.

Preliminaries

Elect officials, set ground rules (norms).

The Problem

Read trigger individually or as a group.

“You are senior dental students in the School of Oral Health Sciences. You have had training in the basic sciences, and some clinical experience in delivering treatment. Until now you have been following exactly the techniques presented in your lectures and manuals. It is now time to begin to realise, that one size does not fit all, and people have special needs at different times of their lives, or in different states of health, socio-economic or cultural situations.

The challenge of this DLP is for you to develop a list of those special life situations which may require that you adapt your approach to treatment. Once you have your list, research the guiding principles according to which you will modify your way of treating people in the various categories, and discuss how the approach and treatment will vary for each group.”

Clarification

Ask the group whether there are any words or concepts which need to be clarified for full understanding of the problem.

Buzz Groups

Put the students into pairs or triads, and let them discuss the problem.

Brainstorm

This is a group activity.

The goal here is to record key words representing the main concepts in a non-threatening way. All suggestions must be treated seriously. The scribe records the main key words from the group (one or two words only). You may sometimes need to prompt them into the issues that need to be considered.

Organise

- Mind map the categories of special patients
- Suggest some guiding principles for each category

Finalising of Issues

Some of the issues can be identified as topics that can be discussed immediately. Others will be identified as learning issues which will require the gathering of more information before they can be meaningfully discussed at the next session. Everyone must agree on these issues.

Allocating Tasks

Issues may be tackled singly or in pairs.

Make sure, that all issues are allocated, and everyone has a job.

Session 2

Elaboration of knowledge

Reports on research findings (fill in assessment slips!!!)

Please note that this session should ***not*** be a “reading back” of the research material. Students must have prepared a report on their research, with copies for each member of the group. The presentation should be a summary and explanation of the written report. Students should have a thorough understanding of their topic, so they can answer questions from the group. Active discussion should take place. One way to encourage this is for the reporter to give a brief overview of the topic, and then engage the rest of the group via questions and provide assistance in understanding of the learning objective.

Each student’s report back should not be too long, so that enough time is available for discussion and feedback on the presentation from the reporter and the group.

Students should also allocate time to discuss the form and content of the presentation and the Group Report. They may plan a meeting to prepare the material for presentation at the plenary session. You can offer to attend this meeting, and give assistance with these tasks.

Remember to give feedback on their performance during the whole of the DLP. This session presents a particularly good opportunity for you and the group to make suggestions to each presenter at the end of their presentation, on how they could improve.

Session 3

Plenary Session

All groups will be give a presentation to the whole class. All students should be prepared to contribute / participate during the plenary. Facilitators should continue to assessment the

students' contribution during this session. Students can earn extra marks for good presentation or engaging in discussion.

Please complete and hand in the assessment forms to the chair.

DO NOT FORGET THE DEBRIEFING MEETING FOR ALL THE FACILITATORS THAT IS TO FOLLOW.



UNIVERSITY OF THE WITWATERSRAND

SCHOOL OF ORAL HEALTH SCIENCES

Dental Learning Package V.3
2007

Case presentation: Department of Maxillofacial and Oral Surgery

Contents:

Introduction

Goals

Assessment

Session 1	FRIDAY May 6:	11.00 – 12.45	DGA / CHSE
Case presentation to whole class, followed by small group sessions			
Session 2	FRIDAY May 13:	11.00 – 12.45	CHSE
Resource session without facilitator			
Session 3	FRIDAY May 20:	11.00 – 12.45	CHSE
Report back small group sessions with facilitator			
Session 4	FRIDAY May 27:	11.00 – 12.45	CHSE
Resource session without facilitator			
Session 5	FRIDAY June 3:	11.00 – 12.45	DGA
Plenary session with whole class			

roduction

clinical case will be presented by the Division of Maxillo-facial and Oral Surgery, whose problems are of
n complexity, that no single solution may be appropriate. Also, the solutions may not be limited to that
ipline. You will be expected to propose 3 different treatment plans, and to justify the rationale for each.

als

- Thoroughly study the information provided for the case
- Discuss the issues governing possible different treatment decisions
- Understand, that there is no ideal treatment plan, and the treatment has to be appropriate to a particular patient's needs and life situation
- Decide on 3 alternative treatment plans, and justify these based on evidence from the scientific literature
- The 3 treatment plans should be appropriate to the following situations:
 - 1 a patient with no financial means, who has time and access constraints being treated by you at a rural clinic
 - 2 a patient with average means and no time constraints in your suburban practice
 - 3 a patient with no financial or time constraints

ssion 1

Case presentation..

This will be delivered by the Division of Maxillo-facial and Oral Surgery

Resource materials

You may be given copies of the case history, radiographs and models or be expected to take notes from the presentation. Please ask the presenter for any additional information you feel you may need.

Working groups

The class will organize itself into 4 small groups, and facilitators will be allocated. The groups will relocate to the CHSE to discuss the case, draw up a working plan, and allocate tasks to the members of the group.

ssion 2

Source session without the facilitator.

Each group should meet to discuss progress, propose need for additional study / research, difficulties, possible requests for assistance etc.

ssion 3

Report back session for the groups with the facilitator in order to:

report back on their findings

discuss their plans for the Group Report

discuss their plans for the presentation

A thorough discussion of the case must take place. Note that it is important that all members of the group should be familiar with all aspects of the work. You are advised to provide copies of the area you have researched to the rest of the group by this session, to enable them to prepare themselves for full and meaningful participation in the report and the presentation. You must understand the whole, to decide how and where your researched area should contribute. Questions will be posed in the plenary by the facilitators to any / all members of the groups to ascertain their knowledge. Marks will be allocated for degree of participation.

ssion 4

Source session without the facilitator.

This session has been allocated to allow you to finalise the presentation and the report, in order that a high standard should be achieved. Full participation must be ensured by the members of the group in the development of the report and presentation

Session 5

enary session with the whole class and all facilitators, as well as invited members of Departments contributing the treatment plan and plan of treatment.

A group will be chosen to present.

Discussion may take place during or after the presentation, according to the ground rules recommended by the presenting group. Any members of the class may be questioned by the facilitators on any aspects of the case for assessment.

Conclusion

There will be a presentation of the treatment plan and plan of treatment by the Division of Maxillo-facial and Oral Surgery .

Evaluation of facilitators by students

Reports must be handed in to the facilitators for assessment. No extensions will be granted.



UNIVERSITY OF THE WITWATERSRAND

SCHOOL OF ORAL HEALTH SCIENCES

Dental Learning Package V.3

Case presentation: Department of Maxillofacial and Oral Surgery

FACILITATOR GUIDE

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Resource session without facilitator

Session 3 FRIDAY May 20: 11.00 – 12.45 CHSE
Report back small group sessions with facilitator

Session 4 FRIDAY May 27: 11.00 – 12.45 CHSE
Resource session without facilitator

Session 5 FRIDAY June 3: 11.00 – 12.45 DGA
Plenary session with whole class

Debriefing Friday June 3: 12.45 – 13.15 DGA

Introduction

Clinical case will be presented by the Division of Maxillo-facial and Oral Surgery, whose problems are of a complexity, that no single solution may be appropriate. Also, the solutions may not be limited to that discipline. You will be expected to propose 3 different treatment plans, and to justify the rationale for each.

Goals

- Thoroughly study the information provided for the case
- Discuss the issues governing possible different treatment decisions
- Understand, that there is no ideal treatment plan, and the treatment has to be appropriate to a particular patient's needs and life situation
- Decide on 3 alternative treatment plans, and justify these based on evidence from the scientific literature
- The 3 treatment plans should be appropriate to the following situations:
 - 4 a patient with no financial means, who has time and access constraints being treated by you at a rural clinic
 - 5 a patient with average means and no time constraints in your suburban practice
 - 6 a patient with no financial or time constraints

For each treatment plan, give a plan of treatment, including sequencing, and who would carry out the various phases

Assessment / evaluation

This will take three forms:

1. Assessment of student performance by facilitators
2. Assessment of a report handed in by the group (a group mark as well as individual marks based on participation will be given).
3. Evaluation of facilitators by students (This will only be made available to the facilitators after the reports have been marked, so please give an honest appraisal, and assist us in finding out where additional improvement is necessary in the programme)

Session 1

- | | |
|----------------------------------|---|
| 1. Case presentation.
Surgery | This will be delivered by the Division of Maxillo – facial and Oral |
| 2. Resource materials | Students will be given copies of the case history, radiographs and models, or will be expected to take notes during the presentation. Students should ask the presenter for any additional information they feel may be needed. |
| 3. Working groups | The class will organize itself into 4 small groups, and facilitators will be allocated
The groups will be relocated to the CHSE to discuss the case, draw up a working treatment plan, and allocate tasks to the members of the group. |

Session 2

Resource session without the facilitator
The group should meet to discuss progress, propose need for additional study / research, difficulties, possible requests for assistance etc.

Session 3

Report back session for the groups with the facilitator in order to:

- 1. Report back on their findings
- 2. Discuss their plans for the report
- 3. Discuss their plans for the presentation

A thorough discussion of the case must take place.
Note that it is important that all members of the group should be familiar with all aspects of the work. You are advised to provide copies of the area that you have researched to the rest of the group by this session, to enable them to prepare themselves for full and meaningful participation in preparing the report and the presentation. You must understand the whole, to decide how and where your researched part should contribute. Questions will be posed in the Plenary by the facilitators to any / all members of the class to ascertain their knowledge. Marks will be allocated for degree of participation.

Session 4

Resource session without the facilitator.
This session has been allocated to allow you to finalise the presentation and the report, in order that a high standard should be achieved. Full participation must be ensured by the members of the group in the development of the report and presentation.

SESSION 5

Plenary session with the whole class and all facilitators, as well as invited members of Departments contributing to the treatment plan and plan of treatment.

- 1. A group will be chosen to present
- 2. Discussion may take place during or after the presentation, according to the ground rules recommended by the presenting group. Any member of the class may be questioned by the facilitators on any aspects of the case for assessment.
- 3. Conclusion
There will be a presentation of the actual treatment plan and plan of treatment by the Division of Maxillo-facial and Oral Surgery

Reports must be handed in to the facilitators for assessment. No extensions will be granted

DO NOT FORGET THE DEBRIEFING



UNIVERSITY OF THE WITWATERSRAND

SCHOOL OF ORAL HEALTH SCIENCES

Dental Learning Package V.3

Case presentation: Division of Maxillo-facial and Oral Surgery

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Resource session without facilitator

Session 3 FRIDAY May 20: 11.00 – 12.45 CHSE

Report back small group sessions with facilitator

Session 4 FRIDAY May 27: 11.00 – 12.45 CHSE

Resource session without facilitator

Session 5 FRIDAY June 3: 11.00 – 12.45 DGA

Plenary session with whole class

Debriefing FRIDAY June 3: 12.45 – 13.15 DGA

Introduction

A clinical case will be presented by the Division of Maxillo-facial and Oral Surgery, whose problems are of such complexity, that no single solution may be appropriate. Also, the

solutions may not be limited to that discipline. You will be expected to propose 3 different treatment plans, and to justify the rationale for each.

Goals

- Thoroughly study the information provided for the case
- Discuss the issues governing possible different treatment decisions
- Understand, that there is no ideal treatment plan, and the treatment has to be appropriate to a particular patient's needs and life situation
- Decide on 3 alternative treatment plans, and justify these based on evidence from the scientific literature
- The 3 treatment plans should be appropriate to the following situations:
 - a patient with no financial means and time constraints, whom you would treat at a government clinic
 - a patient with average means, and no time constraints
 - a patient with unlimited time and financial resourcesFor each treatment plan, give a plan of treatment, including sequencing, and who would carry out the various phases.

Assessment / evaluation

This will take three forms

- 1 Assessment of student performance by facilitators
- 2 Assessment of a report handed in by the group.
(A group mark as well as individual marks based on participation will be given.)
- 3 Evaluation of facilitators by students.
(This will only be made available to the facilitators after the reports have been marked, so please give an honest appraisal, and assist us in finding out where additional improvement is necessary for the program)

Session 1

- | | |
|-----------------------|---|
| 1. Case presentation. | This will be delivered by the Division of Maxillo-facial and Oral Surgery |
| 2. Resource materials | Students will be given copies of the case history, radiographs and models, or will be expected to take notes during the presentation. |

Students should ask the presenter for any additional information they feel may be needed.

3. Working groups

The class will organize itself into 4 small groups, and facilitators will be allocated

The groups will relocate to the CHSE to discuss the case, draw up a working plan, and allocate tasks to the members of the group.

Session 2

Resource session without the facilitator

The group should meet to discuss progress, propose need for additional study / research, difficulties, possible requests for assistance etc.

Session 3

Report back session for the groups with the facilitator in order to:

- 1 report back on their findings
- 2 discuss their plans for the report
- 3 discuss their plans for the presentation

A thorough discussion of the case must take place

Note that it is important that all members of the group should be familiar with all aspects of the work. You are advised to provide copies of the area you have researched to the rest of the group by this session, to enable them to prepare themselves for full and meaningful participation in preparing the report and the presentation. You must understand the whole, to decide how and where your researched part should contribute. Questions will be posed in the plenary by the facilitators to any / all members of the class to ascertain their knowledge. Marks will be allocated for degree of participation.

Session 4

Resource session without the facilitator.

This session has been allocated to allow you to finalise the presentation and the report, in order that a high standard should be achieved. Full participation must be ensured by the members of the group in the development of the report and presentation

Session 5

Plenary session with the whole class and all facilitators, as well as invited members of Departments contributing to the treatment plan and plan of treatment.

- 1 A group will be chosen to present.
- 2 Discussion may take place during or after the presentation, according to the ground rules recommended by the presenting group.

Any members of the class may be questioned by the facilitators on any aspects of the case for assessment.

3 Conclusion

There will be a presentation of the actual treatment plan and plan of treatment by the Division of Maxillo-facial and Oral Surgery.

Reports must be handed in to the facilitators for assessment. No extensions will be granted.

DO NOT FORGET THE DEBRIEFING

APPENDIX 7: ETHICAL CLEARANCE

Wits School of Education

27 St Andrews Road, Parktown, Johannesburg, 2193 • Private Bag 3, Wits 2050, South Africa
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Ggg

9613913H
2007ECE81

STUDENT NUMBER:

Protocol:

27-Sep-07

Dr. PD Moipolai
Conservative Dentistry
WITS
2050

Dear Dr. Moipolai

Application for Ethics Clearance: Master in Education

I have pleasure of advising you that the Ethics Committee in Education of the Faculty of Humanities, acting on behalf of the senate has agreed to approve your application for ethics clearance submitted for your proposal entitled:

An illuminative evaluation of a prosthodontic curriculum

Recommendation:

Ethics clearance is granted

Yours sincerely

Matsie Mabeta
Wits School of Education

Cc: Supervisor: Prof. R Basson (via email)

APPENDIX 8: Consent Letter - Staff

Informed Consent Form & Information Letter

Wits School of Education

University of the Witwatersrand

Project on Evaluating the SOHS Prosthodontic Curriculum

STAFF LETTER

Dear (Mr, Mrs, Miss, Ms, Dr, Prof)_____

Hello. I am Pusetso Moipolai and I work in the Department of Prosthodontics, School of Oral Health Sciences (SOHS), University of the Witwatersrand and currently enrolled with the Wits School of Education studying for a Masters of Education degree in Curriculum Studies.

As part of my study programme, I have to undertake a research project. As you might be aware, the SOHS underwent curriculum transformation, with the “new” curriculum being implemented in 2001. Since implementation there has not been a formal evaluation of the curriculum (using qualitative research methodology) to document in its own terms, how both students and staff (Faculty) have experienced this innovation. My research project will therefore focus on evaluating how the curriculum is performing – whether it is doing what it meant to do. May I therefore invite you to assist me by participating in the study.

The study will require you to be observed during the normal teaching and learning sessions and then interviewed to follow up on these. This will probably take about 30 minutes of your time and will be arranged to not interfere adversely with your schedule.

The study will also include an audio recording of you involved in the learning and teaching activities during the teaching block, specifically the PBL small group sessions, integrated learning sessions and prosthodontic tutorials.

Participation in the study is voluntary. If you do not wish to participate, or withdraw at any time during the study, your wishes will be complied with, and nothing will be held against

you. Your identity will be protected by the use of fictitious names and all data will be stored under lock and key and available only to me and my supervisor. The findings will be used for academic purposes only.

Permission is granted:

To be observed

To be interviewed

To be audio recorded

I agree to these conditions with the understanding that confidentiality of my identity will be protected, as stipulated above.

Name: _____

Signature: _____

AGE (optional): _____

Research Number: _____

Date: _____

APPENDIX 9: Consent Letter – Student

Information Letter

Wits School of Education

University of the Witwatersrand

Project on Evaluating the SOHS Prosthodontic Curriculum

STUDENT LETTER

Dear (Mr, Mrs, Miss, Ms)_____

Hello. I am Pusetso Moipolai and I work in the Department of Prosthodontics, School of Oral Health Sciences (SOHS), University of the Witwatersrand and currently enrolled with the Wits School of Education studying for a Masters of Education degree in Curriculum Studies.

As part of my study programme, I have to undertake a research project. As you are aware, the Dental School changed its curriculum in 2001. Since implementation, one or two projects have been conducted investigating how certain aspects of the curriculum have been perceived by former graduates of the school. There has not been a formal evaluation of the curriculum (using qualitative research methodology) to document in its own terms, how both students and staff (Faculty) have experienced this innovation.

My research project will therefore focus on evaluating how the curriculum in the field of prosthodontics is performing – whether it is doing what it meant to do. I intend to observe small group teaching and learning activities and interview some students involved in these groups.

I would thus be grateful for your assistance with the project and extend an invitation to you being part of the group that will be observed. May I therefore invite you to assist me by participating in the study.

The study may also include an audio recording of you involved in the learning and teaching activities during the teaching block, specifically the PBL small group sessions, integrated learning sessions and prosthodontic tutorials. Furthermore, your identity will be protected by

the use of fictitious names and allocation of a research number to each student randomly by replacement. All data will be stored under lock and key and available only to me and my supervisor. The findings will be used for academic purposes only.

Participation in the study is voluntary. If you do not wish to participate, or withdraw at any time during the study, your wishes will be complied with, and nothing will be held against you. Your comments during the observational periods will not be used to your disadvantage and will not be part of any assessment of your programme.

Permission is granted:

To be observed

To be interviewed

To be audio recorded

I agree to these conditions with the understanding that confidentiality of my identity will be protected, as stipulated above.

Name: _____

Signature: _____

AGE (optional) _____

Research Number: _____

Date: _____