Exploration of Medical Professionalism Across Postgraduate Medical Education in Indonesia

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Abstract

The implementation of competency-based medical education (CBME) and accreditation worldwide have influenced the emergent national policies in Indonesia's postgraduate medical education (PME). The policies demanded a more open, accountable, authentic, and stable definition and elaboration of the graduated learning outcomes commonly declared as a competency framework. Medical professionalism (MP) has emerged as one essential domain in this national competency framework. However, the globalised competency approach raises some difficulties in its deployment as a competency framework, especially for MP, when it is applied into the teaching-learning practice in a specialist context especially where there is minimal information on how MP is conceptualised. At the same time, PME has been the primary workplace for clinical skills learning for both undergraduate medical students and junior medical specialists.

Additionally, as a clinical learning site, PME continues to be the top place for clinical referral in the hospital-based healthcare system. This means the proportion of patients with complex clinical needs is higher than would be encountered in undergraduate training. Medical professionalism is an important element in the provision to realise good medical care and ensure patient safety. In that case, understanding MP conception and how to deploy it in such complex medical specialist practice and learning is an urgent agenda. However, the lack of information and publication about MP in Indonesian PME/MSE indicates that the agenda has not been scrutinised and warrants exploring. Therefore, this study serves as the first attempt to explore the conception of medical professionalism in Indonesia's medical specialist context.

This study asked how MP is conceptualised by specialists and residents in neurology and orthopaedic surgery training. Specifically, whether and to what extent do conceptions of MP in Indonesia's postgraduate medical education differ from current MP concepts and discourses within the, largely western, ME literature. The study adopted a socio-material perspective, believing that constructing the MP concept is an integral part of professional learning and social practice where learning is distributed and mediated in many activities and multiple social actors. In social practice, ideas, concepts, and ideologies are represented as discourses captured in various talking genres, such as an interview. Consequently, the study combined two modes of interview: semi-structured interview (SSI) and interview-to-the double (ITTD). While the SSI attempted to explore the discourse informing ideas of professionalism and

professional learning held by participants, the ITTD problematised these ideas by capturing the everyday discourses of professional practice.

Fairclough's critical discourse analysis (3D-CDA) has been used as a data analysis method. The analysis shed light on MP conception in practice, which is related to cognitive, operationalised and dilemmatic discourses. These three discourses frame an insight that learning professionalism is not a linear individual learning process but a co-production that evolves in professional activities involving many social actors. Reflecting on these findings, learning MP should be sought both as individual development and social actors' engagement; something rarely tackled in medical professional education practice. The analysis also explored four ideological discourses: 1) postcolonial mind, 2) spiritual-religious worldview, 3) communalism/collectivism, and 4) competing-symbolised externally regulated practice. As ideologies, these four discourses possibly function as powers that influence Indonesian medical specialist communities in different contexts to conceive and apply MP, and as such, warrant further investigation.

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3D-CDA	:	Three Dimensional Critical Discourse Analysis
AAMC	:	American Association of Medical Colleges
ABIM	:	American Board of Internal Medicine
ACGME	:	Accrediting Councilg for Graduate Medical Education
BMA	:	British Medical Association
BPJS	:	Badan Penyelenggara Jaminan Sosial (Social Health Insurance Agency)
CAIPE	:	Centre for the Advancement of Interprofessional Education
CBME	:	Competency-Based Medical Education
CDA	:	Critical Discourse Analysis
COAS	:	Co-Assistant (Junior Doctor)
COP	:	Community of Practice
CL	:	Corpus Linguistic
GMC	:	General Medical Council
GP	:	General Practitioner
IMA	:	Indonesian Medical Association
InaMC	:	Indonesian Medical Council
IOA	:	Indonesian Orthopaedic and Traumatology Association
IPC	:	Interprofessional Collaboration
IPE	:	Interprofessional Education
ITTD	:	Interview to the Double
KODEKI	:	Code of Ethics of Indonesian Medical Doctor
ME	:	Medical Education
MKDKI	:	Majelis Kehormatan dan DIsiplin Kedokteran Indonesia (Indonesian Board of Medical Honour and Discipline)
MKKI	:	Majelis Kolegium Kedokteran Indonesia (Indonesian Board of College of Speciality)
MP	:	Medical Professionalism
MS	:	Medical School

MSF	:	Multi-Source Feedback (360 degree assessment)
MST	:	Medical Specialty Teacher
MSTN	:	Initial for Neurology Medical Specialty Teacher participant
MSTO	:	nitial for Orthopaedic Medical Specialty Teacher participant
NBME	:	National Board for Medical Examiner
NBSE	:	National Board for Speciality Examination
NLE	:	National Licensing Examination for Graduate (GP)
OPPE	:	Ongoing Professional Practice Evaluation
PME	:	Postgraduate Medical Education
RES	:	Resident
RESN	:	Neurology Resident Participant
RESO	:	Orthopaedic Surgery Resident Participant
RSB	:	Researcher's Initial /pronoun in interview excerpt
RSP	:	Research participant pronoun interview excerpt
SKDI	:	Standar Kompetensi Dokter Indonesia (Competency Standard for Indonesian Medical Doctor
SPPD	:	Standar Pendidikan Profesi Dokter (Standard of Education for Medical Profession)
SSI	:	Semi-Structured Interview
WFME	:	World Federation for Medical Education
WHO	:	World Health Organization

Chapter 1 Introduction

1.1 Rationale and the background of the study

Medical professionalism (MP) reflects how professionals work and deal with their own self to maintain a certain standard of conduct in interacting with colleagues, patients, and wider society. Before 1970's, teaching professionalism was not regarded as the main agenda in medical education (ME) (Pellegrino and Thomasma, 1993; Collier, 2012). However, after numerous critical studies on the medical profession conducted by sociologists (Freidson, 1970b; Larson, 1979) and several high-profile public inquiries in western countries such as the Bristol Inquiry (Kennedy, 2001) and Alder Hay Children's Hospital inquiry in the UK (Redfern et al., 2001), and the publication of the National Academic Press report, *To Err is Human*, showing a high number of preventable deaths associated with doctors' misconduct in US Hospitals (Kohn et al., 2000; Committee on Quality of Health Care in America, 2001), there has been an increased focus on teaching and assessment of MP across the ME continuum (from undergraduate education to continuing professional development). While the scandals might have not significantly changed public trust in physicians as the most trusted physicians, some studies in the USA showed a decreasing belief among practising physicians about patients' trust in physicians. These reports have corroborated much public debate and criticism, especially in 2001, a US national task force funded by the National Institute of Health, proposed a strategic reform agenda in medical education and healthcare organisations to improve the health workforces' professionalism and patient safety. However, physician stakeholders in North America and Europe countries seem to agree that teaching MP explicitly in the education continuum would be able to safeguard and maintain the public's trust in the medical profession which has been a very foundation of the doctor-patient relationship and medical services (Calman, 1994; Cruess and Cruess, 2004; Royal College of Physicians, 2005; Cooke et al., 2010; General Medical Council, 2016; Hafferty, 2017).

The need to restore public's trust in ME has stimulated extensive scrutiny which led to the emergence of discourse, studies and social MP movements. The studies include the inquiries on finding appropriate theoretical frameworks,

deconstructing components of MP (Swick, 2000; Cruess et al., 2004; Birden et al., 2014; Jones and Thaxton, 2014; Wang et al., 2016); as well as identifying the appropriate teaching and assessment strategies to ensure only doctors with high levels of MP are allowed to practice (Stern, 2006; Wilkinson et al., 2009; Hawkins et al., 2009; Hodges et al., 2011; Birden et al., 2013; Goldie, 2013; Steinert, 2016; Li et al., 2017). Some discourses also appeared on the importance of incorporating MP in improving health and patient service and incorporating MP in legal frameworks in medical and health regulation (Hilton and Slotnick, 2005; Thistlethwaite and Spencer, 2008; Levinson et al., 2014; Wynia et al., 2014). However, most of these works still relate to the undergraduate context along the ongoing reorganisation of medical education in many countries following the reform led by outcome-based education approach in Western countries (Harden et al., 1999; Cumming and Ross, 2007). The restructuring of the medical education continuum in Europe (Cumming, 2010) and North-America countries (Cooke et al., 2010), took undergraduate medical education as the priority. It became a field-laboratory to develop and validate various innovations, including teaching and learning medical professionalism, that constitutes a new field of medical education study (Bleakley et al., 2011; ten Cate, 2021). However, despite these reforms also emerging in postgraduate medical education, exploration of MP in postgraduate and continuing professional education's context are still limited; potentially missing a vital opportunity to address some of the problems associated with unprofessional behaviour in postgraduate practice (Jha et al., 2007; Birden et al., 2013; Birden et al., 2014).

The wide discourses of MP developed in 'western medicine' have influenced medical regulatory bodies to establish systems that incorporate the institutionalisation of MP in ME standards (Irvine, 2001; Frank et al., 2015) and include these standards in professional revalidation processes (AAMC_NBME, 2002; Paterson, 2010). In the United States (US), Canada, United Kingdom (UK) and Australia, MP has also been used as a standard to determine quality of ME in their accreditation system either for undergraduate or postgraduate level education and training programmes (Breen et al., 2010; Boulet and van Zanten, 2014; LCME, 2016; General Medical Council, 2018)..

Although MP has been widely studied and has driven a transformative movement in current outcome-based medical education (Wear and Kuczewski,

2004; Lynch et al., 2004; Mann, 2006; Frenk et al., 2010; Birden et al., 2013; Wynia et al., 2014), many medical educators are still struggling to internalise and institutionalise MP in education and healthcare organisation due to the fluidity of the concept of MP (Mattick and Bligh, 2006; Doukas et al., 2013; Hafferty et al., 2016). The evolving and fluid definition of MP aligns poorly with the provision of outcome-based education which demands more defined learning outcomes (Holmboe et al., 2010; Frenk et al., 2010). This has driven a need to recognise the context-specificity of MP in ME (American Board of Internal Medicine, 2002; Martimianakis et al., 2009; Hodges, 2012; Chamberlain, 2013). Recognizing contextuality of MP, Hodges et al. (2011) provide a conceptual framework for overviewing the array of MP definitions and practices from existing discourses. Hodges et al (2011) find, that despite the plethora of writings on MP, very little has been dedicated to exploring the concept of MP in the different linguistic and cultural context outside western societies. Scholars also argue that the current mainstream of MP conceptions are western minded (Ho et al., 2011; Hodges, 2012; Nishigori et al., 2014). The inability of some educators to adapt to this contextuality is a possible explanation of why institutions are failing to incorporate MP (Hodges et al., 2011).

The issue of contextuality stimulates a growing debate on the applicability of ‘western MP’ in a wider global context (Ginsburg et al., 2000; Ho and Al-Eraky, 2016; Al-Rumayyan et al., 2017; Hodges, 2017). The introduction of ‘western MP’ in global ME discourses has been charged as a one-size-fit-for-all approach (Ho et al., 2011; Jha et al., 2015), and a form of modern western-imperialism (Bleakley et al., 2011; Hodges and Lingard, 2012). Despite the criticism, the knowledge transfer of MP from western to non-western academic medicine has progressively taken place. The discursivity of western MP, nevertheless, have stimulated ideas and spirits of reform in ME in non-western countries (Ho et al., 2011; Al-Rumayyan et al., 2017). However, although taking different form of professionalisation pattern, western and non-western are likely agreed that elaborating MP in ME is a promising way to improve the quality of care, patient safety and health for all people (Frenk et al., 2010; Ho et al., 2011; Jha et al., 2015; Bleakley, 2015; Wang et al., 2016; Al-Rumayyan et al., 2017; Greene and Jones, 2017).

Recognizing that the MP discourse in developing countries tend to come in the form of top-down regulation approach, some scholars warned that it might potentially reimpose the problem of modern imperialism. Especially, when the context-specificity of the local culture and critical analysis of the fitness of the adoption's purpose are not considered (Bleakley et al., 2011). Therefore, it is viewed that research could guide educators and researchers to critically develop an evidence-based approach, and at the same time promotes the context-based transformation of professionalisation (Bleakley et al., 2011; Monrouxe et al., 2017a). Any extension of conflict between western versus non-western view of medical professionalism is therefore not productive in promoting change in the future ME (Bleakley et al., 2011). Supporting this view, as a ME researcher from a non-western country, I agree that promotion of MP in a developing country like Indonesia should be through an evidence-based approach. Current MP discourses that have been initiated in older-western countries therefore can be used as a reference in developing a context-based approach to medical professionalism.

Reflecting on what has happened in Indonesia over the last two decades, MP has been introduced through top-down approach. It is institutionalised into medical school and professional bodies through the enactment of national laws and regulation standards for example Medical Practice Law 2004; Medical Education Laws 2013; Standard for Medical Education (Standar Pendidikan Profesi Dokter / SPPD); National Competency Standard for Medical Doctor (Standar Kompetensi Dokter Indonesia / SKDI), and the national licensing exam (NLE)'s policy are the regulatory frameworks for ME and profession in Indonesia. For most medical educators and medical professionals, these emerging regulations signify a sudden challenge to the model of medical professionalism which have already exist from Colonial era (Hesselink, 2011b; Neelakantan, 2014).

The introduction of MP toward formulation of competency area such as 'professionalism', 'effective communication' and 'self-awareness & patient safety' in the first SKDI (National Competency Standard for Indonesian Physician) (2006) were the result of adoption of the 'western MP'. Mentioned in the SKDI 2012 (KKI, 2012), the standard has been adapted from some national competency or medical school competency framework such as Tomorrow's Doctor from the GMC England (General Medical Council, 2009), The Scottish

Doctor from Royal College of Physician Scotland (Simpson et al., 2002), and Brown Nine Core Competencies (Smith and Dollase, 1999). In 2012, I was involved in a national taskforce to run several studies to gather information on whether the SKDI requires any revision. For reasons which are not clear, the remit of the taskforce was limited to undergraduate medical school and the licensing provision for general practitioners (GP). Therefore, the studies supporting the SKDI 2012 were limited to evaluating and creating constructs relevant only for undergraduate medical education and GP contexts (KKI, 2012; Kusumawati et al., 2015). This means that the SKDI 2012 has lost its power to promote MP across medical specialist practitioners.

The absence of standards for postgraduate trainees poses a serious problem for ME. Medical specialist communities still serve as the main source of teachers for undergraduate students in clinical rotations. Role modelling is a powerful method of professionalism transfer among physicians (Passi et al., 2010; Birden et al., 2013), consequently it is unlikely the role-modelling would occur optimally when the teacher does not have the set of criteria of MP in their specialty education. The absence of descriptors of MP for postgraduate medical education potentially endangers the knowledge transfer of MP in current and future generation of profession (Wali et al., 2011; AAMC, 2014; Wagner et al., 2017). Unlike in undergraduate level, little is known on what and how the specialists in Indonesia teach their junior resident about MP. A study of the introduction of western-style communication skills i.e., application of the Calgary-Cambridge communication model (Fragstein et al., 2008) for entering residency, revealed sceptical comments from residents that these skills are not very relevant with resident's current remit in Indonesia (Bekti, Fitriani, et al., 2018). This finding emphasizes the importance of further inquiry on what determines the professionalism among the local specialists. The bigger question follows whether the conception of MP in these specialists really makes difference with SKDI and current mainstream discourse of MP, and more importantly the possible teaching-learning of MP in-context.

Some individual efforts have been made by local medical educationists to promote a context-based movement on MP in undergraduate or postgraduate programme (Bekti, 2013; Claramita, et al., 2013; Sari et al., 2016; Purnamasari et al., 2017; Bekti, Irnanda, et al., 2018). However, concerning the scope of the study, the progress being made are unlikely to induce a significant change in

MP conceptions or implementation of these concept in postgraduate level due to a possible different context and trajectory. There are some beliefs among medical community that what works in one context (undergraduate) would not necessarily work in other (postgraduate) context considering the different nature of teaching-learning between undergraduate and postgraduate medical education. While most of undergraduate courses are still based on class-based learning, learning in postgraduate medical education occurs totally in the workplace alongside real patient health services. In fact, since my study started, there have been no publications, on postgraduate medical professionalism in Indonesia.

In this sense, the exploration of beliefs and the worldview of medical specialists toward professionalism that is embedded in written expression of thoughts, regulation and daily teaching-learning practices are an essential pathway for articulating the context of Indonesia's understanding of MP. It is assumed that if the concept of professionalism can be defined, and the reasons behind the daily teaching-learning and assessment practice in specialist training are captured, then appropriate progress and proper intervention in postgraduate medical education or even the whole medical continuum can be expected to be developed. Therefore, case-study research exploring MP in the postgraduate medical education context in Indonesia is undertaken.

1.2 Research Aim

The aim of this study is to explore the conception of medical professionalism across different postgraduate medical education context in Indonesia by using a nested case study approach.

1.3 The Expected Contribution of the Research

The understanding of MP conception in medical specialist practice and education will shed light to at least three contributions. First, it is expected to contribute to the enrichment of discourse on international views of the concept of MP, especially on the situated condition of a South-East Asian context where it has not been explored. Second, the understanding of how specialist conceive MP in their practice and convey it into their training will become a reference to understand further how MP is appropriately nurtured (taught) and learned, not

just in the studied specialties, but also in other medical disciplines (specialist), especially in the South Asian region where it has not been explored before. And third, as a practicing medical educator working in a Faculty of Medicine running a number of specialty programmes in Indonesia, this study become a catalyse to initiate a project on improvement in my own institute, especially in nurturing professionalism among studied specialities.

1.4 Structure of the Thesis

The thesis consists of nine chapters, including this introductory part that provide the setting and broad outlines of the study and the aim of the study. The literature review in Chapter 2 starts with an exploration of the issues related to defining profession, professional and professionalism from review studies and some renowned positioning papers that influenced the study on professionalism. In this exploration I used Fairclough's three-dimensional critical discourse analysis approach (3D-CDA).

Chapter 3 describes the study design and operation. This includes rearticulation of the research question and aims, research methodology and design, sampling of participant, data gathering and analysis. It also includes an outline of the training journey for the two specialist areas from which participants were recruited.

Chapter 4 is about setting the boundary of research object and context to frame the analysis in the following chapters. The chapter starts with problematising the meaning of context in learning professionalism as part of professional learning. This includes the general features of the medical education continuum in Indonesia. The chapters then set out the critical utility of socio-cultural (also called socio-material) theoretical perspective, especially CHAT in making sense of the activity systems in medical specialist situations as a context for learning MP. The chapter continues with the critical positioning of 3D-CDA as the data analysis and interpretation framework to explore MP conceptions.

Chapter 5, 6 and 7 all present the data analysis which is consecutively themed by the phases in 3D-CDA. Chapter 5 for the text analysis which is the first phase, chapter 6 for the discursive analysis and chapter 7 on the analysis of social practice of MP conceptualisation. Each chapter consist of the results and the discussion which is collated together at the end of chapter 7 to form the

general discussion of the result of 3D-CDA and how this has relevance in socio-material perspective that frame the answer to the research question.

In Chapter 8, I provide a critical reflection on the methodology used in the study. I believe this extended discussion is necessary as it supports one of my claims to contribute to knowledge. In addition to formulating the distinctive Indonesian understanding of MP, the research approach employed to do so is methodologically innovative in Indonesia and, arguably, in wider studies of medical professionalism.

In Chapter 9, the final chapter, I summarise the findings of the study followed by comments on the contribution and implication for teaching-learning practice and research on medical education field.

Chapter 2 Medical Profession, Professionalism and Professional Learning

2.1 Introduction

In order to set the ground of this research, it is important to understand what the literature has to say about the profession of medicine, medical professionalism and professional learning. The review of professionalism and professional learning are important considering that professionalism and professional learning are sometime seen as two separated entities or ontologies. In this study, I understand the professional learning of medical specialists to include the continuum of practice from undergraduate (primary medical qualification) to continuing professional practice and specialist postgraduate accreditation. This includes learning for and about the profession they are entering, their postgraduate disciplines, and also includes learning what is expected of them in order to act with professionalism at all stages of their career. This learning occurs in the healthcare workplace, through informal processes of acculturation and role modelling as well as more formal instruction and assessment. In the critical and sociocultural perspectives of learning, as Sfard (2013) indicates, the understanding of "concept formation" of a certain topic cannot be separated from the entire process of discourse that relates to the topic itself. Consequently, an inquiry to understand medical professionalism as an expertise or domain of competence can be seen as an epistemological process of understanding how learning occurs for the profession as a whole and for individuals within that profession (Sfard, 2013). In this research, the discourse of medical professionalism as particular topic in the medical profession and professional learning has to be regarded as complete unit of analysis (Sfard, 2013, p.146). In other words, while professionalism can be regarded as the expertise and characteristic or identity of the profession, professional learning in contrast is a discourse explicating how professionals develop and attain both their expertise and identity prior to or during the enactment of their professional duty. This chapter provides a review of the relevant literature on how a profession and professionalism are defined and

related, and how these definitions give consequence to the practice of medical education as a form of professional learning.

Inspired by the contemporary theory of knowledge emergence and the sociocultural tradition in social sciences (Miettinen, 1999; Fairclough, 2011; Sfard, 2013) and its application to professionalism (Martimianakis et al., 2009; Bleakley, 2010; Fenwick, 2016; Hodges, 2017) I chose a method for performing a literature review which is frequently adopted by these theorists. There are many approaches to the scholarly review of literature, and I chose to adopt the critical narrative synthesis approach (Wall et al., 2015) using the critical discourse analysis (CDA) method introduced by Fairclough (1995). More specifically, this approach considers MP conceptions as latent within trans-national ideology movement (Evetts, 2003) and sociocultural-political issues (Hodges et al., 2011; Jha et al., 2015) and translated into different meaning and language (discourses). This chapter will start with a brief explanation of the review methodology to provide a background of how I approached the literature, followed by the results of the review, which are presented under the heading of three dimension of discourse (i.e., discourse as a text, discursive practise, and social practice). Finally, I will close the chapter by providing a summary of what has been described.

2.1.1 Critical Discourse Analysis to review the MP literatures

The literature review in this study is applying the CDA approach. Although being considered as an emerging approach to review the literature, the application of CDA as a an approach has become popular in several academic disciplines such as in media and information system studies (Wall et al., 2015), health policy studies (Evans-Agnew et al., 2016), and medical education (Hodges et al., 2008; Hodges, 2012; Wall et al., 2015; Feilchenfeld et al., 2017). This approach is relevant in this study about MP for the following reasons. First, as an English (originally Western) ‘text’, professionalism is representing a western worldview. This typically represented on a tendency that ‘Western’ MP has evolved as a hegemony in current MP discourses. Second, approaching and identifying term as a discourse will provide a navigation map for study analysis that is conducted in different socio-cultural and linguistic background, especially in the context where English is not its first language such as Indonesia. The third reason for choosing CDA as a means to make sense of the literature is a

matter of consistency when adopting a critical research paradigm and methodology. It does not mean that more common approaches of literature review such as PRISMA and/or systematic meta-analysis have methodological deficiencies which would be overcome by performing CDA. Rather, as Sfard (2013) suggests, the decision to employ an epistemological approach in research, such as CDA, can be seen as a participation of the researcher in a well-defined discourse (Sfard, 2013) and epistemic practice. Sharing the critical perspective on knowledge emergence (the development of new knowledge as social practice), I believe adopting any literature review method is not just a matter of employing one academic technique, but it is also a commitment to adopt scholarly social practice where ideologies are reproduced and hegemonies are promoted and sustained (Alvesson & Sandberg, 2011; Maxwell, 2013). Moreover, Orlikowski and Baroudi (1991) provide evidence that the Information System (IS) field, where most literature review methods have been produced, was heavily dominated by positivist research (Orlikowski and Baroudi, 1991). This contributed to my decision not to follow the dominant approach to reviewing literature when I had deliberately chosen to use CDA as a methodological approach for the research project.

Among many versions of CDA, I came across Fairclough's three-dimensional approach of critical discourse analysis (3D-CDA) (Fairclough, 1992) and found his generic text exploration which involves reviewing term based on text analysis, discursivity and social practices (includes the ideologies and agencies) was very helpful. In this approach, discourse is defined as "a discursive event" or "the way of representing aspects of the world' (Fairclough, 2003 p.124). The 'way' might comprise processes, relations and structures of the material world, feelings, beliefs, and the 'social world' behind the text (Fairclough, 2003). CDA focuses on how language, as a cultural tool, makes up relationships of power and privileges in social interactions, institutions, and bodies of knowledge (Foucault, 1972; Rogers, 2002; Rogers, 2011; Gee, 2014). Given this notion, in CDA's perspective, publications can be treated as the representation of discursive events which relate to the synthesis, exchange, and production of knowledge. Therefore, CDA is potentially a method that can be utilized to review literature, especially to examine how the knowledge is existed and reproduced (Dant, 1991; Wall et al., 2015).

Fairclough's 3D-CDA approach focuses on; 1) linguistic features of text or linguistic descriptions of the object of analysis), 2) processes related to the production and consumption of the text (discursive practices), and 3) the wider social practice to which the communicative events belongs (explanation of social practice) (Fairclough, 1992; Phillips and Jorgensen, 2002). Different to narrative or meta-analysis review, the 3D-CDA approach does not purported to objectively summarize information from a systematically selected literature. Rather, it attempts to characterize the different ways language is used to constitute of truth about the object of analysis (i.e., texts) (Hodges et al., 2011), and therefore CDA deliberately concern with understanding, uncovering, and transforming conditions of inequality caused by power gap emerged in both hegemony and marginalized discourses (Wall et al., 2015; Rogers et al., 2016).

In the following sections, I use three steps in the 3D-CDA as the guide to characterize and understand what literature informs us regarding medical profession, professionalism, and professional learning discourses. With this understanding I expect to be able to navigate this study into the uncharted gap that possibly lies in between theoretical perspectives, studies, and practices of professionalism, both in International and local Indonesian contexts.

2.1.2 Text analysis of MP

Before stepping into the first level of the 3D-CDA, like other discourse analysis type, it is important to define the object of analysis. The object of analysis is how medical professionalism is textually conceived in medical education and medical practice (context). This identification of the object of analysis will guide the literature search.

A number of publications have been collected through online database searching by eliciting terms "medical professionalism" and "medical education" for definition and teaching-learning practices. The search was performed by using MEDLINE, Web of science and SCOPUS search engine in some renowned online electronic databases (Medline, Embase, Cinahl, etc) by using query keywords either single and combination of "medic*", AND "professionalism", AND "definition" AND [education OR training] OR [teaching OR learning] (please see Appendix J for the searching method records). In addition to these searches, I also included "grey literature" publications such as local Indonesian language publications, policy guidelines or books which I had

previously acquired as the result of my previous professional interest in this area. These items were mostly undetected by the journal index services, or because they were not journal articles (e.g., books, guidelines, policy documents, or generic publications). The summary of literature searches and involvement of publication in this phase is presented in Figure 2-1.

After determining the object of analysis, the next step of the 3D-CDA is performing text analysis. The text analysis is a step where the text (area of interest in the body of literatures) is analysed by using a set of analytical principles which are mainly rooted from linguistic tradition of analysing text (Fairclough, 1992). The purpose of this step in a whole 3D-CDA is to set the structure of meaning and interpretation of the text in the existing written narratives. In doing. To facilitate the process, I have collated the resources based on its publication year and try to sample reading in some cluster year (certain years where there are many publications). This is under the assumption that a surge in publication in certain topic in certain time is likely indicating something happened in the society. And then, from the text collection, I tried to find the relation of medical professionalism conception with the medical education and medical service practice.

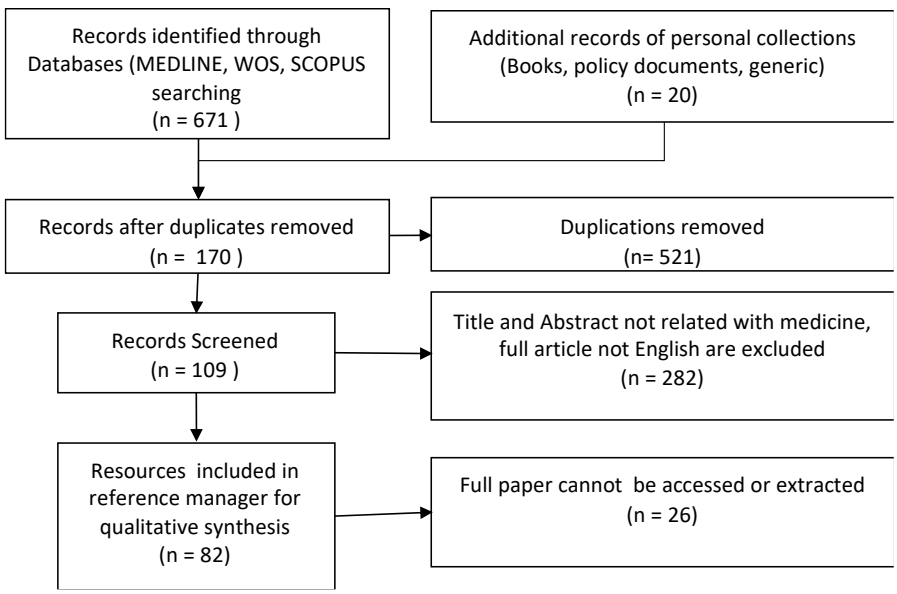

Figure 2-1 The summary of literature searching strategy in database and inclusion of grey literature

Lexically, the term “professionalism”, at its simplistic meaning is defined as “ism” (a system, principle, or ideology) of “professional” (Dictionary.com, 2018). Most of English dictionaries define professionalism as the quality or identifier of professional. The quality is described in different words such as skills, competence, character, high standards, or status depend on which professional it relates to (American Heritage Dictionary, 2018; Oxford Advanced Learner’s Dictionary, 2018; Miriam-Webster, 2018; Evetts, 2018). Thus lexically, medical professionalism (MP) can be broadly understood as professionalism related to medical profession.

A significant increase of publication using MP have been found in last two decades. Through the help of further development of the text analysis study which is called Corpus Linguistic (CL) provides more tools to examine the use of text by using frequency, collocation, and occurrence parameters. CL is an emergence field that employ software that are used to analyse the frequency, dispersion and distribution of word or *lemma* among other texts (words, sentences, paragraph, passages, and discourses). In this first step of 3D-CDA, I try to employ CL to extend what Fairclough calls it as the “word analysis”. This is under the intention that the combination of methods would provide a lexical, etymological, and text-historical review of the MP in the current and past literature. I believe that this analytical approach is still relevant to CDA experts as they state that CDA should not be a rigid methodology. Rather, it opens for creativity as an integral part of the analysts’ reflexivity of the researcher to the interpretative nature of CDA and its methodological toolbox (Fairclough, 1992, James Gee, Wodak, 2004). The result of text analysis is presented in the following paragraphs.

Applying corpus-based linguistic analysis techniques on the use of the term MP in scientific databases can show the growth of medical professionalism on a yearly basis and among existing academic fields. Figure 2-2 shows the visualisation of the current usage of MP that are not limited to medical and health-related fields. Rather, it is extended to education, social sciences, and psychology (Web of Science, 2018). This is complemented by Figure 2-2 showing the trend of publication between 1970-2019. Although the initial English use of the term “profession” and “professionalism” was recorded in Middle Ages era around 1600s (Huber and Wynia, 2004), the more extensive elaboration and popularisation of the terms were associated with the

emergence of the sociology field in 1970s. This is why the review started from 1970.

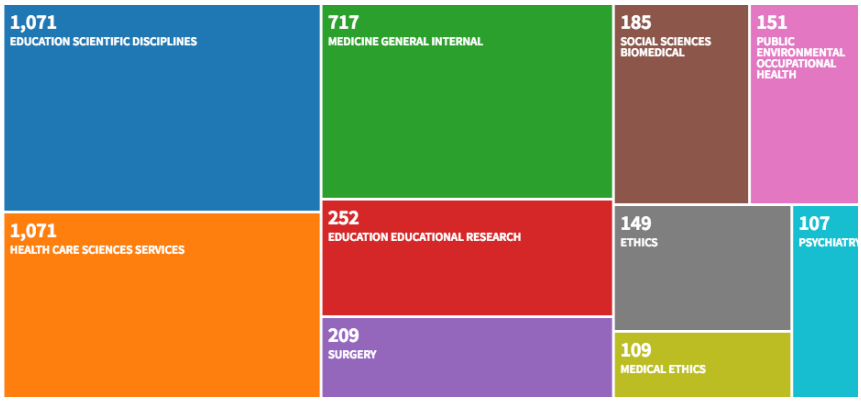

Figure 2-2 The tree map graph of magnitude number on the use of 'medical professionalism' in Web of Science's field Category databases

An influential physician figures living in the Middle Ages, Thomas Percival, in his opus "Medical Ethics", argued medicine is a profession which is characterised by ethics as their collective virtue and this forms what is called professionalism (Percival, 1803 as cited in Wynia and Kurlander, 2007). Along with the rise of sociology and profession studies in 1970s, this definition remain stable until the issue of measurement of competency and profession accountability come to fore in public discourse in the early of 20th century (Novack et al., 1999; Kohn et al., 2000; Inui, 2003).

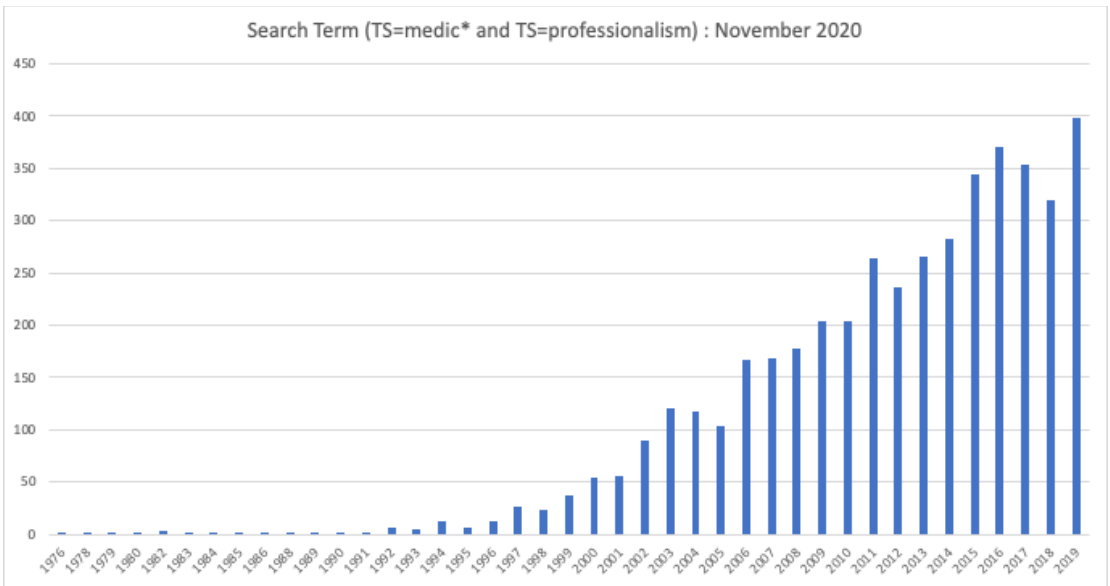

Figure 2-3 Articles on medicine and professionalism by Year: Thomson Reuters's Web of Knowledge (2020)

Because there were too many references founded with the initial search, I decided to narrow-down the search only for review publication that involve the definition of professionalism and tried to list them based on year when they were published (See Appendix J). As expected, there is no single unifying definition of MP found in any review articles. The publications formulating the definition of MP were mostly published by western authors depicting situation happened in western societies, mainly from Northern America and Europe countries. Compiled from the literature on definition of professionalism, the conceptions of MP featured in Table 2-1 represent the developmental accounts of professionalism throughout history. This historical development of meaning and how MP is used in current days indicating that MP both represents a discourse and is constituted by discourses in society.

Table 2-1 Global discourses on conception of professionalism

Conception of Professionalism	Key References
Attribute or characteristic of medical profession as a group in society	(Larson, 1979; Freidson, 2001)
Virtue, ethics, and morality of medical profession	(Pellegrino and Thomasma, 1993; Eckles et al., 2005; Kenny and Shelton, 2006)
A set of behaviours and/or competencies (a tangible / measurable performance)	(Arnold et al., 2001; AAMC_NBME, 2002; Dwyer et al., 2014)
Professional Identity (consist of set of values, attributes, and relationship) of medical doctor that deliberately developed in education and practice	(Royal College of Physicians and Physicians, 2005; Cruess et al., 2015)
Social movement of profession to improve the quality of medical practitioners, healthcare institute and thus quality of care and patient safety	(Wynia et al., 2014; Levinson et al., 2014)
A governmentality discourse of medical profession (a means of directing how to behave and act)	(Evetts, 2003; Martimianakis and Hafferty, 2013; Fenwick, 2014)

Nevertheless, as discourses, these conceptions are also representing the social construct in which they are developed, because discourse is representation of social practice. This means MP is culturally bound and sensitive. A study in non-western context shows that even within one culture, MP can be understood differently (Ho et al., 2014). Studies also indicated that MP conception and

practice are also affected by language and belief (Martimianakis et al., 2009; Jha et al., 2015); paradigm and practice of education both among the educators (Novack et al., 1999; Swick et al., 1999; Papadakis et al., 1999; Kao et al., 2003) and the students perspective (Arnold et al., 1998; Brownell and Cote, 2001; Ginsburg et al., 2002). Some studies have also shown that power and regulation in the health system and education also impact on the MP construct (Jones and Green, 2006; Jauregui et al., 2016). These multicultural and multi contextual perspective on MP are what the western MP criticised to be lacking of (Jha et al., 2015; Hodges, 2017). For instance, in middle east countries, spirituality and religiosity are a dominant discourse that construct the ethics system and thus influence how medical professional behave (Al-Eraky et al., 2014; Ho and Al-Eraky, 2016), or in Confucianism that influence the wellbeing of medical professionalism in countries with Chinese culture heritage (Ho, 2013; Ho et al., 2014; Wang et al., 2016)

2.1.3 Discursive practices of MP

The second dimension in 3D-CDA is exploring the discursive practices of MP. The analysis is performed by identifying how MP is interpreted and produced (interdiscursivity); and used in the different kind of discourses (intertextuality). Fairclough argues that a discourse is not just constructed by society, but it also contributes to construct other discourse in the society and promotes social changes in the society itself (Fairclough, 1992; 2001; 2015)

2.1.3.1 MP in medical education context

In ME context, MP discourses have intensively developed and elaborated with other discourses. Fairclough calls this condition as 'manifest intertextuality' (Fairclough, 1992). The initiatives were featured in the first publication of '*Tomorrow's Doctors', 'Duties of Doctor'* and '*Good Medical Doctor'* by GMC in 1993, and British Medical Association's (BMA) report in 1994. The work of American Board of Internal Medicine (1992) on professionalism has also signified similar discursive practice in North America. However, the discourses on MP formal teaching was still represented by MP as virtue which heavy on teaching ethics and moral reasoning (Self et al., 1992; Pellegrino and Thomasma, 1993; Gillon, 1994; Calman, 1994; Calman, 2006; Hodges, 2012). The practice of teaching professionalism as a formal teaching ethics and moral reasoning are criticized as too focus on the idea of perfection being professional

or the past story of ideal image of medical doctor, and neglecting the real demand of professional to adapt and prepare the uncertainty and complexity of professional practice (Wynia et al., 2014; Doukas et al., 2015), or developing longitudinal identity across different demand of health care organisation and societies which often posit real challenges of learning and applying professionalism (Murrell, 2014; Almahmoud et al., 2017). This gap invokes an insight to revisit and reformulate how professionalism is learned and taught.

Two dominant social discourses in education (i.e., the advancement of measurement science and the outcome-based education movement), likely influence how MP is defined and deconstructed. Definitions of MP provided by ABIM (2002); Cruess et.al., (2004), The Royal College of Physician of London (2005) which much more relating professionalism with measurable attribute or competence (a set of knowledges, skills, or behaviour) of medical doctor indicating this influence. The positivist view of MP in these excerpts is also representing the elaboration of MP discourse with cognitivism learning paradigm amidst the extensive development of neuroscience knowledge based in medical society (Epstein, 2002; Mann, 2011).

Following the discourse on measurable traits of MP, a number of studies have been dedicated to providing evidence of how measurement issue are in line with the learning provision of MP (Lynch et al., 2004; Stern, 2006; Wilkinson et al., 2009; Hodges et al., 2011; Goldie, 2013). This measurement discourse has helped to support the view of the importance of high-stake examination prior to receiving the privilege of carrying out professional service. The emergence of national licensing, certification and revalidation exams are examples of practices in medical society influenced by this measurement discourse.

Recognizing the abundance of sources and discourses, defining a unified conception of MP therefore is a challenging task. Some attempts in doing so have come in a failure result (AAMC, 2011; Birden et al., 2014). MP is already evolving as a social construct produced within the interaction of profession and the society it serves. Given that conceptions of MP are influenced by the culture, beliefs, power and place of either the profession and the society, it is amenable to see MP as discourses rather than a taken for granted conception (Martimianakis et al., 2009; Hodges et al., 2011; Birden et al., 2014; Jha et al.,

2015; Monrouxe et al., 2017a). By using CDA, Hodges et al (2011) have set a conceptual framework to map MP discourses that relevant in educational context. They draw the framework into a table (Table 2-2).

The table provides a set of MP conceptions viewed in major academic paradigms and learning theories (positivist-constructivist) and individual-societal discourses which affect the conception of MP. Coincidently this table has similarities with the Axis graph model created by Mann (2011), featured in Figure 2.2, which was intended to map the existing educational theories used in ME. Both frameworks (table and graph) are using two parameters, called Individual-Societal (as the axis) and Complex/Abstract – Concrete/Practical (as the ordinate). While the Abscissa axis (horizontal line) represents the level of occurrence of learnings or generation of knowledge, the ordinate axis (vertical line) articulates the level of complexity and applicability of the theory.

Table 2-2 Worldview and paradigm map in teaching-learning and assessment of professionalism (Redrawn from Hodges et al 2011 with permission)

Epistemology / Paradigm		Individual	Interpersonal	Societal/Institution
Positivist-Objectivist	Generalizable	1 Professionalism is an objectively definable **phenomenon** to be found in individuals, **generalizable across cultural contexts**	4 Professionalism is an objectively definable **phenomenon** to be found in interpersonal interactions, **generalizable across cultural contexts**	7 Professionalism is an objectively definable **phenomenon** to be found in social groups, **generalizable across cultural contexts**
	Limited generalizable	2 Professionalism is an objectively definable **phenomenon** to be found in individuals, but **shaped by context**	5 Professionalism is an objectively definable **phenomenon** to be found in interpersonal interactions, **shaped by context**	8 Professionalism is objectively definable **phenomenon** to be found in social groups, **shaped by context**
Subjectivist-Constructivist		3 Professionalism is subjectively **constructed** within individuals, **arising from cultural context**	6 Professionalism is an interpersonally constructed **phenomenon**, **arising from cultural context**	9 Professionalism is a socially constructed **phenomenon**, **arising from cultural context**

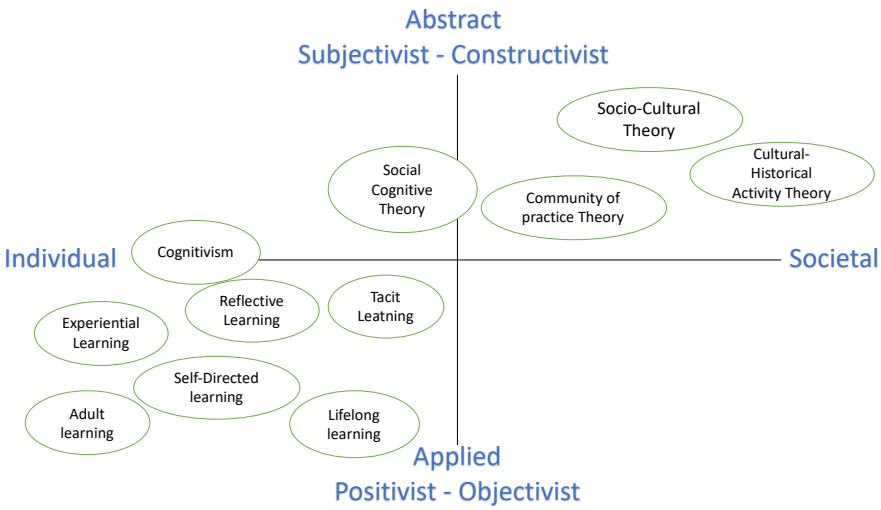

Figure 2-4 The revisited map of learning theories applied in medical education and presumably affect the MP discourse (Modified from Mann, 2011)

2.1.4 Professionalisation as a social practice of MP.

As the MP discourses unfolding, the efforts of translating the ideas of MP into real implementation in professional practice and education have occurred through a social process called professionalisation (Evetts, 2003). Referring to the third phase of Fairclough 3D-CDA, it is argued that professionalisation would represent the social practice of MP. It represents a process where MP is learnt, internalized and institutionalized by the medical profession both in individual or organisational level. The next paragraphs will show that professionalisation have constructed a valuable dimension of MP discourses and provide significant relevance in this study.

Regarded as a social process, professionalisation in developed-western-medicine is occurred in two different forms, called professionalisation 'from within' (internally driven) and 'from above' (externally driven) (McClelland, 1990 p.107; Collins, 1990). Given the two major social practice of professionalisation, Chamberlain (2012) examines that the second form of professionalisation has been more popular in the current days of medical profession's life. Two public reports "To Err is Human" (Kohn et al., 2000) and "Crossing the Quality Chasm" (Committee on Quality of Health Care in America, 2001), published in US showing how medical profession in liberal-America unable to manage a high number of adverse events and preventable death, has caused a greater public concern leading to perceived deterioration of US medical professionalism. These later reports have significantly changed the landscape of

professionalisation of medicine even in the country that used to campaign its ‘from within’ model of professionalisation across the globe (Cooke et al., 2010; Bleakley, 2011; Chamberlain, 2013).

2.1.4.1 The universality and context-specificity in professionalisation

A large number of publications on conception of profession and professionalism which are written by scholars from western countries (Birden et al., 2013; Birden et al., 2014), are being criticized as being too Western focussed and therefore unlikely to be applicable in non-western culture setting (Ho et al., 2011; Jha et al., 2015; Al-Rumayyan et al., 2017). Studies in Arab, South Asia and East Asia countries show that medical professionals (educators and practitioners) and society (patients, citizens and other stakeholders) in these countries have different conceptions on what determines a good medical profession and professional (Nishigori et al., 2014; Al-Abdulrazzaq et al., 2014; Abdel-Razig et al., 2016; Haque et al., 2016; Monrouxe et al., 2017a; Park et al., 2017). For example, respecting patient autonomy in western conception convey meaning that physician should allow patients to make their own medical decision. In contrast, in paternalistic culture founded in Arab countries (Morrow et al., 2013; Jha et al., 2015), Pakistan, Uganda, Malaysia, India (Ho and Al-Eraky, 2016) and Indonesia (Claramita, Susilo, et al., 2013; Claramita, Nugraheni, et al., 2013; Sari et al., 2016), physician is likely making decision on behalf of patient as the way of respecting patient. In paternalistic belief, medical doctor perceived as a “master” and therefore grant privilege to decide what is best for their patient. The doctor will be regarded as less competent if they express diagnostic uncertainty. Moreover, various studies in non-western countries also invite us to consider the roles of faith, values, and history in shaping professionalism in various cultures which likely have not been addressed in western’s conception (Ho and Al-Eraky, 2016). Different historical and cultural dynamic of society might produce different kind of human worldview which affects the working conception of ethics and morality across nations (Durante, 2009; Worthington et al., 2014; Jennings, 2016).

The western and non-western MP conception debate influences the raising of another discourse, that of seeing the dispute as mainly due to an identity crisis of medical professionals in the society around the world. This logic argues that it is because of the identity crisis of the medical professional, the

medical professional, represented by the regulatory and professional bodies, produce narratives on the importance of redefining MP and furthermore putting MP as a critical agenda for the medical education curriculum at all levels. Therefore, some medical educationist thinkers argue that rather than using cherry picking to the western or non-Western conceptualisation, MP need to be conveyed by acknowledging the fact that health care has been transformed into a global-local commodities. It means that both the universality and local-contextuality should be flexibly acknowledged and translated into a proper action at the same time. Current and future health professionals need to be familiar with the universal conception of practice as well as the richness of context-difference involving culture, language, and political power dynamics (Hodges et al., 2011; Hodges, 2017). Unfortunately, studies eliciting the cultural richness of MP conception are still lacking. Therefore, more space for research in exploring how MP is understood, applied and lived in the global-local daily practice of health professionals in the different cultural, language, socio-cultural and political background in all level of ME continuum should be provided (Jha et al., 2007; Hodges, 2012; Jha et al., 2015; Hodges, 2017).

2.2 Researching MP in postgraduate medical education in Indonesia

Exploration of country's cultural-specific voice and worldview on professionalisation (creating conception and translating into practice) is argued as a compelling agenda in professionalism studies (Ho et al., 2011; Hodges et al., 2011; Jha et al., 2015). Unfortunately, current attempts in reviewing the non-western perspectives on MP (Nhan et al., 2014; Al-Rumayyan et al., 2017) are still unable to capture all the different culture and linguistic nuances which existed in non-western countries, including Indonesia. Although attempts in promoting MP in ME have been made, the scope of the research and the quality of academic rigor of the inquiries are unlikely to achieve the critical mass for a readable discourse. Fewer publications written in English or low number of articles published in renown scientific journals probably become the reason why Indonesia's voice is not loudly heard (Wiryawan, 2014; Horton, 2016). Another possible explanation is the research and writing on MP especially in postgraduate context in Indonesia is still lacking

In order to establish a constructive scene of the Indonesia context, a brief socio-historical background and critical narrative of medical profession are presented in next sub-chapters. The analysis using same Fairclough's 3D-CDA approach.

2.2.1 The text analysis of MP in Indonesia Context

Bahasa Indonesia (Indonesian language) is the official language of Indonesia. Although being official, in daily life Bahasa Indonesia is not the first language of most Indonesian. In regard of MP, professionalism is translated as a noun, '*profesionalisme'*. Entry 'professionalism' can be found in the Kamus Besar Bahasa Indonesia (KBBI - The Great Dictionary of Bahasa Indonesia). This dictionary is produced by government as the official reference to terminology. Based on KBBI, *profesionalisme* has a single definition as "a quality and attitude that characterize of certain profession or professional" (Badan Pengembangan dan Pembinaan Bahasa, 2018). Compared to English, the development of entry in KBBI is really slow. Apparently, there is no change in definition of '*professionalisme'* entry since the KBBI was created in 1970's. Currently, there is lack of etymological information how this '*profesionalisme'* was(?) developed or originated. This condition provides difficulty in identification of discourses represented in the entry.

Currently, there are some definitions of MP depicted in SKDI 2012 and *Kode Etik Dokter Indonesia*/KODEKI (Code of Ethics of Indonesia Doctor) (Pengurus Besar Ikatan Dokter Indonesia and Indonesia, 2012). However, the definition of MP portrayed in these documents are not straightforward because MP is represented as a set of tasks. The lack of reference in both documents becomes another challenge to analyse the cohesion and intertextuality of Indonesian's version of MP.

2.2.2 Medical Professionalisation in Indonesia

As a part of the government reform agenda, a set of regulation and deregulations in health care are issued by the government. A most provoking Law on Health Coverage System (*Sistem Jaminan Kesehatan Nasional* known as SJKN) was enacted in 2004. This Law has made Indonesia entered into the health financial system, which is based on universal health coverage principles, leaving the "*out of pocket*" system behind. The system is scrutinised through the establishment of The Social-Security Administrative Body (*Badan*

Penyelenggara Jaminan Sosial / BPJS). Directly below President, BPJS is responsible to manage the majority of payment for public health care. This law has changed significantly the way medical professionals are renumerated. This condition resembles what Friedson and Larson noted in past western medical history where the change in health financing policy would likely become the source of disturbance in professional autonomy and the nature of the doctor-patient decision-making relationship (Freidson, 1970b; Larson, 1979; Freidson, 2001).

Another important undertaking which affects the nature of power of medical profession is the enactment of Medical Practice Law in 2004. Under the patronage of the law, in 2005 government established Indonesia Medical Council (InaMC) as the new regulatory body for the physician and dentist. InaMC consists of 11 persons, appointed by Indonesia President from representative of medical & dentist stakeholders (Medical & Dentist Association, Colleges of Medicine, Association of Medical School & Dentistry, Association of Teaching Hospital, Ministry of Health, Ministry of Research, Technology and Higher Education (now called Ministry of Education and Culture), public figures, lay people, and Non-Government Organisations that are concerned with public health advocation. The main purpose of the establishment of this council is to protect people who receive medical and/or dentistry care by assuring the quality of health care provided by a physician or a dentist. InaMC has authority to grant registration for all practicing physicians and dentists, to issue standard of competency and standard of education for training in medicine and dentistry, and to provide, with other stakeholders such as lawyers, public figures and lay persons, oversight of medical and dentistry practice. By the establishment of the InaMC, public rights such as competency certification that used to be granted to Indonesia Medical Association (IMA) are now allocated to several stakeholders like Medical School and College of Medicine. This privilege, called ‘monopolies of competence’ is progressively fading away from Indonesia’s medical profession, resembling the situation of western medicine in the early 20^{th} century (Larson, 1979; Starr, 1984).

A year after its establishment, InaMC issued the first Competency Standard of the Indonesia Medical Doctor (SKDI), Standard of Indonesia Medical Education (SPPD), and Standard for Postgraduate Medical Education

(SPME). SKDI is a set of performance descriptions (outcome standards) that must be met by all medical graduate prior national registration by InaMC (KKI, 2012). SPPD is the education standard for undergraduate medical schools and SPME is education standard for specialty training. The enactment of these standards has meant that ME in Indonesia has formally adopted a competency-based approach both at the undergraduate and the postgraduate level. For most medical school (MS), this competency-based adoption is regarded as an evolutive practice. It requires not only changes of lecture subjects, but also demands a change of entire organisation and management of the school.

As a standard of performance, SKDI has been intended to fulfil two purposes. First, it functions as a reference for medical regulators to provide competency certification, and second, it functions as expected learning outcomes for medical schools and their students. It is why the writing format of SKDI is significantly different with previous Core Curriculum of Medical Education of Indonesia (*Kurikulum Inti Pendidikan Dokter Indonesia*/KIPDI) document which were produced by IMA. One distinguished feature of SKDI is the emergent introduction of competency framework areas such as Communication Skills, Self-Awareness, Continuous Development, and Professionalism (Appendix A). These frameworks have brought not just a reform in nation's medical curriculum, but they also bring a paradigm shift in teaching-learning and MS management. Due to my personal involvement as evaluator in the Directorate General of Higher Education (DGHE) evaluation project of new medical school in 2010-2011 witnessed how the CBME has disturbed the balance of power in existing departmentalisation of knowledge, especially in specialty departments. For example, moving from subject-based modules, which would be hosted by the speciality department (in KIPDI I and II), to integrated modules (In SKDI) that could be hosted by any department. Thus, all current features of government regulation indicate the shifting of medical professionalisation in Indonesia from self-regulation by professional associations towards external regulation.

2.2.3 The urgency of understanding the conceptualisation of MP in Indonesian postgraduate medical education

The implementation of SKDI, SPPD and National Licensing Exam for Medical Graduate (UKMPPD) were expected to improve the quality amongst

doctors and thus the service they provide. Nevertheless, there is little evidence to support that the enactment of SKDI & SPPD since 2006 have reached its goals in improving the MP and quality of doctor. More intriguingly, the information whether the standards have contributed to change in teaching-learning practice where professionalisation is expected to be happened is also hardly to be found.

Based on my personal reflection as a physician, medical educationalist, former secretary of Association of Indonesia Medical Education Institute (AIPKI), former of secretary of PNUKMPPD (National Committee of UKMPPD), and principal assessor in UKMPPD, there seems a problem in the teaching-learning and professional practice, especially on medical professionalism discourse. From many conversations with both senior and junior teachers and practitioners, I found them wary of the term medical professionalism. Many senior lecturers who become UKMPPD assessors still wonder of what is meant by MP. This is surprising given that in SKDI 2012, “noble professionalism” competency was put at the first place over the other six descriptors of area competency domains. Moreover, professional behaviour is also a domain in the UKMPPD assessment blueprint.

The persistent maldistribution of GP and specialist between urban and rural areas has also stimulated criticism of the professionalism and the quality of Indonesia’s medical society (Meliala et al., 2013; Anderson et al., 2014a). Studies in the socioeconomic field found that the maldistribution is affected by the number and concentration of hospitals in urban areas, government’s policy of allowing doctor to practice in more than one place (Anderson et al., 2014a), and the number and distribution of specialty training programmes (Morrisson and Roberts, 2003; Rokx et al., 2010). These findings imply a problem in medical education, especially at postgraduate level, concerning how they transfer the concept of professionalism in their teaching-learning practice. Therefore, these conditions stimulate an inquiry to explore how professionalism is currently conceptualised within specialist training.

2.3 Summary of the chapter

This chapter provided a review of literature on how medical professionalism is conceived and applied in medical education. With the help of critical discourse approach, the review allows us to see MP as a discourse in the social practice

of Indonesia's medical professionalisation (the development of the medical profession). As a discourse in social practice, MP can be considered as a node in the intersections of many social practice discourses (e.g., politics, socio-economic, organisation and power conflict) in which it is shaped and normalised (Bernstein, 1993). This leads to the position that MP as discourse and product of social practice can never be totally universal or universalised. In this notion, a context-based investigation of MP has a critical place in determining medical education practice, especially in postgraduate level which in the past has been neglected by the priority of reshaping undergraduate medical education.

The trend of competency-based medical education promoted by speciality associations in western countries is likely to focus attention on postgraduate medical education due to the hegemonic status of CBME in education and the healthcare legal system. Unfortunately, this disruption happened in the minimal number of local studies of professional learning and professionalism giving a potentially unsteady bedrock for building a knowledge (evidence) base for competency-based medical education, which requires a degree of deliberation in setting local definitions of competencies that are needed by the society in which the medical specialist graduate will work. Complications arise from the current findings in the socioeconomic field showing maldistribution of medical specialists in Indonesia. These findings imply a problem in medical specialist postgraduate level of how they transfer the concept of professionalism to their teaching-learning practice. Given the lack of studies on professional learning and professionalism by researchers in the Indonesian context, a grounded exploration of how professionalism is conceptualised in medical specialist education is warranted.

Chapter 3 Research Questions, Methodology & Methods

3.1 Aim and Research Questions

Informed by the literature review presented in the previous chapter, the aim of this study is formulated as follow:

3.1.1 Aim

The overarching aim of the study is to understand how professionalism is conceptualised across postgraduate medical education in Indonesia.

3.1.2 Research Questions

To achieve this aim, the following research questions will be explored:

1. How is medical professionalism (MP) conceptualised by medical specialist teachers in Indonesian postgraduate medical education (PME)?
2. How is MP conceptualised by the resident[1] in neurology and orthopaedic PME?
3. To what extent, if at all, do conceptions of MP within Indonesian postgraduate medical education differ from current MP concepts and discourses within medical education research literature?

3.2 Research Design

3.2.1 Methodology and Conceptual Framework

The research is an exploratory study, utilizing a nested case study that takes an interpretivist approach. This approach is taken based on the aim of the research, which is to understand the phenomena of MP across PME in Indonesia. Previous questionnaire survey-based studies, integral to the development of the SKDI 2012 which I was involved, were meant to create consensus and imposing theory rather than understanding the reality, and therefore they could not provide a satisfactory explanation of how MP is conceptualised in residency training. Taking lesson of these experience, it is necessary to adopt different approach in researching medical professionalism and the interpretivist approach has the potential to provide this deeper

[1] In Indonesia, it is common to call the specialty student as a resident (“residen” in Bahasa Indonesia) rather than specialty trainee. Therefore, I will further consistently be using ‘resident’ to refer to these subjects.

understanding (Plano-Clark and Creswell, 2015; Waring, 2017). The research takes an original approach to medical education research in Indonesia, in that it is concerned with MP as a discourse. To explore the discourse, the research will deal with ideas, opinions, feelings, values, knowledge, and experience associated with MP. This will include talking to the people who shape, and are shaped by, the discourse. The development of the discourse is therefore represented as texts, not numbers (Phillips and Jorgensen, 2002; Creswell, 2007; Cleland, 2015).

Reflecting on the review of literature, my experience as a medical practitioner, educator, and policy maker in Indonesia, I have developed a preliminary conceptual framework which explains how I understand MP. This will guide the research. First, MP is a discourse in medical society. As a discourse, it is grounded in the knowledge, experiences, feeling and values of the social actors and expressed in their day-to-day activities or social practices (Fairclough, 2003). Social actor is a term coined by van Leeuwen (1992:61) to represent the people component in society that actively engage with the development of discourses (Van-Leeuwen, 1996). Although somewhat different in detail, the principle that a social actor is the human component of social structure is comparable with 'member resource' in Fairclough's CDA (Fairclough, 1992; Fairclough, 2015), or the concept of 'agency' in sociology. In this research, the social actors are the specialty practitioners and their residents.

Second, as a discourse, MP is influenced by power relations within the community of practice (CoP). The CoP becomes the medium in which the discourse is developed and transferred. The current MP discourse (the dominant or the mainstream) is usually exerted by figures who are able to exercise power due to either their superior knowledge or legitimate status gained through a legal position in a social organisation (Foucault, 1973; Bleakley, 2011; Fairclough, 2015). In my research these figures represented by specialists who gained their professorships in university or were granted specialist consultants'[2] status and those in-charge as leaders in the College of

[2] The label 'K' (stand for 'konsultan' in Bahasa or 'consultant' in English) is usually given by college of specialty to those who are already able to fulfill the merit performances set by their peers and grant status as reference person in the particular specialist community. In current Indonesia National Qualification Framework (NQF) system, the consultant is the

Specialty or organisations such as the Indonesian Medical Association, Indonesian Medical Council or Board of Medical Specialty.

From this perspective, I developed an initial conceptual framework (Figure 3-1) to guide data collection and analysis in the study.

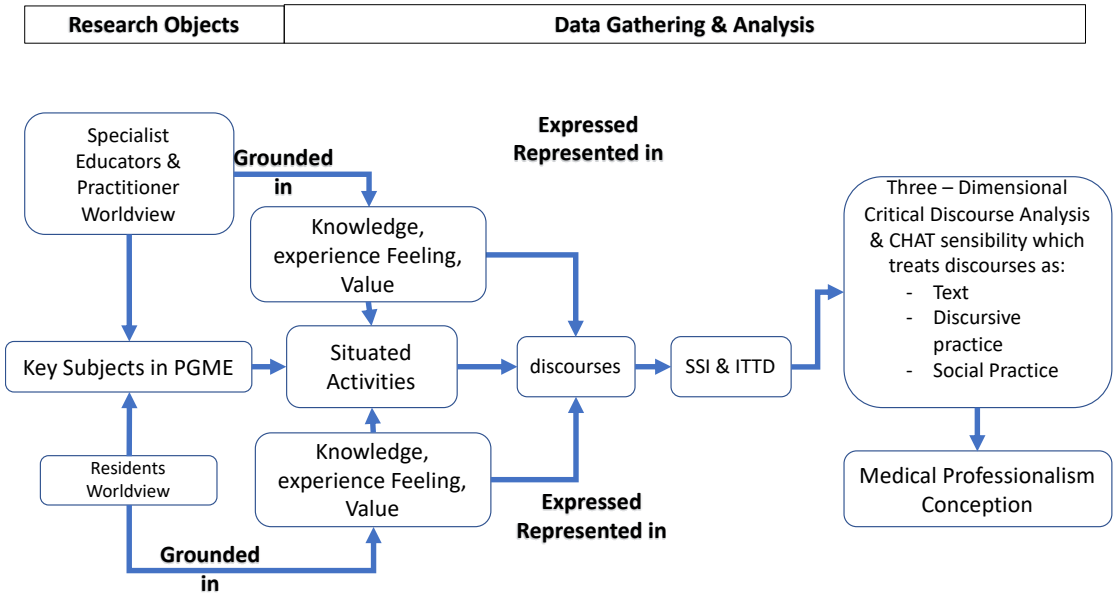

Figure 3-1 Conceptual Framework of Research Design

Notes on Figure 3-1. PGME: Postgraduate Medical Education**, i.e.,** Indonesian medical specialist education**; ITTD:** Interview to the Double.

3.2.2 Population and Sampling

3.2.2.1 Population

According to the Board of Specialty Colleges of Indonesia (Majelis Kolegium Kedokteran Indonesia / MKKI), there are currently 32 medical specialties in Indonesia. A review from MKKI and Faculty of Medicines' websites shows that there are 234 postgraduate programmes run by only 14 out of 85 registered Faculty of Medicines (See Table B.2, Appendix B).

3.2.2.2 Sampling Methods

A purposive-theoretical sampling is applied in this study (Yin, 2003; Plano Clark and Creswell, 2015). This means that the number and characteristic of

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highest credential/degree a medical specialist could get either through a deliberated training, recognition of certain amount of professional work credits, or combination of both. Meanwhile, professorship can only be gained through involvement in teaching.

participants are determined by the researcher based on the knowledge of the characteristics of the population (Yin, 2009).

Two specialty groups, orthopaedic surgery and neurology, are chosen as the units of analysis. These specialties were chosen for the following reasons. First, they represent the surgical and medicine (non-interventional) group of specialty. This grouping may appear not to represent the current complicated division and sub-specialisation development of the medical profession in the UK. However, it does represent the classification of the medical profession in Indonesia, which has existed since modern medical service and education was introduced and developed in Southeast Asian countries in the 18th century (Boomgaard, 1993; Hesselink, 2011; Pols et al., 2017).

Orthopaedic surgery is chosen because it is a surgical-group specialty that has a high prevalence of psychological burnout and professional lapses, arguably due to the nature of workload (Sargeant et al., 2009; Arora et al., 2013; Daniels et al., 2016). Neurology is chosen because it also has a high prevalence of burnout among medicine-group (non-interventional) specialties (Sigsbee and Bernat, 2014; Burton, 2018). However, neurology has fewer subspecialties compared to other medicine specialties (i.e., Internal Medicine or Paediatric). This makes the need for sampling smaller but at the same time provides balanced comparability with orthopaedic (i.e., less sub-specialties).

The second reason for determining the units of analysis in advanced is the need to optimally achieve data saturation to identify the conception of MP. Although it is common in a qualitative study to achieve saturation during the study, it is also arguably possible to estimate the sampling number in advance. As the aim of the study is to explore the conception of MP in Indonesian PME, two specialties are considered adequate to achieve the necessary comparison required to develop theoretical categories in the emerging conception (Dey, 2007; Saunders et al., 2018). This type of purposive sampling is called theoretical sampling (Dey, 2007; Plano-Clark and Creswell, 2015).

The estimation of the number of participants involved in this study is determined by a theoretical estimate using the Information Power model proposed by Malterud et al., (2016). For research with an exploratory purpose and cross-case design, it is estimated that 6-10 participants each case are adequate to uncover the existing narratives or discourses (Malterud, 2012;

Malterud et al., 2016). Based on this reference, in this study, there will be 12 participants each unit of analysis (specialty). Each specialty will consist of 6 of medical specialist teachers (MST) and 6 residents (R).

The selection of MST is determined based on my own exploration of 'influential persons' during my time as chairman of professional organisations in Indonesia prior this study. This judgment will also be enriched by a recommendation taken from the relevant College of Specialty. The sampling could have been different for researcher with different experience and network as well as the selection could be different to other researchers as the title, positions and the influence of participant might change anytime. The resident participants were recruited from the pool of residents' population in medical schools where the MSTs are chosen as participants. As an example, if Doctor E (initial of an MST) is from a neurology programme in medical school A, then the resident participants will also be from neurology programme in medical school A.

3.3 Data Collection

I realise that scholars have different views about how to name and describe the case study design (Yin, 2003; Thomas, 2016). Based on the aim of the study to explore conceptions of MP across Indonesian postgraduate medical education (PME), a nested case study design, as proposed by Yin (2003), has been chosen. The reason for choosing this design is that it allows me to explore MP in depth and to explore what specialties may, or may not, have in common, with regard to MP. The nested case study allows both depth and range. PME in Indonesia is regarded as the context of the case, and the two different specialties (neurology and Orthopaedic surgery) become the nested unit of analysis (Thomas, 2016). From this design, there will be two groups of participants in each unit of analysis comprising MST (influential figures) group and resident group. The rationale for choosing these two groups is described in the following section.

3.3.1 Rationale for choosing specialist teacher and resident as key participants

Despite being recognized as an independent individual in decision-making (diagnosis process and treatment choice), physicians are known for having a

typical collective social culture, values and tradition. This is sometimes referred to as a community of practice (Lave and Wenger, 1991). These culture, values and tradition are often influenced by powerful and charismatic figures within the community (Lave and Wenger, 1991; Mann, 2006; Helmich and Dornan, 2012; Crowe et al., 2017). These set of values then influence the way members of the CoP behave and perform their collective identity (Bleakley et al., 2011; MacLeod et al., 2015). It is why, long before MP is considered formally in the curriculum, medical teachers become the source of knowledge transfer and the role models for their students regarding professionalism. In an era where teaching MP is mandatory, studies show that role modelling is among the preferred methods for teaching professionalism competency (Passi et al., 2010; Birden et al., 2013). That is why I think it is critical to explore the views of influential figures in the specialty community on the concept of MP.

The involvement of residents in this study is also important due to the intensity of the involvement with their teachers. Residents are deemed the future of the specialist community. But reflecting on my experience regarding MP development, despite the opportunity to learn from many sources of knowledge and moments of reflection, residents appear to do the majority of their learning about MP from their specialist teachers. This takes the form of a transfer of behaviour between the specialist and the resident through role modelling, which can often be unconscious. Arguably, residents represent the marginalized subjects in the development of MP discourse in a speciality community, it is rare to see residents speak up about professionalism in any academic events. Their role in education management (e.g., accreditation), and service organisation (e.g., teaching hospital) are very limited.

Table 3-1 The number and location of participant interviews

	Specialist			
	Neurology		Orthopaedic Surgery	
Faculty of Medicine	**MST**	**RES**	**MST**	**RES**
University A Jakarta	3	2	-	-
University B Yogyakarta	2	2	1	2
University C Malang	1	2	2	2
University D Surabaya	-	-	2	2

Note on table 3-1: MST: medical specialist teacher participants; RES: resident participants.

3.3.2 Inclusion Criteria

For MST Participants:

- Practicing their expertise for no less than three years
- Currently active in teaching-learning activities
- Hold any of the following:
    - University Course Director,
    - Chair of College of Specialist at a national level,
    - Chair of Indonesia Medical Association at any level,

For Resident participants:

- Registered in the targeted school
- In their last two years of training (i.e., entrusted to see patients and teach undergraduate students or junior residents)

3.3.3 Data Collection Methods

Following a broad interpretivist paradigm in qualitative research (Creswell, 2014), this involved a prior assumption that the conception of professionalism is perceived as a form of knowledge that is located in a professional's mind, feeling, activities, and context. The interview consequently has the major potential to uncover this kind of knowledge. Kvale (2007) asserts that the interview is a key approach for exploring how interviewees experience and understand their world. This provides situated access to the living world of the interviewees, which is conveyed through their own words and language (Kvale, 2007) However, as social researchers frequently comment, the utilisation of interview is dependent on the research paradigm adopted by the researcher. Among three major research paradigms/worldviews (i.e., objectivist/positivist, interpretivist, criticalism/criticalist), the criticalist research paradigm has influenced my perspective on how I see the role of interview in this study. This allows me to perceive that professionalism as a knowledge is neither objective nor subjective. Knowledge is fluid and exchanged among people and competing agencies in the society (Bunniss and Kelly, 2010; Humphrey, 2013; McMillan, 2015). Moreover, this paradigm frame recognizes an assumption that

knowledge (MP) is also discursively changing in different contexts and times. In this way, interviewing functions as an active process in which the interviewer and interviewee produce knowledge through their conversation and discourse exchange (Kvale, 2007; Brinkmann, 2014). In this theoretical perspective then I believe the research questions can be addressed.

3.3.3.1 Semi-structured Interview

Among the variation of interview methods, I intentionally chose the individual face-to-face interview method, which known as the semi-structured interview. The semi-structured interview (SSI) has been widely known as a standardised interview approach in a qualitative study (Brinkman, 2013; Flick; 2002). Kvale and Brinkman define a semi-structured interview as "… an interview with the purpose of obtaining descriptions of the life world of the interviewee in order to interpret the meaning of the described phenomena." (Kvale and Brinkmann, 2009, p.3) This definition fits the intention of this research which wants to explore how professionalism is conceived and taught in the daily life of medical specialist practice and education. Furthermore, as an educationalist, I believe that knowledge is constructed in each person's mind. Therefore, the individual/ one-on-one SSI is chosen under an assumption that this will tap the unique development (situated ecology) of knowledge about professionalism for each participant.

3.3.3.2 Interview to the double (ITTD)

As a physician who had been nurtured in dominantly objectivist worldview in my past education and professional workplace, asking about any aspirational concept such as professionalism, through the SSI *per se* still left anxiety in my mind that it would only capture the superficial cognitive, ideological, and theoretical aspects about the profession which is not what I sought from this study. Following the literature review and journal club meetings in LIME and discussion with the supervision team, I found the ITTD had the potential to become a method that would help tap the everyday situation in each participant's context. I assumed it would deeply reveal ideas about the very local origin of MP and how it is developed, whether it is at individual, organisational or specialist society levels.

The ITTD, as an emergent qualitative data gathering method. Compared to SSI, which has been used for more than a century (Kvale and Brinkman, 2003), ITTD is less than 30 years old. The name of the method, “interview to the double”, was first introduced by a group of Italian occupational psychologists in 1970s as a critical method to capture the situated knowledge of how assembly workers learned on their job and how they passed this knowledge to the new novice workers (Nicolini, 2009a). In its original version, the ITTD was carried out in a series of workshops where the researcher acted as the double and the worker as the instructor. The ITTD was introduced to raise awareness that workers, as a ‘homogenous group’, were the bearers of valid and precious 'know how' technical knowledge. Consequently, the ITTD resulted in a set of long monologues of the workers, and each lasted about two hours. It was called monologue because the workers were never interrupted in producing their special knowledge by giving instruction to their double. The interview sessions were tape-recorded and transcribed using four main categories: relationship toward the task, the comrades, the factory hierarchy, and the trade union or other workers' organisations (Oddones et al., 1977 in Nicolini, 2009). However, since 2009 there have been publications using and reviewing the use of ITTD. Therefore, I decided to perform a literature review of how the ITTD has been used in research. I carried out the review in 2018 to inform my pilot exercise in using the ITTD. However, because I found ITTD so useful in carrying out my research the review included here covers material from 2017-2020 because I went back to review the method and its potential advantages and drawback of using this method when writing this chapter.

The use of the ITTD as a data gathering method for investigating medical professional learning and medical professionalism conception in a study, is rare. I have searched three renown databases; Web of Science, SCOPUS analytics, MEDLINE, by using keywords [instruction OR interview] AND [“to the double”] to explore this method. From this search, 78 publications were found. After deduplication and picking only English article, only 15 papers fit the searching criteria. Following this, I also collected the publication through hand searching by looking up the citation on the found articles and with this strategy 19 publications were eligible to be reviewed. Of these, one is in a thesis report form, two book chapters and the rest are journal articles. From the 19 publications, two are methodology review and the 17 empirical studies. The field

and discipline of the papers are varied. Six publications are in the health professional context or researching about health professional, and only one of these six studies is specifically related with general practitioner physicians (e.g., telemedicine case). Because the purpose of review is learning about methodology of ITTD, and concerning the limited number of publications, I decided to include all 19 publications to be reviewed (See Appendix K.). The summary of the review is presented in Table 3-2.

Table 3-2 Feature of ITTD in the literature

Aspects	Features
Research Paradigm	Social Constructivist Criticism (using term used by McMillan, 2015)
Alternative name	Interview to the double (original) Instruction to the double Interview with the double
Form of instruction	Oral (dominant) Written (sometimes this form is called instruction to the double to distinguish it from the oral version)
Professions being studied	Assembly worker in Car Industry School principals, Head Chef, Engineer, Business Rescue Practitioner, Administrative Organisation Manager, Radio Broadcaster, Aged-Care worker, Health Care Manager, Nurse, Medical Intensivist, Midwives.
Form of Use	A. Single ITTD use with short preludes on the feature of work/activity B. Combined with other methods: 1. With Interview-based method a. Semi-structured Interview b. In-depth interview c. Self-confrontation interview 2. With Image-based participatory reflection elicitation a. Thinking / Concept Map elicitation b. Photo elicitation c. Triptych poster 3. Observation-based a. Work observation b. In-situ/ field observation (Wellton et al., 2019) c. Impact observation d. Video recording (Theron, 2020) 4. Complex data gathering (More than two methods) Combination with some of above mentioned such as SCI (Shadowing, Conversion, Interview) method (Theron, 2020)
The use of ITTD in a combined data gathering	• ITTD at the front • ITTD in the middle (especially in participatory / action research design) • ITTD at the end
Potential benefit	1. As a Data Gathering method: • Capturing the local/situated context of practice or activity of human agency (Gherardi, 1995; Nicolini, 2009; • Describe the ecology of professional practice and learning involving the human and the non-human component of the practice (Nimmo, 2014; Scoles 2017) • Understanding local situation of professional learning or how

Aspects	Features
	they develop their knowledge 2. As an intervention method (Participatory research): • Trigger self-confrontation and reflection on improving practice or activity (Gorli et al., 2012; Bouchamma and Basque 2012; Theron, 2020)
Disadvantages / Drawbacks	• Difficult to maintain participant to provide the details of activity naturally, especially in written form of ITTD • In the oral/verbal form of ITTD, this might trigger boredom in the participant, which reduces the possibility to get detailed description/instruction. • So far, it used in a detached professional environment – separated from direct field observation. However, Nicolini suggests that it may be used as a complementary in a walking interview where space and pace might become the trigger. • The participants might only provide the "normative" version of their activity.
Some Ethical Concerns regarding the use of ITTD	• Requires lengthy time (1-1.5 hours), which potentially disturbing health professional schedule • Past conflicting behaviour or conduct during practice that might be elicited through the course of instruction of participant • With other visual-based ethnography, data gathering methods should ensure that the privacy right of the participants or organisation has been taken care of seriously.

Among the 19 publications on ITTD, all resources published after 2009 cited Nicolini (2009) as the main source of reference to the ITTD. Referring to this key article, Nicolini writes that the idea of the ITTD is from the work of Oddonnes et al. (1978) and Clot (1999). Unfortunately, these two publications were published in the non-English language and beyond my ability to comprehend. This is possibly why the ITTD, as a research method, not popular before 2009. This makes Davide Nicolini is the most referenced scholar using and theorising the ITTD. Consequently, I decided to contact him for the latest suggestions on the use of the ITTD. In this e-mail conversation, Nicolini offers two suggestions. First, he suggests that ITTD can be used more creatively when being explained and introduced to the research participant. He argues the ITTD can be used both as a data gathering and intervention method. As a data gathering method or intervention, ITTD can be used as an instruction in a written task, as a digital diary, as a walking interview which assumes location would become memory triggers, or by using two participants to interview each other. Second, based on his experience using the method, ITTD would rarely be used as a stand-alone method. This gives an insight that ITTD should consider the time commitment of the participant. These direct suggestions and my review

have helped me to combine the SSI and the ITTD, especially when explaining what participation would involve to potential participants.

3.3.3.3 Piloting SSI and ITTD

As a follow-up from the literature review and consultation with an ITTD expert, I did a pilot SSI and ITTD with two British medical specialists in Leeds and two of my Indonesian medical specialist colleagues. From this, I had opportunities to ask professionals how they felt during the SSI and ITTD sessions. Three critical observations and notes from pilot participants regarding the ITTD are described in the following paragraphs.

My first notes are that the instruction of "explaining the reason" of daily activity in ITTD was mostly unanticipated by participants. Some pilot participants found it difficult to explain the reason of why he/she did this kind of activity because they had never thought it before. As a professional, most of the time they just do their professional duty because it is as it is (a taken for granted activity). I think this is one the critical advantage of the ITTD that it has potential to surface the cognitive component of activities that have already become a routine. This reflection helped me to understand why some researchers in management and organisational field used ITTD as a mean to help managers to improve the decision making quality (Gorli et al., 2015; McGrath et al., 2019; Théron, 2020).

The second observations is that participants had a tendency to become impatient with the “perceived-lengthy” detailed conversation in ITTD. In this situation I noticed some participants tended to shorten their daily activity story into a list or pointed out activities that were perceived to be fit for the interviewer. I got an insight that when participant felt impatient, it might bring two possible consequences. First, the participants talk too much on the details or, second, the opposite, participants: might only talk about what they thought essential to be heard. In order to make sure that participants could concentrate fully on the ITTD, I think it is important to offer participants the choice of performing the ITTD at a different time than the SSI.

The third note from this pilot is that giving an instruction of definite time, such as “tomorrow” in ITTD, as it was used by the previous researcher in the assembly worker field (Oddones et al., 1978) could not be used on its own as,

unlike the assembly workers, my participants had different day to day outlines and responsibilities. Three out of four pilot participants asserted that they had different professional roles on different days in a week. For them, every day in a week has a different professional schedule and activities. Therefore, giving a definite time “tomorrow” would not be relevant and asking about all the weekdays is impossible due to time constraints. Consequently, I decided to modify the instruction by using "the most professional day", which allowed the participant to think of a single day that would represent their busiest day in which their multiple role activities were engaged. The observation about professional day and professional roles gave a clue to the importance of inviting participants to explain their professional role and to describe their professional activity at a glance in advance. To clarify this information, I posed the question about participant’s profession as the opening discussion in most of the SSI sessions.

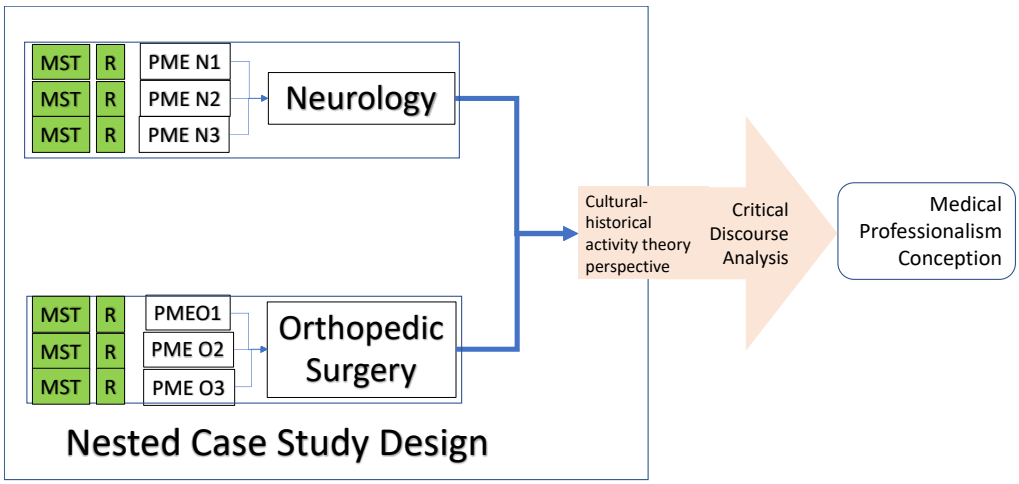

Figure 3-2 The nested case data gathering and the framework of analysis

Notes on Figure 3-2: PME: Postgraduate Medical Education programme; (N1-N3: neurology programmes), (O1-O3: Orthopaedic surgery programmes); MST: Medical Specialty Teachers; R: residents

3.4 Data Analysis

3.4.1 Analytical method

The analysis of the data is performed by applying the Fairclough’s three-dimensional critical discourse analysis (3D-CDA) method (Fairclough, 1992; Fairclough, 1995). The three levels of discourse analysis in 3D-CDA allows

exploration of three dimensions of discourse: 1) discourse as texts, 2) discourse as discursive practice, and 3) discourse as the manifestation of social practice.

Analysis of discourse at the level of text employs intertextuality techniques which seeks the meaning behind participant's use of words and statement and interrelation between the use of one text to another. In doing this, I utilised corpus linguistic techniques by using an open software *LancsBox*[3] to overcome any bias or personal limitations in seeing the connection of words. This is done by applying collocation and keyword identification. Collocate is words that are used together in a statement or set of statements (passages) due to natural selection of speech producer (speaker or author). There is an assumption in the linguistic field that collocate is an indication or representation of certain point of view, therefore a sign of a discourse. For instance, in one corpus (word recorded database), word 'female resident' is collocated with words 'limited', 'less strong', 'slow', and 'emotion' might indicate that in the passage or corpus there is a gender biased discourse which is representing the unequal comparison of female resident with male resident.

In the second phase, the analysis focuses on seeking the pattern of text production, distribution, and consumption (use). These aspects will inform how the texts shape the context or activities in which discourses are produced and vice versa, how the context and activities influence the discourses. In this phase, we might expect to see which situated discourses are related with context. For instance, what MP definitions are specific for specialist practice and to explore why this is the case. Another example, the word ethics linked more with 'professionalism' in orthopaedics than neurology which might be explained further by the enforcement of ethical guidance in orthopaedic training.

The third phase of 3D-CDA, analysing discourse as social practice, is done through identification of ideologies and agencies involved in the development of texts and discourses. The analysis concerns with the use of language (discourse) and the influence of power in the development of discourse and, at the same time, identify which MP discourses are dominantly influential (hegemonic) and marginalized (Wodak, 2001; Fairclough, 2015;

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[3] LancsBox can be downloaded with its how to use guide freely on: http://corpora.lancs.ac.uk/LancsBox/download.php. Appendix J in this thesis provides a brief feature of how the software is used in this study.

Rogers et al., 2016). This will also utilise the theoretical lens and concepts developed by Fairclough on the order of discourse (Fairclough, 2001) and knowledge/semiotic emergence or the development of new knowledge through social practice (Fairclough, 2011).

3.4.2 The demography of the participants

Following the 3D-CDA tradition, it is important the set the scene of knowledge construction by disclosing the source and character of the object of analysis (Phillips and Jorgensen, 2002; Fairclough, 2003). From the fieldwork, 23 participants agreed to be involved in the study. They consisted of 11 medical specialist teachers (MST) and 12 residents (RES) from 4 Faculties of Medicine. All residents agreed to perform both interview techniques but, as anticipated, some MSTs were unable to perform the ITTD session, mostly because of difficulties in fitting it into their schedule. Following the verbal and written consent, 23 SSI and 17 ITTD sessions were conducted, resulting in 3095 minutes (51 hours and 35 minutes) recorded interview sessions. Out of these sessions, 1820 minutes (30 hours and 20 minutes) were on SSI and 1275 minutes (21 hours and 15 minutes) on ITTD. All transcripts of these sessions, researcher notes and reflection during the fieldwork become the object of analysis in this study. The demography of the participants is presented in Table 3-3**.**

Calculated from column 6 of Table 3-3, the mean age of MST participants was 51 (with 11 points standard deviation), and mean age of RES participants was 31 (3.9 points of standard deviation). There were approximately 20 years age-difference between MST and RES participants, and, from the standard deviation, we notice that the RES participants were more homogenous compared to MST. Based on participant's information, the current relatively younger age distribution of RES might be caused by a tendency of residency education in Indonesia to admit fresh and younger undergraduate medical school graduates (below 30-year-old) for entering residency in the last ten years, although most residency programmes are allowing the upper age limit of 35 years old for their new applicants. Considering the age of the youngest MST participated in this study (35 years old), and the average age of residents (which are at the end of their study), the age gap between MST-resident gives a rough insight that it took at least 5 years for fresh

specialist graduates to take an influential role in national specialist organisation (such as College of Specialist or Association of Medical Specialty).

Table 3-3 Demographic feature of participants

Participant	Specialist	FM	Sex	Age	Role
MSTN1	N	A	M	76	Former Chair of College of Specialist
MSTN2	N	A	F	55	Chair of Examination Division at KNI
MSTN3	N	B	M	56	Chair of College of Specialist, HOD
MSTN4	N	C	F	55	Chair of College of Specialist, HOD
MSTN5	N	C	F	45	HOD, Member division College of Specialist
MSTN6	N	C	F	43	Head of Study Program
MSTO1	O	A	M	37	Secretary of College of Specialist, HOSP
MSTO2	O	D	M	53	HOSP, Chair member of college of specialist
MSTO3	O	B	M	54	Divisions College of Specialist, Secretary of Study Program
MSTO4	O	C	M	56	Chair of IOA College
MSTO5	O	B	M	35	Secretary of Study Program
RESN1	N	C	M	30	Chief of Chief Resident
RESN2	N	C	F	30	Chief Resident
RESN3	N	A	F	32	Chief Resident
RESN4	N	A	M	40	Chief Resident
RESN5	N	B	M	38	Chief Resident
RESN6	N	B	F	32	Chief Resident
RESO1	O	B	M	30	Chief Resident
RESO2	O	B	M	30	Chief Resident
RESO3	O	A	M	31	Chief of Chief Resident
RESO4	O	A	F	28	Chief Resident
RESO5	O	D	F	26	Chief of Chief Resident
RESO6	O	D	M	28	Chief Resident

Notes for Table 3-3. F: female; M: Male; FM: Faculty of Medicine (same letters show the same institution); HOD: Head of Department; HOSP: Head of Study Program; KNI: Indonesian College of Neurology; IOA: Indonesian Orthopaedic & Traumatology Association, Specialist N: neurology, O: orthopaedics surgery.

Most MST participants involved were able to fulfil the criteria set at the beginning of the study. The “influential” criteria of the participant were evidenced either by direct participant statements of their past and current roles or by the “influential works” they reported during interview sessions. In term of influential works, these are meant to represent the participant’s involvement with educational policy which may directly or indirectly be responsible for educational change in specialist education. These influential works were all confirmed when I invited them to tell me their background or current daily

activities. Some quotes of typical dialogues showing the participant's credentials and their influential roles are included below. For instance, in neurology:

> RSB: "To begin with, could you tell me, how is your daily activities looked a like, doc?"
>
> RSP: "Well, thank you for the opportunity previously, I am TA ((pseudonym)), **currently serve as a head of the department [HOD] of Neurology**, Faculty of medicine University X ((pseudonym)), CM Hospital ((pseudonym)) since August 2017, **I was also at the college ((Indonesian College of Neurology)) before, in the previous period of 5 years ee (3s). Now I am also still in the college for the position as a Head of Department it must be in the college**. Then I teach for specialists' programme, particularly in my division Neuro-oncology, pain and headache and then I also hold e: (5s) **Involved in several modules for S1 ((Undergraduate)) students, now I am in charge as a deputy chairman of Nerve and Mental Health Module which is an integrated module with Psychiatry, and also being involved with neurology clinical practice module ((Clinical Rotation))**. " (MSTN2, SSI)

And an example in the orthopaedics surgery.

> RSB: "The first thing can dr.I ((pseudonym)) tell me your activities both as an orthopaedic doctor and as a consultant"
>
> MSTO:"As a consultant, firstly, **doing patient care is certainly**, yes (2s) this patient care could be in the polyclinic, can be in the operating room, can be in the inpatient ward. **Then plus the education role. Education in terms of specialist education, professional phase training for physician**. That sometimes ... wait, is this I am as a person, as a consultant or as orthopaedics?
>
> RSB: "Doctor as a professional."
>
> MSTO: "Professional orthopaedics? **I am also at the college ((College of Orthopaedic surgery)), e: (3s) as a chairman of the examination committee, curriculum committee**. I am also a member of the PABOI, as the chairman of the PABOI in this city branch, and **as a developing team for P2KB ((continuing professional development programme))**." (MSTO2, SSI)

All resident (RES) participants were at their Chief phase whether in neurology or orthopaedics surgery. This is possible because in all study programmes, the responsibility to teach other, as it was set as the criteria for recruiting RES, is fulfilled while residents are at this top-end level of residency training. Although the Chief phase might have different responsibilities and work burden, all of the RES participants said that their involvement in this study was possible because they had "relatively" more spare time than their junior residents.

Although Indonesia is known as the biggest Muslim country in the world, it is not a religion-based country. Therefore, in all study programmes selected

there is no formal requirement for a newly appointed resident to be a Muslim, hence all residents with an officially approved religion could enter the speciality program. That is why I did not set religion as a requirement to select the participants because it would be both ethically and legally problematic. However, during the interview I always managed to clarify this issue, especially when a participant elaborated any issue regarding spirituality or religiosity. Because of this, I know that the majority of participants involved in this study were Muslim. Only three participants from residents were non-Muslim, and they were all Christian.

Getting in touch further with participant's daily roles, there is a tendency that the more specialist expertise the participant possessed, the more and wider role the participant had. This role could be in educational organisation, profession organisation, government organisation and/or in non-government organisation (NGO) setting. The number of specialists possessing consultant or sub-specialistic titles are fewer than the number of "just" specialist ones. This feature is important because it portrays participants' multiple identities. Because of their multiple roles and identities, participants needed space to arrange their mind in order to provide a proper description of their professional responsibilities, such as in the second example of conversation with MSTO2 above.

Although less salient, these multiple roles also featured in the RES participants. The vertical movement phases of resident (e.g., Phase I to Chief phase) represent the vertical gradual entrustment to various roles and responsibilities toward being an attending (specialist or consultant). Being a chief resident, in most RES participants, means they bear more responsibilities, even if it was actually not the formal task of a resident, such as representing their supervisor in a meeting, or replacing service of their teacher out-of-hours. This occurred both in orthopaedic surgery and neuro:

> After that, well, I'll do service. Can be to polyclinic or to the OK ((Dutch abbreviation OK=*Operatie Kamer* means surgical operating room)), It depends. If there is an interesting case, then to OK, if there is none and I have other tasks such as, say, attending meetings in representing seniors or there be a poly. Often to poly. (RESO5, ITTD)

> Yes, thank you Doctor for your trust and opportunity. I am, as a student ((resident, the participant was using term "*mahasiswa*" which mean student rather than "resident")) in the final level of the Neurology Specialist

> Education Programme at BU University. My current position is a post chief … So, we're considered as the sidekick of Supervisors. Say, the extension of the Supervisor. We teach our junior resident both in terms of knowledge and services to neuro patients at SA Hospital…that for the academic. The second, non-academic, better I call it the medical services at the teaching hospital. Here we are fully responsible for representing our supervisors in each wards according to the duties and divisions, the ward division. Usually once a month we're moving from one ward to another (RESN3, SSI)

All of the 22 participants were originally from four different faculties of medicine located in Java Island. In each specialist case, three faculties of medicine were involved (symbolized with A-C letter). There are some reasons for this choice. First is the fulfilment of recruitment criteria. The influential MST figures which had become the key criteria of MST participants originated from specialist programmes from these four faculties of medicine. The second and the most critical reason of choosing the Faculty of Medicine in Java is feasibility and safety reason which has to be sought in the submission of risk assessment in Ethical Committee of School of Medicine, hence I myself at the planning time did not have contact at Faculty of Medicine outside Java and the flight plan was difficult which require the possible extension of stay in Indonesia which could not be financially supported by the scholarship Grant.

3.4.3 Data Treatment

Following the transcription of the interview sessions, translation to English was performed along with the coding and memo writing process. 70% of the interviews were transcribed by myself, with the remaining 30% transcribed by 2 professional transcribers. Two sets of records, 2 SSI and 2 ITTD were translated and back translated by a professional translator, to check the quality of translation. I realised from this process that in some instances my translation was more accurate because I could give additional notes about what happened during interview which was probably not quite clear enough in the transcript. Also, I can decide which medical jargon should be retained and explained as it represents common words in medical practice. In presenting the excerpts from participants, I adopted a transcription system convention that is usually used in discourse analysis (Rogers, 2011) and the system used in this study is presented in Box 3-1.

Box 3-1. The transcription system used in this study

(.)	: very brief pause
(3s)	: specific duration of pause in second
(e or e:m)	: voiced pause
(( ))	: researcher notes
RSB	: researcher as interviewer
RSP	: participant as interviewee
MSTN	: medical specialist teacher neurology
MSTO	: medical specialist teacher orthopaedics
RESN	: Neurology resident participant
RESO	: Orthopaedic surgery resident participant

Initially, I intended to use NVIVO to analyse the data. Unfortunately, during the lockdown resulting from COVID19 pandemic working with NVIVO through the University-served platform from home had a significant lagging problem, which seriously affected the progress of work. This made me change to text analysis using Microsoft Excel. In order to maintain the compliance with the Data Protection and Safety regulation, the work has been uploaded regularly to the cloud system of University of Leeds immediately after the work was done remotely. There was a blessing in disguise with this shift because the text analysis step of 3D-CDA can be performed in parallel with Corpus linguistic due to the transferability of the Microsoft Excel (.xls) file. The files can easily be added to the *LancsBox*, a corpus linguistic analysis software which I used to perform the Corpus-linguistic method. The *LancsBox* is a software introduced in the Corpus-Linguistic course I previously mentioned, and I have been learning to use this software through the course and applying it in this study, especially in this first and second phase of 3D-CDA.

The data treatment and analysis process were started with transcribing all of the audio recording. This was done along the process of first coding and translation until all records were transcribed and translated. The process of first coding and memo making then continued for the entire participants. The decision to change from NVIVO to Excel occurred in the middle of transcription. After completing the training on the corpus-linguistics I then enriched the coding process by employing the explorative collocation analysis in the exploration of discourses for the development of second coding and collocation confirmation

in the third coding development which resulted in the elicitation of the final Discourses (D) in this text analysis phase. During the explorative collocation, I applied the Key Word in Context (KWIC) function in the LancsBox, while in the confirmatory collocation, I mainly applied the collocation Graph (GraphColl) function (Please see Appendix I).

Although corpus-based linguistic technique is mostly employed as a quantitative measure of annotated texts (corpus), the decision in the development of discourses and Discourses (order of discourse) is not determined by the result of quantitative measure from LancsBox. Rather, consistent with the interpretivist nature of analysis, the development and elicitation of themes and discourses are determined solely by the reflexivity of the researcher eclectically (Wodak and Meyer, 2011) considering both the senses and meanings in the participants' excerpts and the evidence shown in the LancsBox analysis. As Paul Baker and Tony McEnery repeatedly state in the course and their writings; corpus data has never interpreted itself. It is the task of the researcher to make sense the patterns of language found in the corpus, formulate reasons for their existence or look for further evidence for supporting hypotheses (Baker, 2006). The iterative process of performing text analysis in this first phase of 3D-CDA is illustrated in the Figure 3-3 and the example of the first coding can be seen in in Appendix. H.

To provide navigation on how the three phases in 3D-CDA are performed and adapted, I will provide a brief technical re-introduction in the beginning of each analysis phase presented in Chapter 5-7.

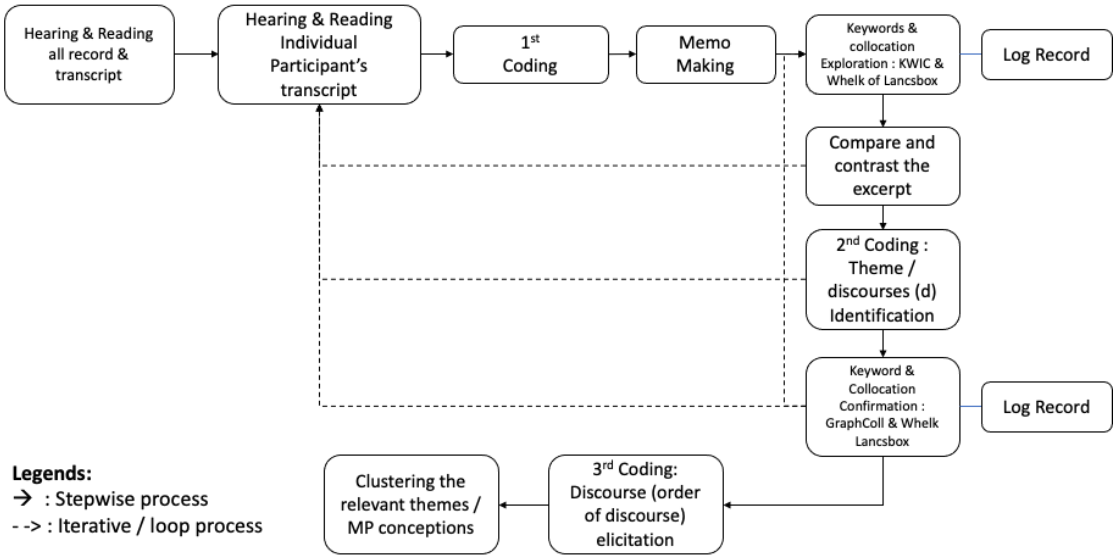

Figure 3-2 The Iterative process of text analysis in the first phase of 3D-CDA

3.1 Assuring the Rigour of the Study

As a qualitative study, the quality of the study is determined by the rigour of its design and implementation. Lincoln and Guba (1985) introduced the use of trustworthiness to articulate the conception of maintaining the rigour of study in a qualitative inquiry.

> "How can an inquirer persuade his or her audiences (including self) that the findings of an inquiry are worth paying attention to, worth taking account of? What arguments can be mounted, what criteria invoked, what questions asked, that would be persuasive on this issue?" (Guba and Lincoln, 1985. p, 290).

In this study, the criteria of trustworthiness are distributed in the iterative process within the course of study, from fulfilling the expected participation, collecting data, coding, analysis and developing theory (Glaser, 1998). The consultation and reporting of the progress of the study periodically to the supervisor is another way to maintain quality assurance. It is expected that during fieldwork some intensive communications with supervisors regarding the progress of data collection and analysis will take place either through email (every two weeks) and/or Microsoft Zoom talk (once a month).

Thick description has also been described as a strategy for ensuring the criteria of dependability (Yin, 2003) and transferability (Lincoln & Guba, 1985). Thick description is a reporting approach that provide a very detail description of

the course of the research. Cohen (2000) describes a thick description report might include:

> “Speech acts, non-verbal communication; description in low inference vocabulary; careful and frequent recording of the time and timing of events, the observer’s comments that are placed into categories and detailed contextual data” (p.311).

Yin (2003) suggests, on judging the quality of research, “The general way of approaching the reliability problem is to make as many steps as operational as possible” (p. 38). Lincoln and Guba argued that it is the researcher’s responsibility to provide a sufficient description of her/his case study that can allow another researcher “contemplating application in another receiving setting to make the needed comparisons of similarity” (Lincoln and Guba, 1985, p. 360). This means that presenting the detail of the study so that other researchers can replicate the study is one way to defend the rigour of the study. In this sense, I hope that all the information included in the body of thesis, in addition to those included in the appendices, provide sufficient details of the research process in this study, though I also realise that providing a “good and relevant" thick description is not easy.

3.2 Ethical Consideration

The elicitation of ethical problems and measure are also a critical component to enhance the trustworthiness of the study. This is because ethical consideration takes into account the condition of the human being as research object or subject which might be different from one to another study. This research involves mature human beings as participants. Therefore, ethical principles have been strictly applied during the study.

All participants were recruited on a voluntary basis. They were informed about the research and what their participation would involve using oral and written information before they signed written consent.

Protecting the privacy of the participants has also been of primary concern. Information from each participant was analysed using pseudonyms. Audio-recordings, field notes, and interview transcripts used in the research are stored in the University of Leeds cloud database using a double layer

encryption (both in folders and files) and will be retained for a period of ten years (University of Leeds, 2018).

The success of data collection relies on the willingness of the participants to be interviewed. Should any circumstances arise that puts individuals at risk or causes unresolved stress, participation was not pursued. This happened with two potential MST, one in neurology and one in orthopaedic surgery. On many occasions of contact, these participants showed hesitation which was expressed as inability to provide time to be interviewed. Due to time constraint, I decided to delist their participations and seek other potential candidates.

The participants are all service providers, teachers, or residents with busy schedules, and it was a challenge to arrange appropriate times for individual interviews. Consequently, interviews were scheduled far in advance and grouped together when I visited the corresponding city where the participant's workplace was located. I had been as flexible as I could if the time arrangements need to be changed, including the use of participants' most preferred mode of communication (phone, email, text, etc.). When the interview sessions were done, each participant received a voucher as a thank you for their time.

The status of the researcher as a lecturer in a medical school and former chairman of some professional organisations might have affected the relationship with participants. However, since these positions were not active during my PhD study leave, this risk was reduced. Participation was entirely voluntary which enabled anyone with concerns to choose not to take part in the research.

Participants are active physicians working under ethical codes and legal regulations. Professionalism is potentially a sensitive topic and participants might wish to tell a story or share opinions about a third party, such as a patient, student, peer or hospital/clinic employer. Participants were advised that if such stories were essential, they should not use real names. They were also informed that should a participant report any behaviour in breach of the law or professional conduct, the researcher would terminate the interview and follow the hospital or medical school's guidelines for dealing with such an incident. This information was clearly outlined in the Participation Information Sheet and Consent form (See Appendix D to F). At the end of data gathering, no breech

has been reported or occurred, so I did not need to invoke this termination procedures.

Ethical approval for the research was sought and gained from the School of Medicine Ethical Review Committee, University of Leeds and from the Ethical Committee from Faculty of Medicine in Indonesia, as shown in Table 3-4 (The copy of ethical approval letters are provided in Appendix C)

Table 3-4 List of Ethical Approval

Ethical Committee	Institute	Date of Approval	Code of Document
School of Medicine Research Ethics Committee	University of Leeds, United Kingdom	31 May 2019	MREC 18-067
Health Research Ethics Committee (HREC)	Faculty of Medicine Universitas Brawijaya, Malang, Indonesia	14 May 2019	153/EC/KEPK-S3/05/2019
Medical and Health Research Ethics Committee (MHREC)	Faculty of Medicine Universitas Gadjah Mada, Yogyakarta, Indonesia	30 April 2019	KE/FK/0458/EC/2019

Chapter 4 Constructing Context for Researching Medical Professionalism

4.1 Introduction

In the literature review chapter (Chapter 2), I explored the literature to contextualise the relevance of researching medical professionalism in postgraduate education and Indonesia's setting to explore that MP is context-dependant. This chapter reviews three major concepts of the 'context' under the socio-cultural perspective on professional learning studies. I argue that framing context as activity systems is appropriate in this study. This explanation is necessary to precede the analysis to avoid a common misunderstanding of what is meant by 'context'. The misunderstanding has commonly come from a frequent view on generalisation bias of articulating cultural heritage (e.g., region, race, country heritage) as a sole source of different emergence of conceptions or behaviours in professional learning. This generalisation bias can be found in some studies on professional learning and professionalism setting in Asian countries. For instance, Claramita et al., 2019, utilising Hofstede theory of cultural dimensions, assumed that their country-based sampling participants shared same 'socio-hierarchical" characteristic of health-professional society of non-western context. Suhoyo et al, 2014, also reinforce Hofstede theory, use term culture as a taken for granted influence for different behaviour in receiving and providing feedback between Dutch and Indonesian medical students and educators. In my view, this generalisation bias potentially shrinks and misleads the meaning of culture and context under socio-cultural paradigm of learning that might hinder the potential to harvest the richness of situated perspective and knowledge emergence in health professional education.

This chapter will start to review the three 'socio-cultural contexts' concept known in education research. From this review then I argue conceiving context as an activity system informed by cultural-historical activity theory (Engeström, 1999; Engeström, 2001) is more sensible in understanding the conceptualisation of MP. I provide and elaborate information and reflection from the fieldwork to support this claim. Moreover, I further argue that adopting CHAT in the framing context influences how MP, as the object of interest in

activity systems, is investigated and analysed. Finally, this chapter concludes with highlighting the critical potential of 3D-CDA as data analysis method to understand how MP discourses are conceptualised in the multiplicity of activity systems (contexts) of Indonesian medical specialist practices.

4.2 Revisiting the meaning of context in professional learning

In the previous chapter (chapter 2), I explained how contextual professionalism is more sensible to be adopted in a country-based study. However, this “contextual” term is still too general to feature the specific situation or case in conceptualising complex professional learning such as professionalism. Hence, among contextual-based professionalism views, especially brought by non-western scholars (Ho et al., 2014; Wang et al., 2016; Al-Rumayyan et al., 2017), the socio-cultural aspects have mostly been referred to as the situation/container that detached but influences the different definitions of professionalism. Reflecting on the two chosen cases (i.e., neurology and orthopaedic surgery) in the fieldwork and more reading on scholars’ socio-cultural perspectives, I needed to escape from this particular context-culture generalisation framing. This escape will widen the situatedness of the context in which MP is constructed or mediated.

The discussion about the learning context is critical in professional learning or work-based research. Moreover, it becomes more engaged by the development of the lifelong learning discourse (Edwards, 2009). The development triggers a question: if learning is lifelong, what is explicitly a learning context? Lave and Wenger (1991), with their extensive work on situated learning, put significant attention on expanding the definition of context for learning outside educational institutions following their work on situated learning. Lave and Wenger’s work expand the possibilities of defining context beyond traditional educational environments (e.g., college, school, classroom etc.) through presentations of the workplace, the home and the community; and the dynamic situations inside each of them as strata of learning. There are learning contexts distributed across these contexts and associational order of these and embedded in activities of the practice within it where the order is itself already a learning context. Within these works, context is conceptualised through understanding practice or everyday-based learning.

The first and popular conception of context is the conduit/container model (Lave, 1988; Edwards, 2009; Russell, 2009). In this discourse, context is regarded as the container/conduit (e.g., bowl or cup), and the behaviour and knowledge as objects of research interest become its content (e.g., fluid material like tea or soup) which context is giving shape to it. In this concept, the content and its conduit used to be viewed separately. Lave (1988) argues that this separation of human actions and learning with context is typical among behaviourist and cognitivist researchers. Although this view might be powerful for research purpose such as classifying forms of human behaviour or understanding the individual mental model and cognitive structure (e.g., investigating cognitive steps and behaviour development in learning surgical stitches, or understanding heart sound anomalies), Lave (1988) and Engeström (1996) suggest that this approach gives insufficient room for human flexibility on the construction of novel context (e.g., learning in new or transformative places). This discourse has appeared in some studies on medical professionalism in Asian country settings where researchers referred to country ethnic culture or regional ethnic culture as an overarching context (conduit) responsible for the emergence of different conceptions of professionalism (content). Frequently argued in taken for a granted form of expression, this discourse is likely the dominant view of among researchers in conceiving culture as a significant representation of the context of learning. An excerpt from a comparative study on feedback might illustrate this typical taken for a granted form of reasoning: "To examine cultural differences in feedback processes during clerkships, we replicated a Dutch study in the Indonesian context" (Suhoyo et al, 2014. p.227). In this study, the researchers intentionally put country ethnicity as the representation of culture -and thus context specificity- which is responsible for causing the differences of feedback behaviours of clinical supervisors to junior medical students. Although it is appropriate to see a relationship between the conception of professionalism and ethnic culture, in some instances, this discourse has been used to preserve the status quo of certain (perceived) valuable culturally originated behaviours or principles (indigenous knowledge or practice), and therefore restrain for any possible intrusive external values or initiatives. Nishigori et al (2011) show that cultural-based life principles of Samurai's Bushido have served as a source of unique

professional practice that preserved Japanese medical practitioners' professionalism.

The second concept views context as both situated and experiential spaces (Engeström, 1996). In this view, context is conceived as both social situations and virtual spaces of interactive experience. These views are popularised by phenomenological and ethnomethodological researchers who see context as simple as when two people or more, meet and exchange ideas. Although contexts are conceived as interpersonal constructions, they are commonly treated as purely linguistic, symbolic, and experiential entities, independent of the deep-seated material practices and socioeconomic structure of the given human culture. A study by Ming Jung-Ho et al (2014) is one example of how context is articulated with this discourse. The researchers in the study conceived that student in Taiwan and Beijing shared the same Chinese culture and therefore they are eligible to represent Chinese culture. However, the study shows professional conceptions generated in the two schools are significantly different.

The third and the most aspiring to be adopted in this study is the socio-material perspective of context. This view on context is first introduced by Vygotsky (1978) and Leont'ev (1981), followed by a prominent Vygotskian researcher figure, Yrjo Engeström, who then expanded Vygotsky's activity theory into the third generation of activity theory or Engeström and Cole (1993) later popularized it as cultural-historical activity theory (CHAT). In cultural-historical activity theory (CHAT), contexts are neither seen as containers nor situationally created experiential spaces. Contexts are conceived as activity systems where people and their tools, rules, division of human functions (divisions of labour) and community are weaving together into a unified whole (Engeström, 1996, 2001). The CHAT perspective often takes network as a metaphor for conceiving context (Russell, 2009). It is interesting to know that etymologically, context is derived from Latin, *contextus* (from con-'together' and *texere*-'to weave', like weaving in textile or texture (Merriam-Webster Dictionary, 2021, context entry). This chapter and this study will be the example of how this discourse on learning context is utilised.

Applying socio-cultural perspective, such as CHAT as an underpinning theory in conceiving context is vital in the study on complex situations of

professional learning such as with medical practitioners. The healthcare setting where medical practitioners work is complex with the rapid (sometimes overwhelming) emergence of medical knowledge and technologies which continuously develop new guidelines and new professionals, impacts of changing public health policy, and changing patient demography and expectations. In this notion, I will argue that adopting CHAT is necessary to frame the context in this study as follows.

4.3 Adopting cultural-historical activity theory (CHAT) to frame context in studying medical professionalism conception and learning

In professional learning and work-based studies, socio-cultural perspective, theories and concepts such as: activity system (Engeström, 2001; Morris, 2010); communities of practice (Lave and Wenger, 1991) actor-network theory (Fenwick and Edwards, 2010), social semiotic (Bezemer, et al, 2011) and complexity theory (Bleakley, 2010) have come to the academic discourse to expand our understanding of pedagogy (or andragogy) and address some of the perceived deficiencies of cognitive and behaviourist approaches to learning in a work-based setting. Under these underpinning theories, professional learning is understood to be rooted in activities, in the community of practice, and importantly, in interactions between humans and their mediating artefacts/tools (such as instruments, working tools, organisation structure, semiotic and language), and in complex organisational networks. These approaches are concerned with how learning interacts interdependently with the systems in which professionals work: the cultural, political-economic, and social dynamic of particular group and settings. With more focus on the materiality aspects of human interactivity, scholars also called these socio-cultural perspectives as socio-material approaches.

The third generation of activity theory or cultural-historical activity theory (CHAT) developed by Yrjo Engeström, is one among the major approaches in socio-material approaches on professional learning or work-based learning studies that took healthcare professionals and institutes as an area of study. CHAT endeavours to make sense of the messy networks of human interactions with human and non-human elements of an activity system as they engage in a

knowledge-producing activity. This messy network or context is typically called the activity system (Leont'ev, 1981, Engeström 1999, Russel, 2009). As previously mentioned, an activity system consists of enmeshed (weaving) of human subjects (e.g., individual professional) and their mediating artefacts/tools (e.g., patients, medical tools, healthcare guides etc), rules, community (e.g., health professional community, hospital community, academic community), division of human functions (divisions of labour and roles e.g., head of department-member of the department, chief resident-resident, sub-specialities object of interest. In this notion, CHAT asserts that learning is mediated from and through, shaped and being shaped by this enmeshed reality of activity systems. CHAT used to be illustrated in a webbed triangle of its elements (subject, mediating artefacts, object, rules, community, division of labour) seen in Figure 4-1.

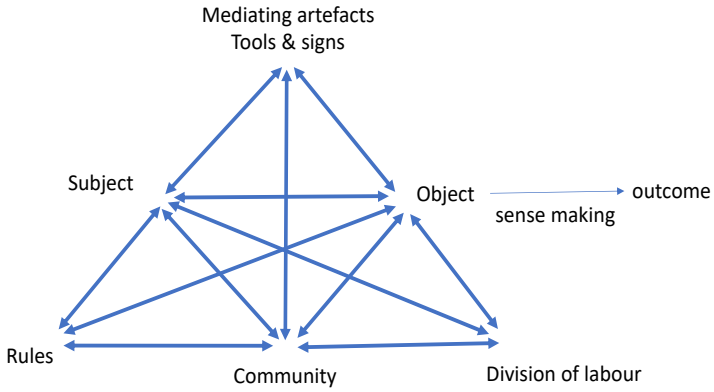

Figure 4-1 The structure of a human activity system (Engeström, 2001)

The use of CHAT for conceptualizing context in this study is also relevant with the current trend of adopting constructivist paradigms in theorizing and implementing teaching-learning in medical education curriculum and research (Ng et al., 2014; McMillan, 2015; Dennick, 2016). The Constructivist paradigm is a broad term that is also influenced by Vygotsky's activity theory in conceptualizing the nature (ontology) and reproduction (epistemology) of professional learning (Mann, 2011; Dennick, 2016). Therefore, CHAT also has a close connection with the constructivist paradigm of learning that has been applied in medical education practice and research.

Thus, the application of CHAT helps with sense making of both learning and learning contexts. Therefore, if we regard MP as knowledge about the

profession where it is generated and applied in medical professional practice, then an inquiry to understand MP needs to be framed in this corresponding conceptual framework. There are five principles in which CHAT is applicable to make sense context of the learning (Engeström, 1999; Engeström, 2001; Morris, 2010), and in the next paragraphs, I will provide a brief explanation of what these principles are and will elaborate on these concepts along with the information from the fieldwork in the subsequent section.

The first principle is multiple activity systems as the object of analysis. As Engeström theorized, CHAT considers the researcher to explicitly recognize the presence of shared activity across systems whether they are artefact-mediated or object-oriented activities. The duality of academic and service professional practice of the medical practitioner is the classic example of multiple activity systems. A study by Morris showed that undergraduate medical education is an example of a shared activity system where participants (or actors) in this activity system are engaged in two interacting activity systems i.e., NHS activity system and university medical school activity system (Morris, 2012). To begin conceptualisation of context as activity systems, it is important to identify that there are at least two shared activity systems to be examined (Engeström, 1999; Morris, 2011)

Second, *multivoicedness* or interdiscursivity of activity systems. An activity system is a community of multiple interest, perspectives, traditions and power. The division of labour in an activity creates different positions for participation where each participants carry their own diverse histories, and the activity system itself carries multiple layers and strands of history engraved in its artifacts, rules and conventions. This multivoicedness is grows as it enmeshed in more complex networks of activity systems. This multiplicity of discourse is both a source of problems and a source of innovation, demanding multiple interpretations and negotiations (Engestrom, 2018).

Third, the critical role of historicity in the activity systems development. Activity systems take shape and transform over a long time. This means their problems and potentials can only be understood against their own history. History itself needs to be studied as local history of the activity and its objects, and as history of the theoretical ideas and tools that have shaped the activity. Thus, medical work needs to be analysed against the history of its local

organisation and against the more global history of the medical concepts, procedures and tools employed and accumulated in the local activity.

The fourth principle is the existence of contradictions. Engeström (2004) describes contradictions as the accumulation of structural tensions within and between activity systems. For CHAT's analysts, the persistent existence of contradictions function as sources of change and development of activity systems; this is why an activity system is theorized as an open system (Engeström, 2001). This means that an activity system (AS) could adopt any elements from outside or adopt them from inside. When an activity system adopts a new element from the outside (for example, a new technology or a new object), it often leads to an aggravated secondary contradiction where some old element (for example, the rules or the division of labour) collides with the new one. In this instance, contradictions generate both disturbances and conflicts, and also innovative attempts to change the systems.

The fifth principle is the possibility of expansive transformation of the activity systems. As an open system, activity systems evolve through relatively long cycles of social disruptions, re-balance and transformations (Engeström, 2001). However, there is a time (hypothetical) when the contradictions of an activity system are aggravated, make some actors in activity system begin to question and deviate from its established norms. In some cases, this escalates into collective envisioning, learning and realising an intentional collective effort of change. An expansive transformation is accomplished when the object and other elements of the activity are reconceptualised to embrace a new wider horizon of trajectories than in the previous mode of the activity. Daniels asserts that the expansive transformation of the activity systems is also a moment where the expansive learning of the actors in activity systems is occurred (Daniels, 2004).

I will elaborate these principles by providing evidence from fieldwork to justify that CHAT is appropriate to frame context as well as MP conceptualisation. Rather than describing the principles in a linear way, I will present the arguments by starting with the historicity (the third principle) of the two chosen medical specialists (i.e., neurology and orthopaedics surgery). Starting with the historicity exploration I believe is the key concept to

understand how many activity systems interact in medical specialist education (first principle) and the other four principles.

4.4 Indonesia Medical Specialist Education and Practice as activity systems: a historicity development.

In this section and sub-sections, I will present the historicity of Indonesian medical specialist education and how this historicity helps surface the multiplicity of activity systems within it, followed by multivoicedness and contradiction, and then expansive transformation.

On many occasions, research participants frequently referred to some written materials (e.g., guidelines, laws or any professional organisation issuances) while elaborating their explanation of some critical issues. One example of these critical issues is referred by participants in the history of the specialist. There was a participant who gave a clue that during resident admission it is mandated that in the interview, the candidate should know the history of orthopaedic surgery in Indonesia and in that School of Medicine, which can be read openly on a website. Another example is the development of new professional standards such as specialist-based professionalism and ethical conduct standard. In approaching these written sources, it provided a learning moment' in collecting and putting the pieces of a puzzle into a clearer picture of the specialist education context in Indonesia. I believe the information from these documents is as critical as the information gained from the interview sessions and therefore, need to be written down.

As it will be explored in the next sub-sections, the main data to construct this narrative are mainly from the local documents, field observation and experience notes I collected during fieldwork. The documents might have not been as comprehensive as if I were designing the study as a medical history study because the way to get them were only through following the trace (just following the need to clarify or complementary things that come up in the interview sessions). However, I believe the data poses originality and the accuracy to construct the historicity of each chosen medical specialist education.

4.4.1 General feature of Specialist Education

Before describing the feature of each neurology and orthopaedics surgery cases, I think it is necessary to explain the big picture of the medical education continuum and specialist practice in Indonesia. What I mean by continuum is the three phases that are known in medical education practice, especially after the harmonisation of medical education in European countries with the three cycles scheme of higher education under the Bologna Process initiatives. This term is also firmly used and popularised by the World Federation for Medical Education (WFME) in its trilogy standards inception (WFME, 2003). This continuum consists of basic/undergraduate, postgraduate and continuing professional medical education. There might be differences names of practice of this continuum worldwide, however the principles are quite the same that the medical education consists of basic medical education, advanced training which lead to speciality, comparable to postgraduate higher education qualification or professional doctorate programme, and on-the job improvement which usually integrated as a provision for revalidation of competence and ability for practice in the form of continuing professional development.

The general feature of the medical education continuum in Indonesia has been described briefly by Ten Cate et al (2018) in the opening chapter of the third edition of medical education textbook, Understanding Medical Education. In Indonesia, the basic/undergraduate medical education is a university degree course, started directly after students graduated from senior high school and passing the university admission exam. The length of undergraduate level has been reduced from 6.5 years to 5 years curriculum in 2006 through the enactment of national standard of education of KKI. This made the undergraduate level consisted of 3.5 years bachelor degree (*sarjana kedokteran/S.Ked*) and 1.5 year clinical rotation attachments leading to a MD degree (Dokter/dr.). This MD or dr. degree considered as the first professional degree as a provision to perform the general practitioner (GP) practice. Since 2014, to grant the professional degree, students have to pass the national competence examination (UKMPPD). After granting the dr. degree, all the graduates have to perform internship attachment to get the full registration as dr. and eligible to get licence to perform GP practice from the ministry of health authority. After getting the registration, the registered doctor might choose

whether to perform practice or to continue their postgraduate education in order to be medical specialist.

Concurring with ten Cate et al (2018), postgraduate medical education, most commonly referred to as specialist education in Indonesia is a provisional training for every physician to run specialist services in the country. The length of the training is varied amongst existing specialities but typically runs between 8 semesters (mostly for non-surgical based such as Internal Medicine, OBGYN, Paediatric, Neurology, Pathology, etc) to 12 semesters (common for surgical based specialists). The length of study time of the Indonesian undergraduate and postgraduate medical education can be illustrated in Figure 4-2.

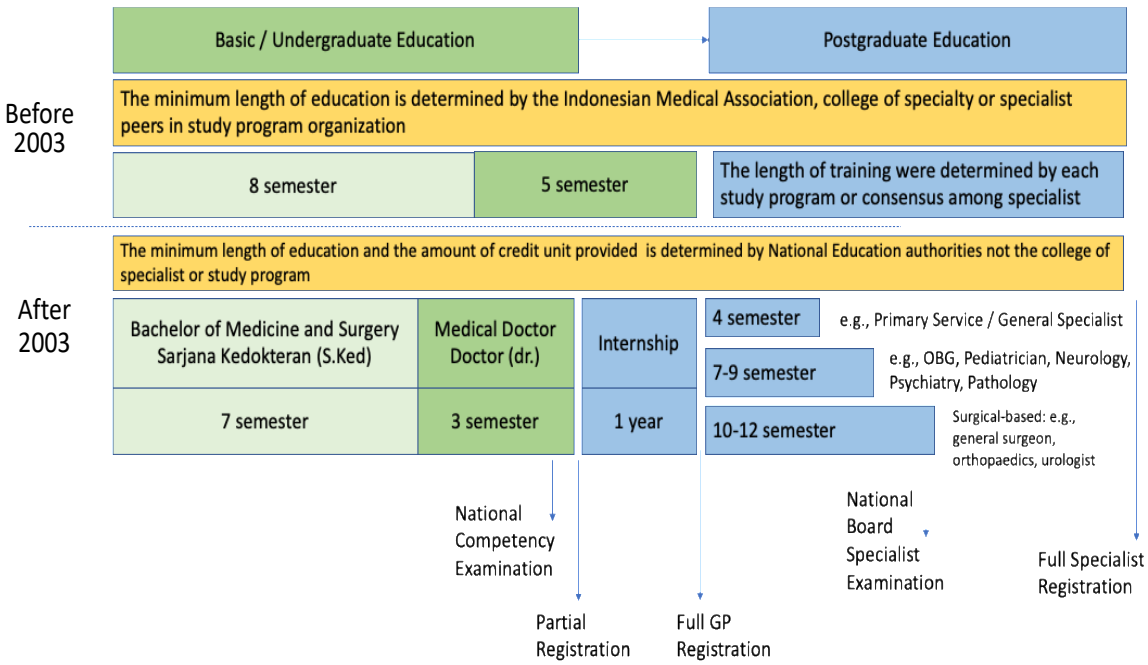

Figure 4-2 The periodisation of the past and current undergraduate and postgraduate medical education in Indonesia

While ten Cate et al (2018) explored the current undertaking to predict the future projection of medical education, contrary, in this section I will give more attention to the development of the current from the past of the specialist education to build the socio-historical context of Indonesia medical education. I will start the description with problematising the 'specialist education' term and then the teaching-learning model trend, internal structure of specialist education and its evolution relevant to the current situation.

The term medical specialist education is the English translation of "*pendidikan spesialis*" which can be regarded as a vernacular term in Bahasa

Indonesia (Indonesian language) to call the postgraduate training for physicians. This vernacular term is especially related to the degree title given to the trainees when they finished their residency programme. The specialist degree is symbolized by an “Sp + Initial name of the specialist” (e.g., SpN for a Neurologist, and SpOT for Orthopaedic and Traumatology specialist). Thus, because the education is producing specialists, then it is simply called specialist education or ‘*pendidikan spesialis’*.

Furthermore, the practice of using the term specialist is not custom alone. It has also symbolized a socio-legal practice in this country. What I mean by socio-legal is that the practice of using ‘specialist’ has socio-cultural and legal origins. The first full-fledged medical school, named STOVIA, in this country was started in 1905. The medical specialist service in public hospitals had not been present in the country until 1927, when the *School tot Opleiding van Indische* Artsen (*School for the Education of Indies Physicians*) or the STOVIA was allowed to admit both European and Indonesian students. Since then the degree had been recognized to be equivalent with those in the Netherlands in which some of these Dutch-based graduates already had a specialist degree (Neelakantan, 2014). Hence, the earliest medical specialist education itself was started in mid 1960 as the outcome of a collaborative project of Ministry of Health authorities with the University of California at San Francisco (UCSF), lasting from 1954–1960 (Pols, 2006; Neelakantan, 2017). Through this projects, many physicians, mainly from two oldest medical schools (STOVIA in Jakarta and *Nederlandsch Indische Artzen School*/NIAS in Surabaya), joined specialist training in the UCSF medical centre and came back to be legitimate medical specialists in Indonesia, either by establishing a specialist department in the medical school or specialist service in related to serving the teaching hospital as well as running specialist training along with these new specialist services (Neelakantan, 2017; Pols, 2018; IOA, 2020). All practising physicians and residents (specialist trainees) in this period were either paid by the government or by the hospital through an out-of-pocket scheme (directly from patient payment) (Hesselink, 2011a). Although paid by the government, the amount of service fee at this period was non-standardised because it was mostly determined by the specialist or agreement between the specialist and the hospital management.

The model of specialist training during 1958-1989 was an apprenticeship, adopted from where the earliest specialists were trained in the USA or European countries e.g., The Netherlands and France (Pols, 2018). The products of medical specialist training during these periods were called specialists. It was initially a name, not a mandated and legalized title or degree as the present. The programmes were not degree-based titles, which means the graduates did not put additional specialist credentials after their full name in the practice plank outside their practice place. However, after the country had a National Education System law, which was enacted in 1989, medical specialist training has been recognized as a higher education degree and legalized to bring the title to the public. Because of this, the term education was then more preferred than training. At this time, required by the law, a specialist should put his/her full credentials in the professional artefacts (name tag, practice board/plank, or in their medical record stamp). Although the specialist degree and title were not meant only for the medicine in the law, until 2015, medicine had been the solely profession using this specialist title, followed by the Nursing profession (Standar Nasional Pendidikan Tinggi, 2015, 2018).

Before the national education system law being enacted in 1989 and the first government higher education act (*Peraturan Pemerintah) no.60, Year 1990 about Higher Education,* was issued. The specialist title was exclusively granted by the college of specialists (peer professional organisation). Unlike in the UK or USA, the college of specialists in Indonesia is a part of a specialist association, and every specialist association is a legal member of the Indonesian Medical Association (the hierarchical structure of membership is illustrated in Figure 4-3). This legal practise was abolished in 2003 when the ministerial administrative enacted the second National Education System law. With this new law, the “specialist” title can only be granted by a university-based specialist study programme. The study programme should be hosted by a recognized Faculty of Medicine which owns the highest accreditation status (“A” Accredited). The specialist title must be known to the public, especially for the patients being served with the speciality service. The provision to make the title known by the public is then translated into other legal practices such as putting a name tag with full credentials, showing a list-board of the working specialist in the patient-admission lounge in the hospital and public health centre, or mounting the

credential in a practice board/plank (*papan nama*) in the front of the private clinic place (see figure 4-4 for some examples).

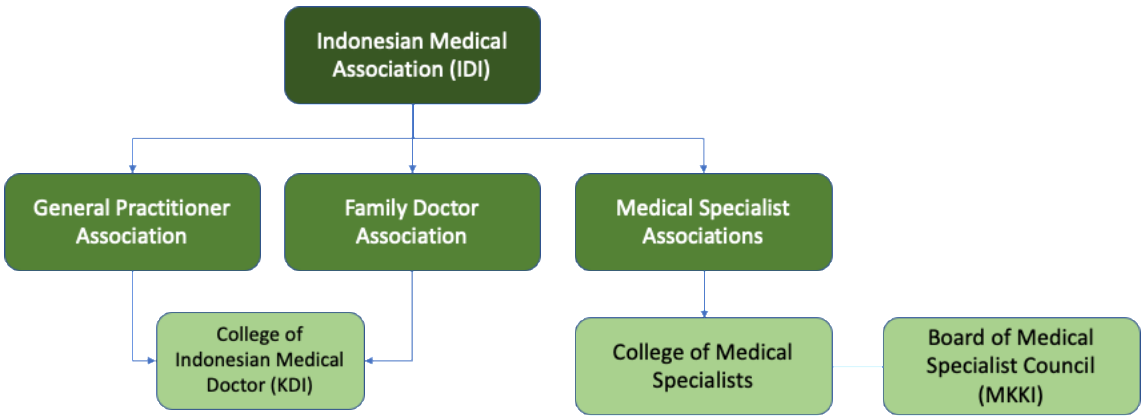

Figure 4-3 The illustration of vertical structure of the Indonesian Medical Association (IDI) and Medical Specialist Association (*Perhimpunan dokter*) and College of Specialist (*Kolegium*)

Dr. XXX YYY ZZZ, SpPD
Internal Medicine Specialist
No. Practice License (From District Health Authority)

Practice Schedule
Monday – Friday: 16.00 – 20.00
Sat & Sun Closed

An Example of some Practice Broads in the front of Private Hospital showing the Name, Specialist Title, and the schedule of practice

Figure 4-4 Practice board with the name and title of the practising specialist installed in the front of the private practice (left), and at the front yard or main hall of the hospital (right).

The teaching-learning model of residency training in Indonesia before 2003 was exclusively determined by the peer specialists convened in a Department of Specialty of a Faculty of Medicine or a teaching hospital. Whilst standard education was usually referred to as the product of the college of specialists, the implementation of residency training was mostly dependent on the agreement among the teachers in each centre of training. Two chairs in the department that bear the most powerful influence in determining the teaching-

learning policy in the department at this time were the Head of Department and the Head of Study Program. All aspects of residency training including the number of admitted residents, the duration of the training, the curriculum and the amount of tuition fee were determined exclusively by the two chairs and somewhat by the senior member of the specialist teachers. At this time, the specialist training profile greatly varied from one programme to another. This situation was the main reason that in 2012, the Ministry of Education was unable to provide scholarships to the resident. This practice has changed in 2014 following the enactment of a new accreditation system for all higher education institutes, which to some extent, was targeted to the health professional education institute. The new accreditation system requires all study programmes to apply a set of national standards of education which is not just the “exclusive” professional education standard issued by a particular college of specialist, but also a standard determined by the Indonesian Medical Council (KKI), a standard of medical education issued by the ministry of education and a standard of postgraduate medical education issued by the accrediting body.

At the same time, there was a case affecting the Dean of a Faculty of Medicine. The Dean was charged for corruption and convicted by the court because of the maladministration of the resident fee payments (The Jakarta Post, 2010). Prior to this case, residency programmes were conducted at the teaching hospital, managed, and determined exclusively by the specialist peer in the specialist department, and it was a common practice that the resident expenses (tuition and other expenses) fee were paid directly through the study programme account. Unfortunately, the financial regulations were not so fully understood by physician-administrators who were used to self-manage their professional education business.

There were also times when specialist education was treated specially because they were perceived to be “different” from other education models. It is why before 2003, specialist training was exempted from centralized accreditation. They were allowed to be accredited by the college of specialist and Indonesian medical council, not by the national accrediting body and were excused to charge tuition far beyond the average tuition fee just because they were specialists that had been “addressed differently in the law and acts”, not because the unit costs to run the programme were really that much. After the

corruption case, there were tensions to force all payments for residency expenses to be made more transparent and centralized with the University accounts. The accreditation and the intervention of university authority on the financial accountability of specialist education to some extent has changed the landscape of power which existed in specialist education.

In summary, the historicity of the medical specialist education practice has witnessed the evolving change of rules and policies that involved different communities of practice (divisions of labours) and the nature of relationships and how specialists learn in the workplace (practice artefacts). In this notion, the historical development of medical specialist practice has been transformed from a peer-group self-regulated practice into a complex multi regulatory (internal and externally regulated) specialist education. In this notion, we can identify two activity systems. The first is the professions peer-practice activity system, and the second is the national education activity system for the medical profession represented by the University-based School of Medicine[4]. Later, through the help of 3D-CDA, we will witness how discourses' multivoicedness and contradictions shaped the expansion of these multiple or polycontextual nature of activity systems which determine how MP is conceived and applied.

4.4.2 Specialist practice in health care

Specialist practice in Indonesia is a combination of public and private service. There was a time when physicians could have unlimited practice places. According to the Indonesian Family Survey in 1993, approximately 80% of physicians in Indonesia were engaged in dual (public-private) practice (Eggleston and Bir, 2006). This dual practice is argued as a contributing factor to the maldistribution of health personnel, particularly specialist doctors (Mahendradhata et al., 2017). The maldistribution is also caused by the reluctance of specialist doctors to move to areas without private practice and with less well-equipped medical facilities where they would miss out on a significant portion of income. A study by Meliala et al., (2013) found that 65.6% of the income for surgeons and 81.2% of obstetricians were from the private

[4] This University-based term is to differ with Western medical education that had been developed from a proprietary school of medicine or teaching clinics.

sectors. Despite the health authority ministry issuing a regulation that only allowed physicians to register in three practice places at a time, dual or even multiple practices is still a common practice for Indonesian physicians, especially specialists (Anderson et al., 2014b).

The restriction of practice places does not mean that there are no more specialists practising in more than three places. The weak law enforcement system either through watchdog system or information system governance are not able to detect the specialists that abused the law. In their study, Meliala, *et al.*, (2013) have also found that despite the practice place regulations, most specialists included in the study were working in more than three practice locations, some in up to seven locations. Very few specialists spent the required hours of work in the state hospitals, which caused limited availability of key services in public hospitals (Mahendradhata et al., 2017).

Before 2013, both public and private services were applying out-of-pocket payment systems for financing health costs. It means the patients have to pay the fee directly to the doctor or health care institution for the expense of the care they received. After 2013, when the country applying Universal Health Coverage policy through JKN (National Health Security) and BPJS (Social Security Administrator for Health agency) laws, most of public health care institutes were forced to accept the health payment from a third party (BPJS) which is usually payable several months after the services were provided. With the existence of two medical services i.e., public and private, it is typical that the specialist medical services, especially for ambulatory patients, are usually held during normal work hours (08.00 – 16.00) and private practice are usually held at evening (17.00 – the end of patient list). Until this section is written, there is no restriction on the working hours for medical doctor. It can be inferred, it is common for a medical specialist, especially the fresh graduate until their mid-career, to work overnight as long as there are patients to serve. Different to general practitioners and the past situation, some excerpts from the interview sessions show a tendency among the specialists that they now prefer to provide their specialist practice at private hospitals rather than at home or private clinics.

In maintaining the wellbeing of practice, it is common that in a town or a district several specialists serve a joint practice. It is possible that in some

districts, competition or niche claims have existed. While in the former, the specialists could form a firm or specialist-led enterprise, in the second condition, where there is a heightened competition, another local regulation emerged to limit the number of practising specialists. Actually, in order to resolve any possible disputes among specialists or among doctors at the regional or district level, there has been a branch extension of the Indonesian Medical Association (IMA). However, it depends on who chairs this town or district IMA. As by law a recommendation from regional or district IMA for practice eligibility should be sought to get a practice license from the local Health Authority, IMA could become the source of dispute rather than the solver to this problem. This is sometimes complicated by an administrative requirement for entering residency. Most of the admission policies for applying residency programme require candidates to have a recommendation from a senior specialist in their district origin. The main reason behind this policy is to support the government effort in maintaining the distribution of specialists and to help the resident secure their career development by returning back to their district origin, not staying in the town where the training is conducted. This policy has been enacted because there is a tendency that specialist graduates are likely to stay in the city rather than return back to their town origin. Unexpectedly, in the field, this policy has given the power to the senior specialists to be a ‘ruler’ of specialist services in the town or district. If the chair of the IMA is the specialists don’t want anybody to come to the town yet, then it is unlikely the recommendation will be given.

Following its historical dynamic so far, we have observed that the Indonesian medical specialist practice is changing over time. In this change, whether represented as public - hospital-based- service or specialist private clinic service, Indonesia's medical specialist practice have presented a full distinct characteristic of the goal-oriented community of practice or the activity system. As an activity system, it has a group of people (subjects) with typical set of characteristics, rules, division of labours, artefacts, and shared transformative goals. Included in the characteristic of this activity system is that it enmeshed together with other activity systems. In this notion, the object of learning such as professional expertise or knowledge emergence becomes an integral part of the change of these networked activities systems. Therefore, analysing the emergence of professional knowledge such as professionalism in medical specialist practice would be unlikely achievable without consciously

recognize this multiple nature of context (polycontextuality). The following sections will take the case on neurology and orthopaedic to understand further the polycontextuality nature of medical specialist education and practice in which professionalism will be explored and theorized.

4.4.3 Neurology and orthopaedics Situation

4.4.3.1 Neurology Specialist Education & Services

The Neurologist (neurology specialist) is one of the oldest medical specialists by practice in the Indonesia (Pols, 2006). The historical development of neurologist as a distinct medical specialist practice represents a unique development of community of practice. Historically, it can be featured in three timeframes.

The first periodization is when it was still identified as a neuro-psychiatry community in 1927-1945. In the 1927, symbolized by the establishment of a neuro-psychiatry department in STOVIA, the community has declared to be among a few medical specialists that own its medical speciality department. STOVIA (*School tot Opleiding van Indische* Artsen / *School for the Education of Indies Physicians)* is the oldest medical school in the Dutch East Indies (Indonesia's name before the independence). In this year the STOVIA had recognition from the Dutch East Indie (DIE) government and medical society in the Netherland and DIE so that the STOVIA graduates were deemed equivalent to those awarded in the Netherlands (Pols, 2019). Since then, the STOVIA accepted students both from European and Indonesian origin. In order to manage this development, by the Dutch neuro-psychiatrists management, the department was responsible for both teaching medical students and serving patients with neurological and psychiatric disorders. Although the patients were taken care together in the Internal Medicine wards, neuropsychiatrists were allowed to perform their own patient care and teaching medical students. The department had also initiated the research and produced several papers that were published in a renowned medical journal at that time. A paper written by a physician working in Dutch East Indies on the trigeminal neuralgia had been published in one of the oldest medical journals in the world, *Nederlands Tijdschrift voor Geneeskunde* in 1852. This is profound evidence that the Indonesian neurology community has been a goal-oriented community of practice both in the academic and service field from its scratch inception. Whilst

continuing to serve the public, and involve in producing physicians and specialist study, the neuro-psychiatry department was solely managed by exclusively Dutch physicians until it received Slamet Iman Santoso in 1927. Dr.Santoso was among privileged bumiputras that had advanced medical training in the Netherland. At that time only talented or rich bumiputra had an opportunity to have education in the Netherland. During these years the Department had also received trainees to become a neuropsychiatrist. The training was three years, consisting of two years in Psychiatry subjects and a year in neurology subject. However, the decision to be fully recognized as neuropsychiatrist was mostly based on the approval from the senior specialists in the department. With this mode of training and credentialling, the timing was not strictly enforced. This invariably and the difficult nature of psychiatric subject possibly become the reason why many medical graduates are not interested in both specialities. The colonial government had to recruit doctors to be trained as Neuro-Psychiatrist in order to fulfil the need to serve their both General (referral) hospital and mental asylum services (Mardjono, 1997; Pols, 2006). When most of the Dutch physicians left Indonesia due to Japan occupation in 1942, the department of neuropsychiatrists only produced very few amounts of Indonesian neuropsychiatrist. Therefore, when the newly recognized country of the Republic Indonesia performed the acquisition of medical school, there were no Indonesian graduated neurologist in the country. So, in this period of time neurology education was in a state of exclusive training where most of the learning occurred through the informal events of apprenticeship between appointed trainees with the official specialist in the Department of neuro-psychiatry in performing neuro-psychiatric service. It seems that neurology education manifested as a single activity system at this time.

The second development of neurology education took place after the independence (1945) up to the establishment of the Indonesian Medical Council in 2006. This lengthy period is possibly the golden ages of self-regulatory role of Indonesian neurology community, especially in the establishment of the national neurology education and practice. This phase was started along the strategy of the newly formed government to steadily abolish the colonial hegemony both in ideology and practice. This strategy was a common practice for many newly established post-colonized countries at that time. One of the features of this practice occurs in higher education, e.g., when the STOVIA was naturalised and

integrated into a newly formed national university called Universitas Indonesia. Further strategy to wash the colonial legacy was that the government funded some Indonesian born physicians to get speciality training abroad, mainly in the USA. The formal purpose was to strengthen both the newly established national Faculty of Medicine and to improve the quality of teaching hospital (Mardjono, 1997). Mahar Mardjono is one among these talented physicians to get training in neurology speciality in the University of California San Francisco (UCSF), USA. Mahar Mardjono (deceased in 2002) was sent to UCSF by Slamet Iman Santoso under the Rockefeller project (1950-1961). After Mahar returned back from the USA in 1958, he took over the department of neuropsychiatry from Slamet Iman Santoso and established the new department of neurology which separated to psychiatry as how he was taught in the USA and visioned the future of neurology service and training in Indonesia. The department of neurology continue to send talented medical graduates for neurology training abroad in order to expand the newly established neurology divisions in a vision to establish the national neurologist training programme. To accomplish this reform agenda, The Indonesian Society for Neurology, Psychiatry and Neurosurgery was founded in 1961. Mahar was appointed as the first Professor of neurology in the country in the following year. In these early years of the second phase, centralised neurologist figures from Universitas Indonesia had been influential in the development of neurology as practising specialist and also the establishment of education system and research of neurology and neurosciences in Indonesia.

In the mid-1988, following the development of neurology as a distinct discipline in the developed countries (European and North American countries), neurologists then dissolved from neurology-Psychiatry society and established their own organisation called the Indonesian Association of Neurologist (PERDOSSI). At the time the PERDOSSI established, four neurology training programmes were existed. These four programmes were contributing to the production of around 16 new neurologists annually. This means that until 1988 the neurology service in the country was indeed an exclusive service for most of the Indonesian people. It is difficult to describe how neurology education was delivered between 1988-2006 because limited written resources existed. However, a critical situation that is worth being noticed at this period is that each programme had become more independent in determining the process of

education. The Indonesian Medical Association (IMA) where PERDOSSI belongs, together with other specialist association, become the most powerful medical profession organisation and significant government lobbyist agency for the major discourse of medica services, professional conduct, payment system as well as an educational process. The hegemony of professional organisation made it possible to amend the national education system so that the speciality programmes were exempted from the national accreditation process and performed their own accreditation system during 2003-2013. Alternatively, the accreditation of the specialist programme, like neurology had been performed by the peer neurology specialists in their own college of speciality and later involved the member of Indonesian Medical Council in 2009 (Program Pendidikan Dokter Spesialis Neurologi, 2022). Consequently, each neurologist community that hosted educational programme, like other speciality programmes, had the privilege to determine the design and delivery of the curriculum as well as the length of the educational programme. Because of this privilege, the study time for completing neurology specialist was different for each study programme, ranging from 7 to 10 semester (Lim and Tan, 2007) In this middle of the second phase, the dominant feature of self-regulatory of neurology as an influential power in determining the form of neurology education is profound. Collective role, sharing decision making dynamic in the neurology community of practice took more formal shape by the establishment of the association and college of neurology. Moreover, this time is also featuring the formal communal identity that set a critical milestone in the development of neurology as a field and academic practice.

The third development of neurology society occurs after 2006 until current days. It was symbolized by the establishment of the Indonesian Medical Council (InaMC) that changes the political and professional community power landscape. The InaMC, which is adopting the idea of the General Medical Council (GMC) in the UK, become an emergence regulatory agency for Indonesia medical practice. Its role was started by the issuance of education and competency standard. These standards, renewed in every 5 years, have been the reference for performing new accreditation system in medical and health professional education study programmes. In 2014 the accreditation of medical education programme, including speciality education is mandatory. Moreover, the study programme should be accredited by a government-

acknowledged independent accrediting body called LAM-PTKes on the compliance of the study programme to the standard issued by the LAM-PTKes. To overcome the conflicting interest of profession organisation and the ministry of education and InaMC, the LAM PT-Kes standard has been developed by merging standards from Ministry of Education and Culture, Indonesian Medical Council as well as World Federation for Medical Education (WFME) standard of postgraduate medical education. This new accreditation requires different approach than previous accreditation system to the quality provision such as the use of external assessor (assessor from different neurology discipline) and annual surveillance report which demand study programme to provide the data on achievement progress of students, publications, and public service activities. Although this new accreditation system provides a serious challenge to most of specialist education programme, uniquely, “college of neurology is one among the leading sectors in the compliance of this system” (MST3, SSI). This is a different standpoint compared to the previous era where neurology community become the opposant of the national accreditation system run by BAN-PT (National Accreditation Agency for Higher Education Institution).

After 2014, all neurology specialist programmes are standardized to achieve a set of national learning outcomes in structured educational programme that spread into minimum 8 semester length. At the edge of the educational time each graduate candidate should pass a national examination that consist of a series of knowledge based MCQ test, OSCE and thesis presentation held in 3 consecutive days. The typical neurology education programme is presented in Figure 4-5

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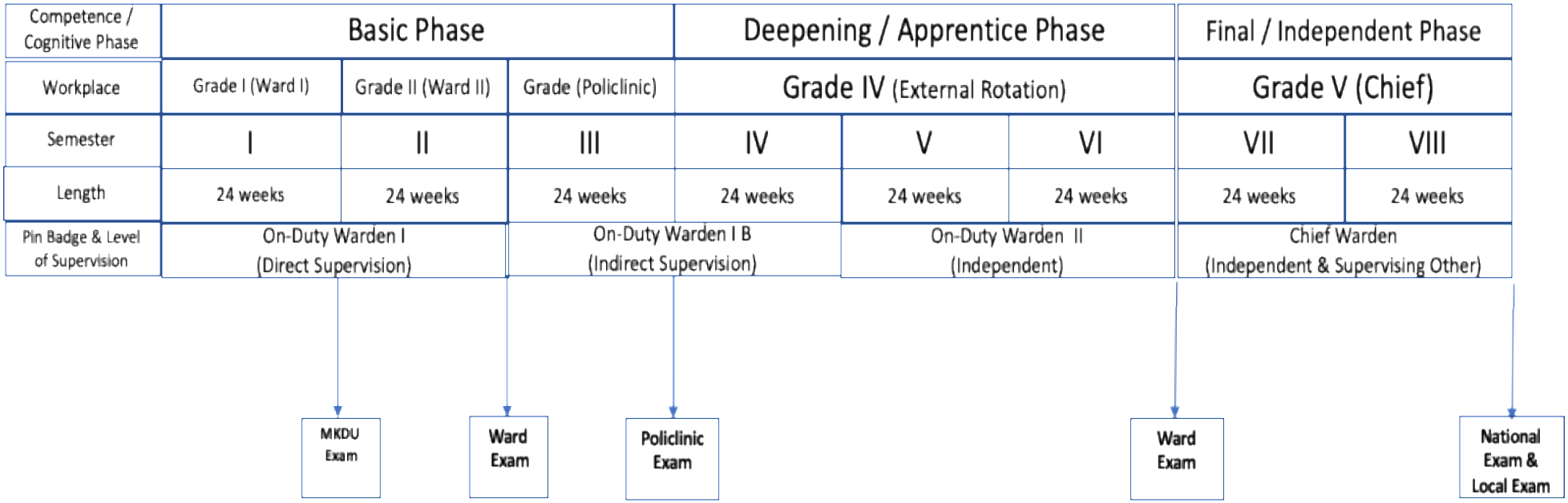

Figure 4-5 The Typical neurology Specialist Program After 2014

4.4.3.2 Orthopaedics Specialist Education & Services

The Orthopaedic surgery training or the Orthopaedic and Traumatology education, as how it is officially declared in Indonesia, can be divided into three periodisation. These are before 1998, 1998-2012 and after 2012.

The Orthopaedic and Traumatology (OT) specialist in Indonesia was initially conceived as a sup-speciality of General surgeons. It was a non-degree deepening programme for any interested General Surgeons. The earliest generations of Orthopaedic were bumiputra (a term to call Indonesian born people) surgeons who had opportunities to get special training on Orthopaedic skills in Australia or USA under the Department of Health patron. Almost all earliest generation of surgeons were Government officials of Department of Health (Ministry of Health). The first recorded orthopaedics sub-specialty training was established in the Faculty of Medicine Universitas Indonesia under a government project called Surgeons Trainers of the Orthopaedic Training Program of Care Medico Orthopaedic Overseas. This project took a few numbers of General surgeons as the trainee, and the curriculum was mostly shadowing or apprenticeship-based programme. The programme was supervised by overseas orthopaedic surgeons from Australia and USA. These supervisors were performing direct supervision and examination during some short visits to Indonesia twice to three times a year. Before completing the training and receiving the orthopaedics certificate, the trainee ought to sit on several high-stake examination events with foreign examiners (mostly from Australian Orthopaedics Association). The speciality training during these periods was hospital-based because most of the instructor were the officials of ministry of health who were assigned a duty to teach. The affiliation with Faculty of Medicine because of the necessity to link the courses with research and basic medical sciences facilities such as anatomy and biochemistry laboratory. In 1980, through the new regulation on degree granting education or training, the orthopaedics education in the Faculty of Medicine Universitas Indonesia grant the formal permission by the Ministry of Education and Culture to run the education programme.

The second period of orthopaedic surgery education development in Indonesia was occurred in 1998 to 2012. In the middle of 1998, the Indonesian Association of Orthopaedics (IOA) made a decree that orthopaedics education

would receive the resident directly (not from general surgeon programme as it was) and each trainee would undergo 2 years basic surgery and 2.5 years specific orthopaedic knowledge and skills. At this period, the Orthopaedic surgery programmes were still varied between direct entry and indirect bridging from the General Surgery training. Some programmes required their residents to complete two years general surgery programme and some programmes accepted the fresh graduate to be educated totally under Orthopaedics and Traumatology programme. In the first model, the organisational structure in the hospital usually placed the Orthopaedic and Traumatology as a sub-division of Department of Surgery. With this structure, the admission and educational process of the resident usually more complicated because more parties would be involved. The second model typically required only six months attachment of their residency at the General surgery department like the current typical programme. The study programme has also been mandated to involve with accreditation process which held by Indonesian College of Orthopaedics and Traumatology. At this period, the accreditation of an OT study programme was different to a common accreditation practice in the higher education institute. While the regular accreditation used assessor from different discipline, the assessors for OT study programme were from their specialist peer in the college of specialist. Because of these different models, the length of educational time to be an Orthopaedic specialist was also varied between 10 to 14 semesters.

Despite the unique practice of training, it did not hinder a unified conception on the importance of a single national competency exit exam because this was regarded as a precious practice that should be preserved and shared by all orthopaedics specialists in the country. The national exit exam has been considered as a precious heritage from the founding fathers of the orthopaedics specialist and representing how the society of Indonesian orthopaedics own international recognition as a member of international orthopaedics. This is possible because since the beginning, the exam has been involving overseas Orthopaedic surgeons as the external examiners which assumed to be the evidence of international recognition of the Indonesian OT education. It is also the evident that the quality of the examination is preserved and positioned the OT education above other specialist education.

The third period is 2012 onward. The curriculum of Orthopaedics and Traumatology has been standardized through the issuance of National Education and Competency Standard for Orthopaedics and Traumatology specialist which has been made by the college of speciality member and issued (legalized) by InaMC. Currently (at the time this thesis is written) there are 13 orthopaedics programmes running in the country which typically run 10 semesters length. The current typical Orthopaedic training programme is portrayed in Figure 4-6. Like other specialty programme, the accreditation process of orthopaedics has also been following the LAM-PTKes system. While the national exam is still present, some adjustments have been made in assessment method by enacting OSCE which involve a new station which specifically assesses the communication and professional competence of the new orthopaedics candidate.

Thus, the last three sections (4.4.1 - 4.4.3) I have provided lengthy historicity of Indonesian medical specialists. All these periodization lengths are influencing the steady establishment of the multiplicity of activity systems as medical specialist education activity system, practice/service activity system and professional organisation activity systems in which these systems frequently put medical professional society in the crossroad. These historicity discussions have fulfilled two out of five principles of how CHAT frames medical specialist education as activity systems. The next three sections will provide the other three principles.

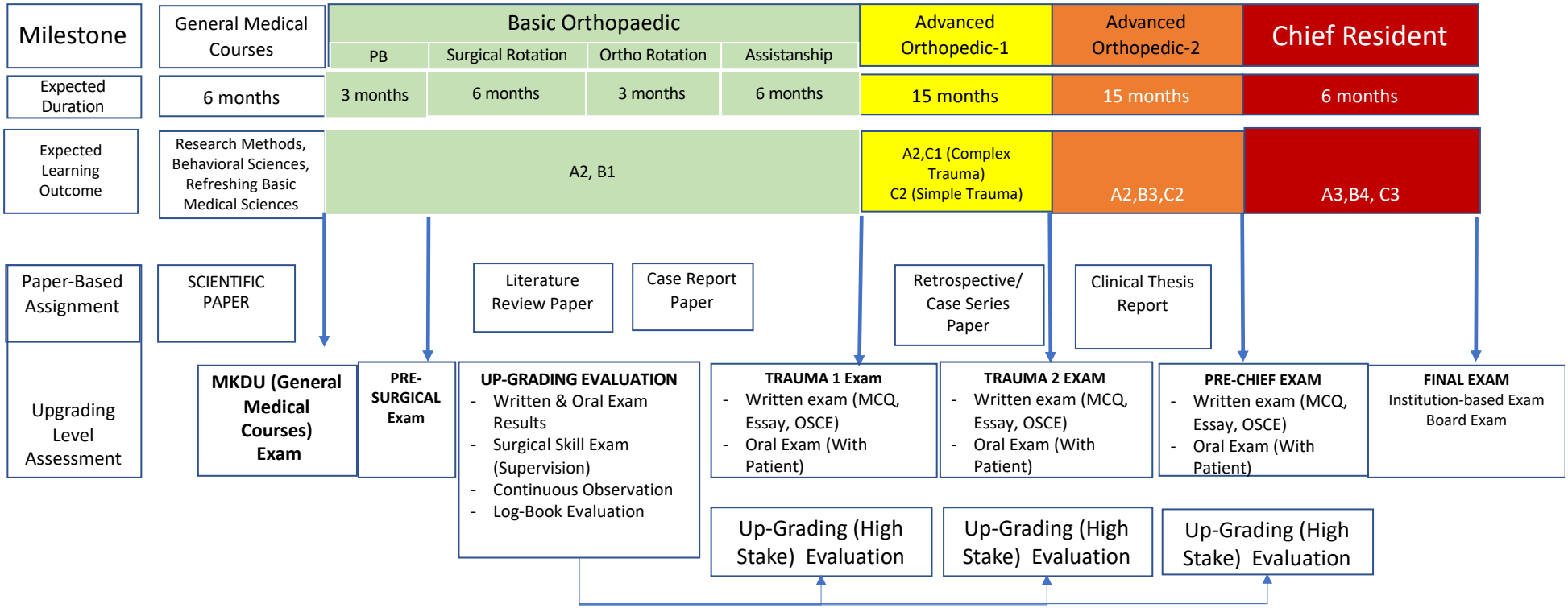

Figure 4-6 A typical milestone of orthopaedic training in Indonesia after 2002 (modified and translated with permission from a study programme)

PB=*Pra Bedah* (Pre-Surgical); MKDU=*Mata Kuliah Dasar Umum* (Basic General Lecture); A1-3, B1-4, C1-3: Code for Learning Outcome Descriptors

4.4.4 Multivoicedness of activity systems in medical specialist education

Daniels extends the definition of multivoicedness in CHAT by attributing the plurality of manifestation of actions and ideas. This is to recognize that actions and ideas in activity systems are informed by many discourses and vice versa (Daniels, 2004. p.). This resembles the concept of genre, styles, and discourse in Fairclough's account. I will show this multivoicedness through how organisation discourse is elaborated in medical specialist education.

From the description I made in the preceding sections, the information resources recommended by the participants lead me to a socio-historical insight of the medical specialist education and practice in my own country which are quite different with what I had previously perceived. The organisational discourse constitutes the establishment of vertical relations between members of specialist community. For instance, the relation between senior and junior residents during their specialist training. When reciting one verse of the physician oath (*sumpah dokter*) at the beginning of granting medical doctor, *"Saya akan perlakukan teman sejawat saya seperti saudara kandung"* (I will treat my colleagues as my own siblings), morally, reciter should have made their relationship with other colleagues horizontal (collegial). However, it seems the vertical relation of senior and junior peers has become a normal situation and discourses found in specialist education and practice. In sociology, this vertical / inequal relation in society is known as social stratification. Giddens defines stratification as" structured inequalities between different groupings of people" (Giddens, 2009. p.432).

Social stratification conceptualises that individuals or groups of individuals pose and assert different thoughts, actions in their relational interaction which is known as agency or social actors. This agency's ability enable society to assert any possible assigned tasks, possession of capital and welfare tools, and acquisition of tools for ruling/governing other agencies. The social stratification concept enables us to identify the internal power structure and gap within an organisation (Fairclough, 1992). In **my analysis**, this social stratification is portrayed by the different level of authorities, role and task possessed by the agencies / actors in the service organization represented as an integrated specialist education-patient service, e.g., the hierarchy in medical

specialist teacher-consultant, tiered duties, and other practising general practitioners, such as those working in the Emergency unit (See Figure 4-7).

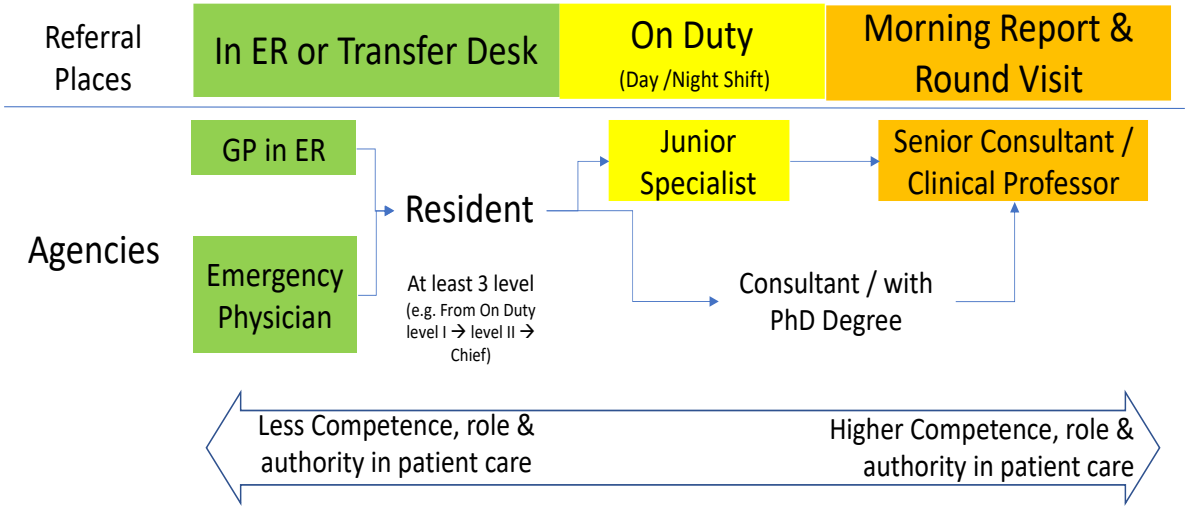

Figure 4-7 The stratification of power in the specialist education-service observed in a typical patient's referral process. **Notes**: ER=Emergency Room; GP=General Practitioner.

The social stratification observed in the specialist department and study programme organisation places the senior specialist consultants, who are mostly working in the teaching hospital, at the top of the hierarchy. Reflecting on my 10 years' experience of being a medical practitioner and medical school lecturer, the degree and experiences become the major source of the difference (power) that enable these specialists to earn their social status. With this top status, this small number of specialists can exercise not just a leadership role in the professional and service organisation, but also influence how the specialist education is organized and delivered regardless of how much or how little knowledge of specialist education theory, concepts or management issues they may have.

> "It was coincidentally, in 2012, I was invited to Seoul to talk about neurology education in Indonesia and I made a presentation there. **This is the curriculum that I built, frankly, I am using reference mainly from England**. There [in England]. It [The education] is very well structured there, the content, how to teach, how the social accountability is set, they are all there. And each part has a person in charge, a supervisor. **I put the responsibility of the supervisor in a curriculum structure. Yes, it's still running now**…"(MSTN1, SSI)

> "So that's it ... Since we did, wait let me get this, I graduated in 2001, 2002. As soon as I graduated, **I said that there was something wrong in our exam**, because the test items were different, the cases on the test were different, the examiners were different, one candidate could pass on one examiner and the other could not, reliability and validity were missing. **Then we changed it. After it was changed**, the MKDKI disciplinary-breach cases from orthopaedics were the were really high, after communication introduction in the exam, it dropped to 40%, so now we have no complaints for this year. While in 2017 we had 20s, in 2018 it reduced to only 5 complaints ". (MSTO2, SSI)

The vertical relationship is not only featured inside the internal structure of the specialist peer group. It also constitutes the relationship of a member of an organisation with other external peers. In my case, it is depicted by how specialist views of the role and ability of the General Practitioner (GP) and residents in the health care. GPs and residents are regarded at the lowest class of physician, not just in the referral system, but also in academic discourse. It is why some of the participants regarded those GPs and residents are the potential market for any conference or workshop events where the specialists and consultants become the main sources for the speaker.

> "…Maybe we are the only one, not the only one, that I know make events so that residents could earn money, we hold events. Because we know that residency in Indonesia pays. How do they make money, at least to make them able attending scientific meetings? **They support us to make events for general practitioners**. **We, their teacher, become the speakers of these events**, we did not get paid, **the revenues are for supporting their course abroad**…" (MST1, SSI)

In the resident's case, in some instances they should sacrifice their learning time in order to "obey" a command made by their supervisor to teach medical students. This situation sometimes is perceived as putting the resident's status below the medical students in a sense that as a registered learner in same medical school they should have had the same rights as the medical student to get scheduled teaching and feedback sessions.

It is why some GPs in the last decade struggled to establish a policy to improve the social status of the GP. In 2014, there was another attempt to promote a practicing GP to be regarded as a specialist by establishing a Primary Physician specialist, recognising the opportunity through the new

regulation system promoted by BPJS. As might be predicted, this effort received negative responses from the wider specialist community.

Although the chain of communication in the patient referral might be regarded as a common norm, in my view, the communication gap due to different degrees and titles (positions in the health care organisation and professional organisation) between agencies also exists and is represented in other relational interactions such as in academic talk, professional organisation events, as well as in the everyday life of health care management. In the Indonesian context, the social status of a specialist can be projected by the amount of title and degree written along with a person's full name. For example, Dr Eric Bana's title is Dr. dr. Eric Bana, SpN (K), meaning this person will be involved in the third tier of medical service (as a consultant role) and he is working at a public hospital or a Teaching Hospital. This means that a doctoral or a consultant degree is a way to add more responsibility for a specialist in a professional or health care organisation regardless of the leadership or organisational skills (see Table 4-1 for a visual comparison).

Table 4-1 The workplace and title relevance to specialist in Indonesia

Type of Workplace	Degree / Title Stratification		
	GP	Specialist	Consultant/Sub-Specialist
Public Health Center (Class 1- 3)	√	(Class 3 only)	-
Public Hospital (A-C)	√ (C or B)	√ (C-A)	√ (B or A only)
Affiliated Hospital	Administrative	√	√
Main Teaching / Referral Hospital	-	√	√
Private / self-owned Clinic	√	√	-
Private Hospital	√ (ER or General Clinic)	√	√

In Indonesian neurology history, multivoicednes is featured in accreditation discourse which construct the neurology education as an activity system. Neurology communities have become a leading example of promoting accreditation among specialist education. The neurology medical education community pioneered the introduction of accreditation when other medical specialist communities appealed to be exempted from the national accreditation system (2003-2014). At these times, the reason was to improve the quality of

neurology education. Interestingly, Neurology has also pioneered the new accreditation process enacted in the 2014 when accreditation became mandatory for all specialities and performed by an independent accreditation body (LAMPT-Kes). The reason to be a pioneer at this time was to become the leader of excellence compared to another speciality (MSTN4) in order to conduct an externally quality assured program that protected public interest and patient safety (MSTN1; MSTN3). This is an example of multivoicedness, as Engestrom (1992, 2001) indicates, where voices toward accreditation have different underlying values, historical development, and discourses to be understood and accepted by society. Accreditation, among neurology community, is conveyed as a symbol of excellency (voice of practice and act) in different ways of expression (discourses) for different situations and different external regulatory agencies in order to establish their stance toward quality in their education (activity) system. The schematic diagram of the timeline and the multivoicedness found in the historical development of neurology education as an activity system toward accreditation is provided in Figure 4-8

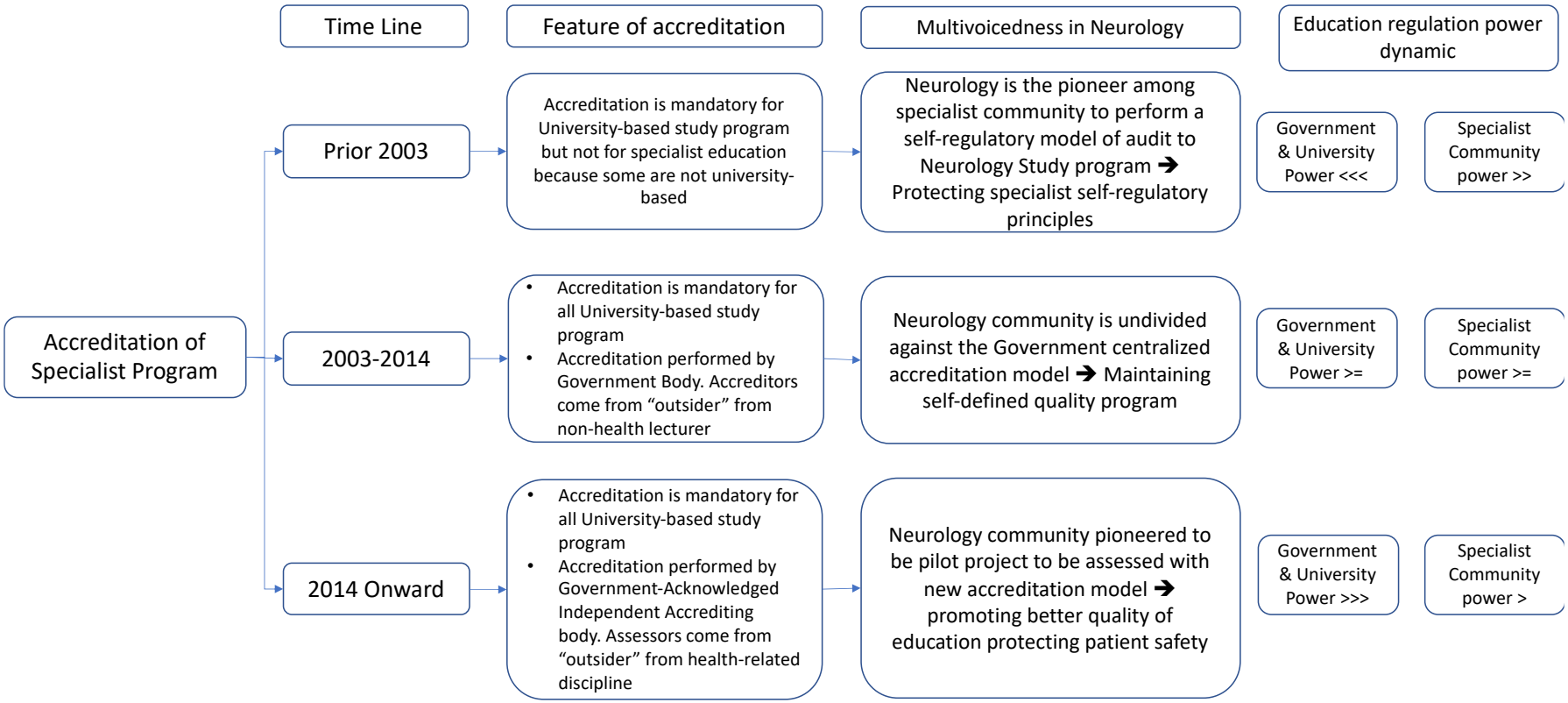

Figure 4-8 Historical development in neurology education accreditation and the multivoicednes related to this development

4.4.5 Contradictions in medical specialist education

As we have learned from Engeström, a contradiction in the activity system is more than just a set of problems (occurring when expectations meet a different reality) and conflicts (dissenting ideas or arguments among actors). Contradiction is an articulation of latent, structured and systemic tensions that occurred within and between activity systems in a lengthy period of times (Engeström, 2001). In this sense, contradiction functions as a key factor for the activity system to expand and transform. This lengthy amount of contradiction made subject of learning enable to reflect and create new solutions and innovations (new object of learning) and thus transform the activity systems. Take an example on the expertise ownership case. Tension between expertise ownership or a niche of specialist practice is one example of the contradictions drawn in the historical development of orthopaedic surgery. What I mean by expertise is that there are knowledge or skills in medical practice that are ascribed to certain specialists. For example, performing *Electro-encephalography* (EEG) procedure to diagnose epilepsy is the ownership of a neurologist, not a psychiatrist. Or doing a bone graft is the niche of practice of an orthopaedic surgeon, not a general surgeon or plastic surgeons. In the development of orthopaedic surgery in Indonesia, there was a time where the orthopaedic surgeon was treated as the sub-speciality of the general surgeon. Hence, the orthopaedic surgery training only was eligible for those graduating from general surgery training (general surgeon). This is because some surgeons still believed that orthopaedic surgical skills are part of the general surgical knowledge world. This systematic tension persisted so there was a period where orthopaedic surgery education in Indonesia split into two modes, direct entry mode (accepting general practitioners) and sub-specialist mode (accepting general surgeons). Only in 2002, due to successful lobby to the Higher Education and Health Ministries (regulators), orthopaedic surgery education fully separated from general surgery training and trained general practitioner and fresh graduate (graduates of undergraduate medical school). However, currently, all orthopaedic surgery programmes in Indonesia still require their residents to take their first 2 semesters to learn at the Department

of General Surgery, to attain general surgery skills under the supervision of the general surgeon (Indonesian Orthopedic Association, 2021).

Thus, historically, neurology and orthopaedic community of practice have featured moments of transformation as the consequence of facing a significant number of tensions and contradictions occurred in the certain period of times. This made these community of practice fulfilled the sign of a transformative activity systems where CHAT, as a conceptual framework to analyse the emergence of MP conception, warrant to be applied.

4.4.6 Expansive transformation of medical specialist education

Through the historical description of how Indonesian specialists move from a non-degree profession to a degree profession, and disorganized training becomes more organized, some features of how Indonesian medical specialist education show the transformation of the medical specialist education as activity systems of professional learning. Moreover, the entire social-historical development of neurology and orthopaedic surgery education and practice provided in the first three sections (4.3.1 – 4.3.3) is the self-described features of the expanding transformation of the medical specialist practice as activity systems. Framing this expansivity requires understanding that as activity systems, context where professional learning is dynamically expanding along the expansion of the system where it belongs. The goals in examining activity systems should be framed as a way to find new trajectories and possibilities of improvement rather than just localising problems and challenges. Therefore, in investigating MP, CHAT allows the potential discovery of new trajectories and possibilities of improvement to nurture MP and medical specialist practice.

4.5 Discussion

4.5.1 Two activity systems as contexts for conceiving MP

I have proposed that activity is the most appropriate concept to frame context of MP as knowledge (learning object) in this study. As Engeström suggests, in order to utilize CHAT in understanding objects in activity systems, there should be at least two activity systems determined. Guided by historicity analysis of the two chosen medical specialists from information gathered during fieldwork, I

contend that the two activity systems are an educational activity system and a service activity system (See Figure 4-8).

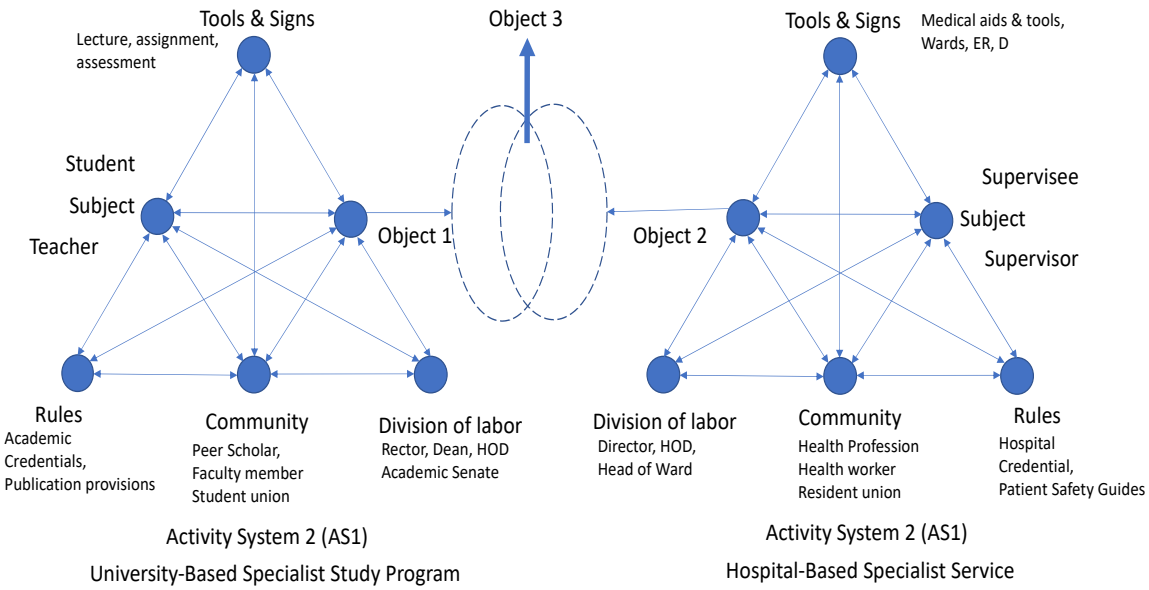

Figure 4-9 Hypothetical two big activity systems based on historicity analysis of Indonesian medical specialist context

4.5.2 Framing discourse as mediation of learning in activity systems

I have presented so far that Indonesian medical specialist education can be framed as context where MP is conceived and applied. However, a question follows: If we can conceive Indonesian medical specialist as learning context for MP, how could MP be located in such complex network of activity systems?

Engeström (2001) highlights that exploring discourses is one of the most plausible ways to identify the situated context of an activity system in which learning occurs. Discourse is basically a language-in-use, or representation of language in which it functions as core tool that mediates human activity in the world (Vygotsky, 1987 in Daniels, 2010). As a part of language, human discourses are cultural-historical products that shape thinking and feeling, which in turn also shape and transform human activity. It is through discourses that elements in activity systems are interwoven and co-create each other (Engeström, 1999; Daniels, 2004; Daniels, 2010). Bernstein (1993) argues that this Vygotskian perspective requires a multilevel examination of discourse. This is because discourses, as the cultural-history product, deny the concept of a singular subject. In other words, the subject is an intersection node of various and conflicting discourses, and a position normalised by these discourses

(Bernstein, 1993). Examining discourse in a Vygotskian perspective needs to expand beyond the functional text dimension and engage with different social structures which discourses represent, and also the relation of power and control that regulate social change and mediate social relations (Daniels, 2010).

Among approaches to social constructionist discourse analysis (i.e., formal-empirical discourse analysis, critical discourse analysis, and discursive psychology) (Phillips and Jorgensen, 2002; Hodges et al., 2008), the critical discourse analysis approach seems to fit with explanations of discourse from Bernstein (1993) and Daniels (2010). Fairclough, who has been referred as the key figure in the development of the Critical Discourse Analysis (commonly referred as CDA) from a method to a methodological approach and movement (Phillips and Jorgensen, 2002; Wodak and Meyer, 2011; Rogers et al., 2016), proposes three dimensions to frame discourse analysis (Fairclough, 1992). These dimensions theorize discourse as text, as discursive activity and as a social practice that represents micro, meso and macro aspects of the social world. Interestingly, although both the CHAT perspective and CDA grow from different traditions -CHAT grew from developmental psychology, while CDA arises from the linguistic and politics field-, they share philosophical roots in social-constructivist ontological perspectives. Engeström discloses this in the beginning development of the third generation of activity theory (1999) asserting that:

> "Marx, in his Theses on Feuerbach, was the first philosopher to explicate pointedly the theoretical and methodological core of the concept of activity " (Engeström and Miettinen, 1999, p.3).

A little earlier, Fairclough (1995) explains that the 'critical' part in his formulation of critical discourse analysis was inspired from the influence of Marxist theory on the role of power and ideology in discourse formation and hegemony in which the society is shaped and being shaped:

> "…what sort of relationships there are between language and ideology, and the methodological question of how such relationships are shown in analysis (which together I refer to as language/ideology'). This is an attempt to build from the achievements and limitations of explorations of these questions within Marxism, especially Althusser's contribution to the theory of ideology and its development by Pecheux into a theory of discourse and a method for discourse analysis" (Fairclough, 1995. p.70)

With different technical words and concepts, both Fairclough and Engeström share their ideas through two conceptual convergences. First is the importance of discourse in the development of knowledge (learning), and second is the idea of social practice as the representation of discourses. Inspired with these convergences, I believe, analysing discourses emerged in the interview sessions with 3D-CDA has the potential in understanding how medical professionalism is mediated, shapes and is shaped by the activity systems.

4.6 Summary of Chapter

In this chapter, I have provided a brief review of how ‘context’ in professional learning is conceptualised and applied in research. Through the review, conceiving context as an activity system has applicability in framing Indonesian medical specialist education as the context of MP conceptualisation. Through the information gathered during fieldwork I conceptualised that neurology and orthopaedic medical education as the context of this study featuring the characteristic of two interlinked and expanded activity systems i.e., university-based education system and hospital-based service system. The chapter has also highlighted how the critical point of discourse as part of human artefacts (tools and signs) mediates learning through activity systems in Indonesian postgraduate medical education. The discussion in the chapter ends up with the potential of 3D-CDA in facilitating data analysis in this research. In the next chapter, I will present the result of this 3D-CDA which is framed with CHAT perspective.

Chapter 5 Understanding medical professionalism discourses as a text

5.1 Introduction

In the previous chapter, I discussed the argument of why CHAT and critical discourse analysis are essential to framing the exploration of MP conception in this study. This chapter will present the result of the first step of the three-dimensional critical discourse analysis (3D-CDA), i.e., text analysis. In this phase, I deliberately employ corpus-based linguistics to extend the intertextuality analysis, a core linguistic method in the first step of 3D-CDA introduced by Fairclough (1992, 2001). This extended version of 3D-CDA has been inspired by the work of McEnery and Hardie (2007); and Paul Baker et al. (2008) on Corpus-based Critical Discourse Analysis. Tony McEnery and Paul Baker introduced this method during an 8-weeks intensive course hosted by the ESRC Centre for Corpus Approach in Social Sciences (CASS) of the University of Lancaster, which I joined through assisted online learning platform, FutureLearn[5].

The chapter starts with a brief explanation of how the text analysis is performed followed by presentation of the result of the analysis phase, which brings up two Discourses of medical professionalism (MP) conceptions. Following this results section, a discussion on how the identified MP texts and discourses have relevance theoretically to postgraduate teaching and the development of the medical profession in Indonesia are provided before I conclude the chapter.

5.2 Understanding MP through the texts

The term “text” in this section is to express that the conceptions of MP have been constituted in the form of words (texts) and part of the language use (discourses). It is assumed that the participant uses the discourse to convey meaning and their understanding (knowledge) of MP and the broader aspects of their professional practice life. Performing analysis on the stated conceptions (texts) of MP by employing principles of intertextuality and manifest-

[5] The course was included as a facility provided by the University of Leeds to support students while learning from home during lockdown policy. The course was accessed through https://www.futurelearn.com/courses/corpus-linguistics

intertextuality (Fairclough, 1992; Fairclough, 2013) facilitated by the corpus-based linguistic method (Baker, 2006; McEnery and Hardie, 2012) make it possible to surface these meanings and understandings.

In order to avoid confusion, I will use the Gee categorization of discourse and Discourse to rephrase Fairclough and Foucault's interchangeable use of discourse as either the representation of talk or the way of talk. Following Gee (Gee, 2011; Gee, 2014), I use the term Discourse (with capital D) for the big theme related to a group of representations and is usually a more abstract conceptualisation of the world. Fairclough sometimes calls such dense discourse abstract discourse, in which it might represent several discourses, genres and styles (Fairclough, 2001). Additionally, I will use the term 'a discourse' or 'several discourses' (as count noun with small letter 'd') to mention the way of talk, language in use or themes that emerged from participant excerpts. For instance, the discourses developed in the third coding is likely to be Discourse, while the discourses developed in the first and second coding likely to be discourse (with small d).

5.2.1 Exploring the definition of MP through Intertextuality analysis of profession, professionalism, good and bad doctor

During the interview, in order to understand the conception of MP, I started almost all of the SSI sessions with questions about the professional background of the participant, followed by an inquiry about how they describe and determine what a good doctor is. Following the participant's perspective on this good doctor conception, I further discussed how they define a professional doctor and whether there is any difference between the "good doctor" and "professional doctor" concept. I found this question sequence made it easier for me to pace the inquiries about MP and felt that participants were more relaxed by starting the discussion with who they are. This strategy gave them a space to build self-esteem and confidence by explaining who they are. From this perspective, I took an opportunity to show my enthusiasm to hear them and their perspective on things related to them. From this position, I invited them to tell me more about what they understood, believed, and conceived about a good doctor and professional doctor. The excerpts from the participants about these two things (a good doctor and a professional doctor) become actual textual constructions

about the conception of MP, which I will use as the starting point in presenting the study results.

In order to widen the possibility of interpretation in this text analysis phase of my 3D-CDA approach, I intentionally employ some corpus-based linguistic methods by performing a collocates[6] exploration for the words “professional” and “professionalism” and “doctor” or “specialist” to the whole and selected transcript records. To support doing this, I took an eight-week synchronous online certified course on Corpus-Based Linguistics (CL) hosted by Tony McEnery and Vaclav Brezina of ESRC Centre for Corpus Approaches to Social Sciences (CASS), University of Lancaster. The CL methods inspired by the course were enriching to the conventional version of the 3D-CDA I had previously performed (without using collocates software). Using the LancsBox, I did the text exploration in the original version of the transcript (written in the Indonesian language: Bahasa Indonesia, or in short Bahasa) and the English translation version. The exploration is mainly performed by utilizing the “GraphColls” (stands for Graph of collocates) and “KWIC” (stands for Keyword in Context) function of LancsBox[7]. collocation searching of the word “profesi” (Bahasa translation of “profession”), “professional” (Bahasa translation of “professional”) and “professionalism” (Bahasa translation of “professionalism”) and their English version provided comparable collocates result. Included in the process of collocates exploration is the decision of determining the text length (distance) from the word of interest. The default setting in Lancsbox regarding this text length is 5 which means that Lancsbox will find the most likely collocates of the word or phrase of interest within five consecutive words to its left or right side. For instance, in searching the collocates for professional in 5 span rules, the Lancsbox will explore up to five words on the right or left of the word professional in every sentence or statement from the participant that contains the word “professional”. Like the advanced feature in the literature search in established databases (e.g., MEDLINE, SCOPUS etc) that can adjust the publishing year, the span of the collocate can be adjusted depending on the result of initial searching. We can extend if there are too few collocates found or reduce the length if there are too many / crowded collocates, especially when

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[6] Collating words that come before or after the word of interest (keyword)

[7] LancsBox is a corpus-based linguistic software developed by Vaclav Brezina that can be accessed through http://corpora.lancs.ac.uk/LancsBox/index.php

the collocates found do not offer meaningful sense making. Following a suggestion from my Tutor in the Lancsbox course (Vaclav Brezina), the default setting of 5 span (distance) is mostly adequate to find meaningful collocates of our words of interest, especially when Lancsbox is set to ignore the stopwords (articles or conjunctions such as “a”, “to”. “of”, “and”, “but” etc., that are usually meaningless in collocates exploration).

From this exploration, I then examined each of the collocates to find the appropriate interpretation. The corpus data and the software do not provide interpretation. Moreover, it is the researcher's job to make sense of the language pattern found in the corpora. Moreover, issues surrounding the social conditions of production and interpretation of MP to understand the related discourses, which become an area of interest in this study, obviously cannot be provided with the existing software (Fairclough, 1989: p.25; Baker, 2006: p.18). The collocates graphs and the collocates list to the words “professional” and “professionalism” are provided in Figure 5.1 and Table 5.1.

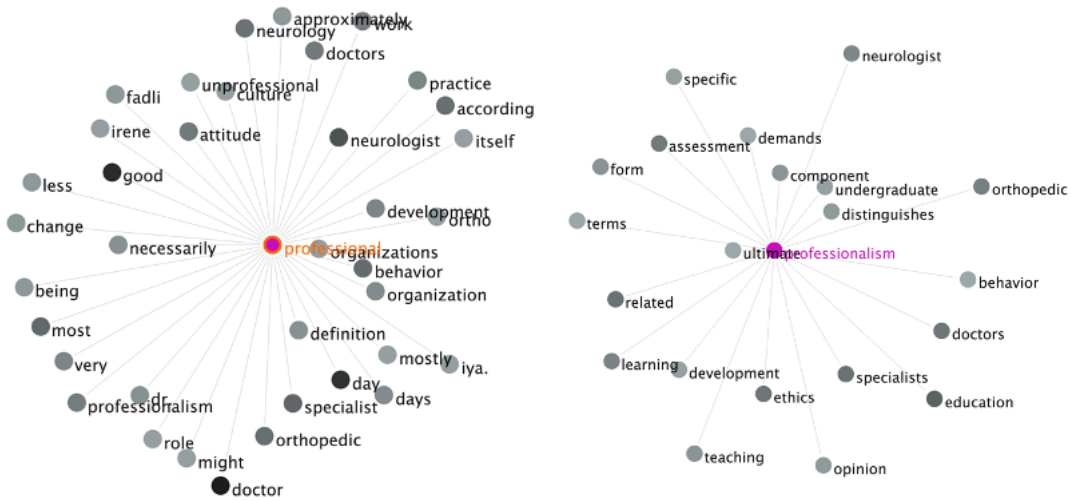

Figure 5-1 The collocates graph showing words that collocate with “professional” and “professionalism”.

Note: The middle dot/node is the word of interest, the circle words are the collocates. The closer the circle word to the middle node, the frequent they are co-occurred. Left and Right position of the collocate words shows the position of word to the keyword being explored (See Appendix I for further technical explanation).

Table 5-1 The top collocates words of 'professional' and 'professionalism' after stop words[8] editing. **(See the details on Appendix I)**

Professional		Professionalism	
doctor	R	education	R
good	L	specialists	R
specialist	R	ethics	L
behaviour	R	doctors	R
attitude.	R	assessment	L
doctors	R	learning	L
work	R	component	M
professionalism	L	form	L
development	R	teaching	L
practice.	R	distinguishes	R
organisation	R	opinion	R
days	R	undergraduate	R
definition	R	development	L
necessarily	L	specific	L
approximately	R	ultimate	L
change	L	demands	L
organisations	R	behaviour	R
culture.	R		
unprofessional	R		
role	R		

Note: The collocates are ranked based on the most frequent word to the least. The R and L in square bracket to show that the collocate comes before [L], and after [R] the word of interest. The following are the log from LancsBox 5.1.2 which identify the search and analytical methods being used.

5.2.1.1 Good and Professional Doctor as traits

As the first exploration, I analysed what words are collocating with the adjective "baik" (Good) because it was the adjective, I used to invite participant in defining and describing the good doctor. As expected, the exploration found that "baik" is knotted in the phrase "*dokter yang baik*" ("the good doctor") or *"spesialis yang baik"* ("the good specialist") and it is in the top collocates of the word "profesi" (noun). This can be interpreted that the use of the term "profession" was in-parallel with the discussion of "good doctor". This finding is not surprising because in almost all of the SSI sessions, I spent a significant amount of time inviting participants to discuss and describe what "a good doctor" or "a good specialist" is. This "dokter yang baik" also naturally collocates with "professional" and "professionalism" because the discussion of "a professional doctor" was followed after the discussion of "a good doctor". This follow-up

[8] Stopwords or functional words are the words in any language which do not add much meaning to a sentence (e.g., to be (are, is, was, were); the; and; to, he, she etc.)

question was intentionally asked to explore whether there was any conceptional difference between a good doctor and a professional doctor.

Following this exploration, I then made categorizations by making coding, notes and, if appropriate, sub-coding to the themes emerging from the participant's response on the question of good doctor. From themes emerging from the coding, I found that 1) being a good doctor and, 2) being a professional doctor are differently understood by the participants, regardless their status as teacher or chief resident. The interpretations of these two themes come into two possibilities, i.e., 1) they are a single conception, or 2) they are two different concepts.

In the first conception, participants argue that being a good doctor is a set of traits that are included in the professional doctor conception. Some said that "being a good doctor" is a mandatory condition of being a professional doctor in the individual level. I found this idea was conceived among some neurology and orthopaedic surgery participants.

> "Actually, a professional, I think it is the same, Doc. There is no way he/she ((In Bahasa we used a non-gendered pronoun for third person man or woman with "*dia*")) can carry out his/her duties professionally if he/she is not a good guy. Well in this case he/she is bearing "o yes I'm a neurologist", I think it is like that anyway. It turns back to the oath of being a physician" (RSN6, SSI)
>
> "Yes, like it was yes ((mumbling)) because the professional is what, putting yourself in the place in accordance with the profession. Equal, they should be the same, and the habit of using the term is just a matter of a language use. A professional doctor should be a good one and the good doctor should be professionals, yes." (MSTO1, SSI)

Participants who perceive that the two terms have the same meaning also conceive that it is only a matter of choosing a term used by lay and professional groups, but basically, they have the same meaning to represent the whole positive and ideal characteristics of individual physician. It is perceived that the "good doctor" phrase tends to be used by lay persons, relating to a set of public expectations of the doctor, while "a professional doctor" relates more to the prescriptive or guide-based definition of the medical profession.

There is also a sense among those perceiving that "a good doctor" is the same as a "professional doctor" to associate it with ethics or ethical conception

of a doctor. Some of the participants even used the phrase “ethical doctor” as a direct synonym of “professional doctor”. For instance, when MSTO1 explained about the need of developing a tool to assess professional traits in the admission system, he uttered this statement which put being ethical as the same thing as being professional.

> “…and conditions like this are very ethical, in the front he might be very good, very professional, good value. This is an indication that the MMPI ((a name of test instrument)) may have been manipulated…” (MSTO, SSI).

In the second narrative, the “a good doctor” is conceived differently to “a professional doctor”. Most statements in this narrative reported that the “good doctor” is a generic ideal characteristic of a person that is culturally established, predisposing and therefore the essential ingredients for becoming a professional doctor. This means that being good doctor is a prerequisite to be a professional doctor. In this notion, the “professional doctor” has more specific meaning than “a good doctor” which refers to a specific set of traits and identity of a doctor as a socially acknowledged occupation in the society which is usually represented by the medical association.

> RSP: “Well, I think, a good and a professional are two different things.”
>
> RSB: “How is that?”
>
> RSP:” This ((a good one)) is a kind of a product that is felt by the patient, family, community. Well, I think the profound one is empathy. We empathize with the patients, that is good, that is the meaning of being good. As for the professionals we need to adhere to the rules and regulations. In our profession, the laws are there, it is like that our obligations in carrying out the profession of a neurologist doctor must comply with the standard set by the KNI ((Indonesian College of Neurology))….” (RESN3, SSI)

The differentiation of being good and professional is also depicted by orthopaedic resident participants such as:

> RSP: “**A good I don't think is necessarily professional Doc.** If good, the intentions may be good Doc, but for example performing surgery. If it's good we only think good without the basis of professionalism, **because professionalism is in accordance with the law, ethics, theory, cognitive, everything should have.** If it's just a good one I guess it's not Doc, it's not the same Doc. So, good is not necessarily professional.”

RSB: “So for this goodness, according to doctor Rz means there are good criteria publicly, **which are cultural by nature, right?**” But, if for professional, it is more, more binding, there is a standard, there are standard rules---.”

RSP:” Yes, persist. Doc.” (RESO1, SSI)

It is interesting here that participants had the insight to differentiate good and professional and relate the influence of society, culture, and past education as the contributing factor to the development of good doctors (See Figure 5-2).

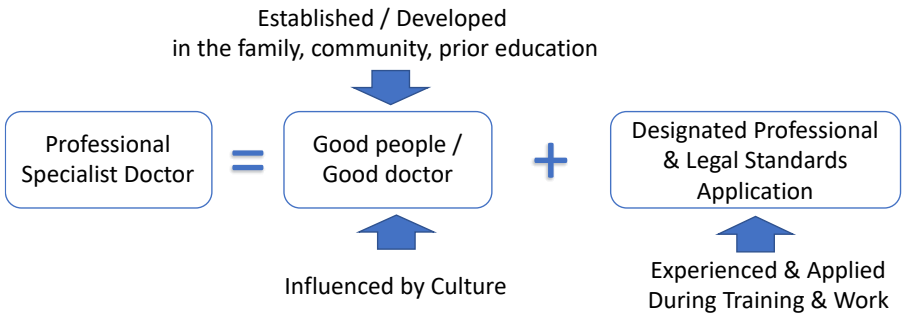

Figure 5-2 A discourse if a good doctor different to professional doctor

It is also interesting to see whether the two phrases, “good doctor” and “professional doctor” are argued as the same or different constructs. However, there is a common way these two conceptions are uttered. Both narratives are indicating that being good or professional represents ideal (positive) characteristics of an individual doctor. Within this discourse, MP is conceived as a set of traits that are either related to 1) personal characteristics (traits, abilities or behaviours), 2) peer-grouped / specialistic traits, or 3) medical profession-prescribed traits. I describe each of them in the next sub-sections.

MP as personal characteristics (characters, abilities or behaviours)

A number of positive personal characteristics come up in the participant’s responses when asked about what determines a good or professional doctor. I chose the “personal characteristics” theme to represent the personality traits of individuals which were inspired by a repeated term used by the participants in Bahasa “*karakter*” to express “character” or personality traits of a person. Personality traits belong to this group are representing good or positive

characters of a person that people expect these traits to be owned by a medical doctor regardless of the speciality. The identified personal traits in this study are described in the following sections.

Altruistic and Compassionate care

I created this category to name the good doctor's character that puts the patient's interest at the prime of the doctor's life, which sometimes means sacrificing the doctor's personal life. These characteristics mainly were depicted by senior participants as a feature of the ideal good doctor. It is represented in a story about a past Indonesian general practitioner named dr. Oen Boen Ing, who was known for his benevolent practice while uttering what characterises a professional doctor. Despite performing his practice until late morning because not wanting to let his patient down, the fee for dr. Oen was also in the form of a charity box, so the patient might opt to pay or not for his services. His name has been used as a name of networking private hospitals in central java regions known for charity in their services. MSTN1 had an experience as a patient of the late dr.Oen while he was a young adult. MSTN1 asserts that the altruistic character and professionality of dr. Oen is an ideal for current and future Indonesian doctors.

> "I had a cough, for months not getting better, I came to Doctor Oen. At that time, I did not eat nor pee, afraid if somebody may cut my queue position…thank you, how much I should pay, Doc?"… ((Doctor Oen replied))…"Later if you are rich enough … I believe because the ultimate professionalism of this doctor ((Oen)) comes from experience, wisdom and *gatekan* (compassionate). (MSTN1, SSI)

Empathetic

Empathetic is a theme used by participants to depict a preferred character of a good doctor. It is articulated as an ability of a doctor to perform empathy, share feelings and experience about the condition of disease in developing their doctor-patient relationship. Empathy is both knowledge and feeling that is projected in a conduct that a doctor could behave as if he/she is in the patient's shoes, and with this behaviour, the doctor develops a thorough and careful interaction with the patient. MSTN5 described that being empathetic is using the neurology knowledge to understand patient's feeling which are most likely presented in non-verbal gestures such as:

> Yes, because it's part of empathy and it was taught…Look at the patient, look at his/her smile, it symmetric or not, his gaze is divergent or not, his hand's movement while telling the story only work on the right side, and so on… So, we are trained to be sharp, observant, detail, and inevitably have to listen to patient story, and with that story, it gives us another moment to learn…we also see whether patient talk is coherent between the question and answer, their talks, whether there is a dysarthria. So, at the end, those things should have been making a memorable trace, if in case they were reporting about patient, I used to ask how about their family, how about patient's current condition, like that, It should make them ((the residents)) remember for being empathetic to patient" (MSTN5, SSI)

Empathy also includes an awareness of the doctor about the readiness of the patient to hear information about the bad news of the diagnosis (e.g., cancer diagnosis): "…it is not possible for us to be direct to convey the diagnosis, we must remain empathetic…" (RESN, SSI).

Spirituality and religiosity

There are many themes regarding spirituality and religiosity. However, in the case of the individual character of a good doctor, participants see that ones that manifested in the verbal and non-verbal behaviour are the most desired features of a professional doctor. The verbal behaviour may involve elicitation of the role of God in disease and health condition while performing communication in the doctor-patient encounter in order to calm and restore the mindfulness of the patient. One story about how a medical specialist teacher provided his experience calming parents whose baby had mild hydrocephalus:

> "…and the parents asked me. Professor, what about my child's fontanelle? *Insyallah* ((God will)) he will be fine. They were Catholics, Ok. What is the best for the baby Doc? Ask to the Al-Mighty, this baby which is a praising from the result of interaction between you and your husband, because of God's will, please ask His mercy for uniting the baby's fontanelle…And the later years she came back to me bringing that girl who became a talkative one" (MSTN1, SSI).

Another feature of desired spirituality-in-action is a tangible commitment to a spiritual/religious ritual (non-verbal/behavioural) behaviour integral to the everyday professional practice. For instance: reciting prayer before doing surgery (MSTO3, ITTD), doing prayer on time in between busy schedule

(MSTN, ITTD), or holding a religious teaching once in a weekday at the workplace to maintain doctors' mindfulness (MSTN2, SSI).

Trustworthy

Being a good doctor does mean being a trustful and respectful person, especially when faced with a possible embarrassing situation of the patient. This trustworthiness is important because there are significant number of Indonesian patients that rely upon this character, especially when academic merit of the doctor is unlikely to be disclosed:

> "…the resident is not so clever, but when this person graduated and doing practice, this person's patients are almost hundreds from the morning until afternoon. What really happen is, I don't know. The problem is, people has already trusted this person…" (MSTN1, SSI)

Regardless of the academic merit, being trustworthy to the patient during doctor-patient encounters is an expected conduct that the doctor should perform.

Resilient

Resilient is not mentioned explicitly in participants' words. However, most of the narratives, especially depicted by resident participants, elucidated the feature of resilience as an ability to survive and bounce back from any adversities that happen in the residency and medical specialist life. This definition is inspired by research in healthcare by McCann et al., (2013) which summarize resilience as "the ability to maintain personal and professional wellbeing in the face of ongoing work stress and adversity" (McCann et al., 2013: p.61).

One theme on resilience came up when I invited a female chief resident to provide an example of how she gave feedback to her junior colleagues, she provided an example like this:

> "For instance, for junior who did a repeated mistake, my style of advice would be like this "don't you realise that you're hurting the patient, harming the patient, do you want to be treated like that? or do you want your parents to be treated like that? If you feel **you are not suitable here**, in residency where we should indeed execute the instructions to coordinate, to cooperate, **you do not need to be here**… I mean I don't want you to be here forcing yourself but actually you are harming patients. It is no use, it is not?" (RESO2, ITTD)

The diction of words in above example is humiliating. The way that RESO2 gave the example of her (humiliating) feedback is a representation of conduct that is encountered by her junior residents as a part of their everyday life that need to be tackled and resolved. Surviving this kind of “everyday” humiliation is, I believe, where resilient skill is needed.

Another example for this resilience is a case brought by RESN3, a male neurologist chief, when assisting his junior resident who was being frequently sick and escaping tasks because of the undisclosed illness. RESN3 asserted his view that to survive residency life means the resident should be able to take a risk of difficult personal circumstances and bounce back to the provision of performing professional duties.

> “..In the end what? Oh well if you are kept ill, not able to be resident in neuro, please resign, we never asked you to be here. But if you feel ill, you need treatment, treatment need to be healthy in order to fully doing your trainee obligations here, we will help. Finally, he paused ((took term leave)) to take the treatment, healed, and then continue to be appropriately doing the proper tasks” (RESN3, ITTD)

Mindfulness and balanced wellbeing

Participants projected that the ability to keep both mindful and balanced wellbeing should be a personal character of a good and professional doctor. This theme mostly appeared in discussions related to the role of spending time for sleeping, interacting with family, leisure and hobby activities and also religious activities amidst the tight professional schedule. Mindfulness and balanced wellbeing are needed to maintain the quality of professional tasks amidst the risk of burnout due to the multiplicity of tasks and emergence (when new tasks always come) schedule.

> “…at resident private room, whether we sleep, whether we make hot drinks, whether we are doing any leisure things, just to be as much as possible use of the time. Because we as a residents **have academic load, has the burden of service**. Many things to do … if there is an empty time, if not using it for beneficial academic things, then it should be for enough sleep, it is utterly important in this condition. The next time we are sick, do not balance, then it will cause problem for other resident colleagues” (RESN2, ITTD)

Some participants regarded that keeping in-touch with family member is one important aspect to keep the motivation doing the burden of busy days, while

the other regards family as the reliever of possible burn out that could happen in professional life. Another highlight of the importance of being mindful and balanced appeared in the explanation to residency programmes and resident organisations to provide a deliberate and protected (if not to say forced) time for residents to do hobbies or extracurricular activities in residency life. Some leisure activities are also associated with the provision to keep a balanced life in order to survive in maintaining the quality of professional tasks. The excerpts for these activities are presented in Table 5-2.

Table 5-2 Activities that related to mindfulness and balanced professional

Activities	Mindfulness and balanced professional	Excerpt
Sleeping	Sleeping is the most needed activity to recharge physical and mental balance / freshness	"…if there is an empty time, if not using it for beneficial academic things, then it should be for enough sleep, it is utterly important in this condition…" (RESN2, ITTD)
Get in touch with Family	Family is a source of motivation and the goals of life and support system in everyday life	We pass this training, but wife is taken by somebody, children do not watch out, cannot read the Koran, cannot pray, swearing a lot, do not like studying, cannot be respectful to his father, and then for what? (RESN3, ITTD)
Doing Sport and Hobby	Sport and hobby maintain mindfulness and goodness in doing tasks	"…still give time to exercise together. So if we had, say a stressful moment, for example after surgery, Saturday-Sunday that we'd have sports together… there we had a relieving, the relieving event" (RESO1, SSI)
Doing Leisure activity	Doing small leisure activity in between everyday task is helping to refresh mind (e.g., social media, online shopping, watching movie etc)	"…Ck ((pseudonym)) usually looks up her Instagram. Once I asked if it was okay to open Instagram at the time of work-stage? ((she said)) It's okay, it can be hidden or something she said. she likes it look at those artists ((in Instagram)), that is Ck. While, other friend, Dw ((pseudonym)) likes to see family activities on YouTube channels. While for me, I like to update and order fashion online…" (RESN4, ITTD)
Doing Religious rituals / activity	Attending religious preaching, providing charity and doing prayer solve difficult situation	"…to do prayer on time, and I always say the same those commencing the national exams, do alms, do charity, do not forget alms…" (MSTN6, SSI)

Residents and teachers' participants of three orthopaedic surgery programmes concur that these activities are necessary to balance their work lives. It is why

reserving and facilitating these activities as a part of the academic programme is also critical. To argue this, they showed that such activities are acknowledged and endorsed by academic authorities. Mainly the activities are organised by resident organisations informally (outside formal academic and service schedules). However, even if it is informal, the activities are “mandatory” - encouraged because they are the teacher’s order.

> “…So yes *alhamdulillah* ((praise to God)) all this time in our study programme still yes it Doc, still give time to exercise together. So if we had, say a stressful moment, for example after surgery, Saturday-Sunday that we have sports together, and all that yes in the same it is ordered by Dr.R. So, sometimes we're outbound, so the term is there, there we had a relieving, the relieving event is usually held at the end of the month. .” (RESO1, SSI)

Humility and Self-awareness on professional ability and limitation

Humility (humble) is a word I chose to represent its opposite, “arrogant”. Across the interview sessions, the word arrogant is more frequently used by participants than humility. However, most of the use of the “arrogant” word was meant to highlight the importance of being humble such as the following excerpt:

> “But what I know is that as much as possible a neuro resident must have a good relationship with the nurse. So when I see all of my resident colleagues in neurology has a good and humble relationship with nurses, no one is arrogant.” (RESN3, ITTD)

RESN3 explained that one intended and proven characteristic of neurology residents is their humility when interacting with other professionals such as the nurse. He uses “arrogant” to emphasise the importance of being humble in developing the relationship.

I put together humility and self-awareness in professional ability because they frequently appear together in a discussion in the above RESN3’s statement. Humility means that a good doctor is humble or does not overrate their ability. This character should have made them aware that their ability is limited, mainly because of their narrowing nature of speciality knowledge and skills regardless of their long and abundant experience of being a general practitioner prior to being a specialist. One neurologist teacher highlighted the

importance of being humble as a provision to have a productive conversation with other non-specialist colleagues:

> "…I emphasized, "Do not entangling patients. If you don't understand, consult!" …, consult with another peer doctor ((different specialist)). Don't be afraid of losing patient ((losing patient could mean losing money)) (MSTN1, SSI)

One orthopaedic participant, discussed humility in comparison with arrogance:

> "…so, since the beginning of training their characters are shaped, they should not be arrogant, if being cocky, they should be beaten ((warned)). They should not be arrogant, in order to be cooperative, disciplined, firm in answering, systematic in thinking, diligent …" (MSTO5, SSI)

MSTO5 further argues that destroying arrogance is the way a resident could learn more, from their peer, senior resident and other.

Open minded and cooperative

A good and professional doctor is expected to be a person who could be open to a suggestion and cooperate with other professionals to solve a patient's problem.

> "Well, I always tell them that there should have eagerness, curiosity, want to know many things. Because the neurology is a wide-open window. How many will go on us is depending how we want to enquire, listen to other, eager to ask from other people, and add more knowledge (MSTN5, SSI).
>
> So, I, yes, I learned a lot from my friend's psychiatrist. So, we pioneered to work together in managing tumour patients, these patients need psychiatric care. May be not all other disciplines agree with it. Some considered, if get in touch with psychiatry it means end, failed ((for the patient)), But we insisted to consult from the beginning. It's a good reception though. I love to share with them ((psychiatrists)) (MSTN5, ITTD)

This open mindedness is also the theme that participants related to interprofessional collaboration which will be discussed in the next chapter on interdiscursivity.

MP as peer-group specialistic traits

This category I developed because the traits were mostly related to the spirit and values developed by the community of specialists. Although it may apply to both specialists or across wider specialists, the traits in this category appeared specifically in certain specialities either among neurology participants only or among orthopaedic surgery participants only.

Thoroughness and comprehensive in the clinical process (consultation, specific physical examination) in neurology

This discourse appeared repeatedly both among neurology residents and MST in different study programmes. They asserted that thorough and comprehensive care is vital to indicate a neurologist's professionalism.

> "A good neurologist is neurologist as a whole, holistic. Because in determining the diagnostics in neurobehavior that we also consider other clinical symptoms as well, not only cognitive function per se. That's the main thing. The second is, if in my opinion, for a good neurology yes (MSTN4, SSI)
>
> "Because we, whatever fast we think, there is one factor that forms the professional element, that is careful and thorough…We could have said professional, but we're not careful and thorough, it's not professional! (RESN3, SSI)

This thoroughness characteristic is claimed to be a common identity of a neurologist which is admired by other medical specialists.

> "The one that stands out is that (exam comprehensively) … Well, sometimes they confused to determine the location of the lesion. Because topical diagnosis will determine the supporting examination. Determine where the MRI should be focused on, and which area should be examined. Well, **they ((other specialists)) often asks for our help** to determine this topical lesion…" (MSTN3, SSI)

Physically (manner and attire) *acceptable* in neurology and orthopaedic

The theme comes from the idea that physical attire and manner are important aspects of professional characteristics. This idea is expressed frequently among residents both in neurology and orthopaedic surgery. For example, in neurology, being physically acceptable in attire and manner is associated with a provision to perform well as a means to respect others:

> RSP: "Yes. We do have to wear skirts in neurology, women anyway".
>
> RSB: "But, why?

RSP: “Polite” ((nodding)) (RESN2, ITTD)

RESN2’s response to the question was very short, “polite” (*sopan* in Bahasa). The term “sopan” has a taken for granted meaning among us Indonesian that this means respecting others passively.

In one of orthopaedic surgery programme (training place of RESO1), wearing appropriate clothing on a day-to-day basis is associated with professional behaviour. Interestingly, this discourse is enforced through the study programme regulation:

> “This university … **has a rule on clothing**, shirts should be inserted, as Dr.RD ((a Head of Department)) obliged, except for batik Doc yes. We are required to wear batik on Monday and Thursday, it's already the regulation in the orthopaedic study programme. And **no resident is allowed to pull his clothes out while he is on duty**, when he is active as a resident, **they must tuck in their clothes, must be neat, look neat**, and then residents **must wear socks**.” (RESO1, SSI)

Brotherhood sensibility in orthopaedic

This discourse arises from participants’ statements, especially in orthopaedic surgery. The discourses, stated in different words, convey that part of professional characteristics is establishing relationships with peer specialists like a family. Furthermore, participants’ who conveyed the idea of a brotherhood sensibility argued that it is the role of professional training (i.e., specialist education) to develop and nurture this ability as a provision to develop the communal identity of specialists, as seen in this following excerpt:

> “For extracurricular activity which we’ve always emphasized, and *Alhamdulillah* ((Thanks God)) this has been recognized by other centres ((other orthopaedic study programmes)), to develop our brotherhood. **Yes brotherhood. So we're as a family**…the **barrier between those very seniors and junior, like Prof. H, and me for instance, is thin**. Or for example, like dr.I ((senior supervisor)) and dr.E ((junior supervisor)), they are equal and egalitarian. So, this is what happened with the resident too. We do not .., like I never claimed I am their teacher. In this manner we expect them to share more problems either in studying or working. We thought this would make us more approachable to them” (MSTO6, SSI).

MSTO6 associates the brotherhood spirit and activities developed in his study programme with the “identity” of the orthopaedic surgeon community in his institute which has been recognized by the national orthopaedics society.

Being informative and educative with patient in orthopaedic

Being informative, communicative, and educative to patients is a major discourse built by the orthopaedic community to promote professionalism. It is even claimed as the discourse that saves the orthopaedic surgery community's face in reducing the amount of disciplinary misconduct (sentinel event). The sentinel event is a term formally used by the national accrediting body, adopted from the Joint Commission standard on patient safety conduct in the hospital. A sentinel even refers to a patient safety event that results in death, permanent harm, or severe temporary harm (The Joint Commission, 2022). In addition, communicating well with the patient was identified as something that had been neglected as part of teaching in orthopaedic education:

> “You know what, orthopaedic surgery today, in MKDKI the one who scored most cases is orthopaedic. The most cases in a national scale on the problem against patients, linked to disciplinary and ethics problem is orthopaedic surgery. Formerly was OBGYN. Now orthopaedics. Why? We have not been educated for doing ((good)) communication bro! ((laughter))” (MSTO2, SSI)

Leading others in both neurology and orthopaedic

Some participants, both in neurology and orthopaedic surgery expressed similar ideas on the importance of nurturing leadership skill in performing practice as part of professionalism. This includes leadership for internal specialist peers (e.g., nurturing innovation across the nation) and also for leading multi or interprofessional healthcare teams (e.g., surgical team, cancer care, emergency care etc.).

> “… **a Neurologist should be a leader**, because historically and philosophically we are working at the brain, and the brain is the centre of control of all. And interestingly, the brain and the nervous system are connected through billions on synapse, so it means that we would never be able to work alone but must working with others.” (MSTN5, SSI)

> “We demand reserve ((total commitment)) yes. You have to enter the operating room at 7 ((am)), you e… **must work together in the team, hierarchy is important!** |, hierarchy is important! | I, as a leader of one

> of the groups of people in the operating room. **If I do not show that I am a leader, if for example my members e… doing actions that I think is beyond propriety.** I must do something hard to them in my opinion, and it's a learning process., classic it is not? It is not modern at all. Classic!" (MSTO1, SSI)

Managing resource efficiently (involving matching care with payment scheme and selectively choosing diagnostic procedures and treatment modalities)

The ability to manage resource efficiently also appeared across neurology and orthopaedic surgery participants. This theme especially related to the implementation of a payment scheme which requires medical specialist to be selective in performing diagnostic procedure or treatment modalities.

> RSP: "Yes and everything **has to be in accordance with existing SOPs** ((manual procedure)). Just yes now it mostly collides with our current health system ((BPJS))".
>
> RSB:" How is that supposed to mean?"
>
> RSP: "BPJS now make a situation, where sometimes, **by the book** ((textbook)), it says to do this, but this collides with the available ceiling budget, all sorts, making us sometimes give up to not be able to do as good as possible." (RESO5, SSI)

> "No longer there. The thing may be a BPJS problem anyway, so it's because there are many rules that sometimes **we are so difficult to perform all diagnostic because there is ceiling ((budget))**. So, for example, in neuro a series of examinations should be included within the package, that is to say, if there were two examinations, KHS and EMG **should ideally be done at the same time**. But because of the limitations of our ceiling must perform the KHS alone in the first visit, then the patient will need to make another appointment for EMG, which take time and delay the diagnosis". (REN3, SSI)

Doing guide-based practice (as a translation of evidence-based practice)

Doing guide-based practice, which developed by evidence-based medicine, is one merits which characterize a professional specialist.

> "I think, a professional start from attitude and knowledge. Knowledge, if for example he does not read much and he does not update to a knowledge and he treats patients **with knowledge that is not updated**, it is unprofessional. I think it is. And if he gives the patient a choice of therapy according to what's good for him and **not based on evidence**, that's not professional in my opinion." (MSTN5, SSI)

However, this discourse is also related to the necessity to protect the specialist from the uncertain nature of the specialist practice as well as to preserve the niche of practice from other specialists.

> "If the EBM ((evidence-based medicine)) by ((referring to)) guidelines, what we use is usually based on guidelines. Particularly, guideline in Indonesia if for neurology specialist. Because what I've noticed it's very different anyway, there are differences! There are some differences to the guidelines that have been implemented overseas and in Indonesia. So usually, we tend to use guidelines existed in Indonesia." (RESN1, SSI)

> "Yes, more or less it is **national guide for clinical service** ((with not quite convincing sound)) …Well now this guide has just been signed by the Minister of Health, the guideline for Stroke, revised in each specific period. Now that's actually guiding the neurologists to obey the principles so that the professionalism later becomes uniformed." (MSTN1, SSI)

Professional dilemma literacy

The use of literacy as a determiner of the phrase 'professional dilemma' in this theme is inspired by the definition of health literacy offered by the UK NHS in its official website (https://service-manual.nhs.uk/content/health-literacy):

> "Health literacy is about a person's ability to understand and use information to make decisions about their health" (NHS, 2021)

So, what I meant by professional dilemma literacy is the professional ability to solve or make decisions to any moral or ethical dilemma that appear in practice life based on a particular moral compass. This discourse is inspired by a repeated argument of participants on how they solve dilemmatic problems found in practice with ideas from spiritual/religious teaching. The source of the problem solving might come from any taught or known literacy such as religious texts (e.g., *Qur'an*, *hadith*) (MSTO5; MSTN2, MSTN6), spiritual/religious teaching (RESN4; MSTO5), medical professional code of ethics guide (MSTN3), and collection of professional critical incident cases (MSTO1, RESO5). The experience of the orthopaedic community in promoting the importance of learning from the collection of cases of real medical lapses to reduce the number of disciplinary cases is the most interesting example of regarding dilemma literacy as part of learning professionalism which depicted in following MSTO1 quotes.

> “Some of the cases ((sentinel incident cases)). For instance, there we had our friend, unnamed, anonymous, performing a surgical operation like this. The case should have not been operated on, but he did it instead. So there were a complaint, because- ((of sentinel cases like this)). I don't know the numbers. But **orthopaedics became one of the highly complained among our community** ((medical)). Because the procedure is related to the cost, and that's a lot…That's why we introduce this approach ((communications examination and ethical conducts)) to champion a different approach to our specialist society, I wish for residents in their 5 years training, to gain this spirit. But we can't ensure everyone understands it. ((I wish)) At least some of them and us could keep convey this.” (MSTO1, SSI)

MP as medical profession traits

This category emerged because the traits listed in the following sections surfaced in both specialities and also related to the regulation discourse either asserted by Indonesian Medical Association or campaigned for by other professional regulatory agencies such as Indonesian Medical Council or Teaching Hospital Accreditation Committee. I am using term medical profession, because there is a subtle nuance of governmentality that applied to medical profession in the participants’ narrative when uttering these particular traits. For instance, when uttering prioritizing patient safety, participant tend to relate this trait as a provision to comply with the hospital vision to pass and maintain accreditation status. Traits under this category are as follows:

Compliance with physician oath and professional code of ethics.

To be able to be a good and professional doctor, one should be in compliance with the physician oath and professional code of ethics including a provision to show *ethical manner* during practice (MSTN1, SSI; RESN3, SSI). Specifically, it is referred to the Indonesian physician oath and Indonesian Code of Ethics (KODEKI) verses which are both the Indonesian version of Hippocrates oath and the World Medical Association Code of Ethics.

> “So I don't really care. Whether it in education or service issues, but the point is how we do therapeutic contracts as a doctor. And if you talked about therapeutic contracts as a doctor, the doctor swore only one, it is how the patient survived and safe, or patient safety in a cooler language now. Actually, for me it's not a patient safety problem. We should just talk about how a doctor realise their physician’s oath properly. That's the point. (MSTN3, SSI)

> “Because professionalism is about being in compliance with the law, ethics, theory, cognitive, everything should have (RESO1, SSI)

Prioritizing patient safety

Prioritizing patient safety is both an expected knowledge and behaviour that needs to be shown by individuals and communities. Participants asserted that they must be shown by individuals or medical practitioner communities, especially by those who work at the hospital.

> "…this professionalism is also actually given by the hospital. So our resident, at the beginning of admission days, they were introduced, what is its name, there is an orientation, apart from FK UX, ((the orientation session)) is from our teaching hospital especially for patient safety topic, yes." (MSTN4, SSI)

In this excerpt, MSTN4 is referring patient safety as a knowledge that can be transferred or "given", and behaviour as it is expected to be performed after the knowledge has been given.

> ""No, the medical audit is now the system is the suitability of Clinical Pathway guideline. Suitability of the guideline. Do we perform practice according to the guidelines or not … Now the audit happened when the patient safety committee asked for a clinical audit. … it is needed, for the administration of KARS ((accreditation agency for hospital)) through the OPPE (Ongoing Professional Practice Evaluation)". But this is all, not just orthopaedic, all". (MSTO2, SSI)

In above excerpts, both MSTN4 and MSTO2 explicitly relate patient safety as a required knowledge and conduct that must be performed by professional medical staff who work at the hospital. Especially, with the specific narrative by MSTO2, it is a provision of quality assurance evidence required in the hospital accreditation which applied for all specialists.

Sensible with cultural background (Cultural competence)

This theme emerged especially in the frequent statements considering the patient's race, socio-economic and education level while performing their specialist service. such as following excerpt: "…we need to be concerned with the condition of the patient, their family, and the humanity aspect of the patient should also be taken care of." (RESN1, SSI). And also:

> "Certainly, here we need an adjustment ((behaviour change)). At the area especially in Medan, Sumatra ((where the resident is originated)) people used to **speak freely, frank and loud**, whereas here we must be

able to **talk a bit indirect, calm, low pitch and full of manner**" (RESN1, SSI)

These traits require the professional doctor to understand a patient's socio-economic background during the doctor-patient visit, not only by reading the demographical data of the patient, but also it is expected that "doctors could elaborate directly this issue during their consultation times" (MSTN5). With this knowledge then, the doctors are expected to offer the fairest (most suitable) service (e.g., drugs, procedural examination) for the patient.

Table 5-3 shows the summary of the characteristics described above.

Table 5-3 List of characteristics of good person leading to good professional

Traits discourses	**List of traits**
Personal characters	1. Altruistic 2. Empathetic and Compassionate care 3. Trustworthy 4. Open minded and cooperative 5. Humble and Self-awareness on professional ability and limitation 6. Spirituality and religiosity 7. Resilient 8. Mindfulness and balanced wellbeing
Peer-group traits	9. Thoroughness and comprehensive in the clinical process (consultation, specific physical examination) in neurology 10. Physical mannerism and attire in neurology and orthopaedic 11. Brotherhood sensibility in orthopaedic 12. Being informative and educative with patient ➔ orthopaedic 13. Leading others in neurology and orthopaedic 14. Managing resource efficiently involving matching care with payment scheme and selectively choosing diagnostic procedures and treatment modalities ➔ neuro and orthopaedic 15. Doing guide-based practice (as a translation of evidence-based practice) in neurology and orthopaedic 16. Mitigating and surviving considerable amount of professional dilemmatic circumstance (Professional dilemma literacy) in neuro and orthopaedic
Medical Profession Traits	17. Prioritizing patient safety 18. Compliance with physician oath including ethical manner related to profession code of conduct 19. Sensible with cultural background

5.2.1.2 Good and professional doctor and competency

'Competency' frequently appeared when participants attempt to define a professional doctor. A group of participants indicated that it had a shared conception to competent doctor, meaning being professional has parallel

meaning with being a competent doctor. Another group of participants clearly positioned professionalism as different traits to competency. Although it seemed there were typical conceptions of the competent doctor which referred to a generic competent doctor related to either their abilities, fulfilment of the patient's care task, or doctor's responsibility, participants had a different vision whether "professional or professionalism" is a part, or a wholeness, of being competent doctor.

> "She is really professional. (5s) **She is really professional because she wants to learn more and wants to create a tidy recording documentation**. This for me, frankly, I am proud of her. And now she is taking Doctoral degree." (MSTN1, SSI)
>
> "… **So, in principle we will produce a professional doctor, a competent one**. Who is able to compete in the international world, continue to improve the capacity of personal ability? These are all competencies listed here. Then later the doctor was in addition to a clinic ((professional related to clinic)) **also as a person who has managerial abilities, collaborators with other disciplines, entrepreneurs,** right. So … this is a standard competency, this is now even 22 ((list of competency components)), because they are still divided into further smaller scales."(MSTN2, SSI)

In both above excerpts, participants perceived that professional has a same meaning with competence, means being professional is being competent and vice versa. However, like in the following excerpt, MSTN6 asserts that "competencies", uttered as a plural noun and referred to as abilities, indicating that the competency differs from "professional" concept:

> "So, there are competency in EMG poly. **There are competencies that patients can be done by PPDS first**, then I see the results of their work. There are also patients which they have to work while I was being there confirming, and there is also case where I have to do myself. So, there are three levels that we have to choose which patients are done by PPDS, which ones my PPDS does have to be there, and which ones I have to do myself." (MSTN6, ITTD)

Participants believed that a professional doctor is the sole goal of being medical doctor perceived that there is no need to elicit a specific elaboration of MP in teaching-learning because the whole educational process is the process of nurturing the trainee to be a professional one.

> "Neurology, **neurology professionals as a whole, not just fragmented**. At here, we've been working under sub-specialist

> section, right? But **a good neurologist is a whole neurology, yes a holistic one**. Because in determining a diagnostic in the neurobehavior we also consider other clinical symptoms, not merely cognitive function, that is the main thing. The second one anyway, if you ask me, **a good neurologist now I'd agree on the current concept, tends to the prevention, preventive medicine**. So that, there would not be a severe neurology cases anymore, … more on preventative, *lah* ((slang imbued article))." (MSTN4, SSI)

In the Indonesian context, finding that some MST participants still held a perspective that simplified the concept of a professional doctor as simply competent doctor was surprising given that the competency standard of physicians which textually brought MP as an explicit domain of competency has been introduced since 2006. This indicates that a unifying concept of competency, where professionalism is thought to be part of competence, has not been well understood by the specialist communities. Moreover, it also indicates that the legal mechanism of enacting competency standards through an assurance of academic guidance has not been effective in changing specialist perspectives on competency. Therefore, it seems that this conception is representing the major “naïve” conception of the professional doctor across specialities in this country. Nevertheless, if the term “professional behaviour” or “professionalism” is used, participants quickly grasped that this theme specifically related to ethical or positive behaviours of a doctor and the discussion easily nudged to the assessment topic (e.g., national examination, 360 degree, or behavioural evaluation of physician performance).

> RSB: "if about the professionalism of neurologist, how do you see this issue so far in Indonesia? The process of achieving it or making it maintained. or you may have opinion regarding professionalism of neurology in Indonesia?"
>
> RSP: "So ee (2s) professionalism after we have completed our education. Education yes, (2s) staged-based education. And then there's the ee (3s) **the acknowledged professionalism is that we at that level of competence**. Well, there is a collegium ((college of speciality)), there is one commission whose chairman is me. I have been 2 periods of **this national competency test to oversee the competence**. He has to be competent. So, for example he **did not pass this one competency, to see professionalism and so on, ee. He could not be a neurologist**. Because the authority who created a certificate or diploma is the University, but he can't practice. Professions shouldn't be allowed. So there is still one more stage to work as a professional doctor, working as a neurologist and now the burden of being a neurology neurologist Sp.N.

> Specialist doctors are quite obliged to take a competency test until graduation." (MSTN2, SSI)

> RSB: Oh, and it ((formal teaching learning for professionalism education)) did not yet exist according to your knowledge?
> RSB: Not available yet
> RSB: What about assessment of the professionalism?
> RSB: I think there is assessment for professionalism anyway. So, in the neurology, on every test, there is a form. **So, we, for example, had a ward physical examination exam, in that form the attitude of professionalism aspect was assessed**, how we greet to patients, how we what to communicate about the disease so yes, **it was there, the checklist**.
> RSB: But no teaching-learning?
> RSB: There is no teaching-learning. (RESN1, SSI)

This is possibly the explanation behind why in collocation analysis, “assessment” is more sensitively collocated with “professionalism” rather than with “professional” query (see Figure 5-1 and Table 5.1).

5.2.1.3 Good and Professional Doctor: prescriptive versus developmental identities

My interpretation of MP can be expressed in two distinct ways. Firstly MP, whether as personal traits or a conceptual framework (peer or whole professional traits), conceived as a given, prescribed conception written in a sacred book or guideline. Secondly, MP is also perceived as living-performance of a professional as a result of dynamic interaction with the individual or community with whom the professional works. The first expression is characterized by a repeated use of “powerful” source of reference such as standard, regulation, and professional guideline. This is depicted in the following excerpts.

> RSB: "If for neurology itself doc, **are there any specific expectations that for a neurologist** should be like this and that?"
>
> RSP: "There is. **The standard of competence itself.** We in neurology also have standard ee.. competencies that must be achieved."
>
> RSB: "if you could summarize in that standard of competence, maybe you can give me an overview or summary of what is neurology specialist?"
>
> RSP: "Oh yes, a moment please, this briefly there is a book .. ((taking a moment to take a standard of competence for neurology Specialist)) yes, so it's readable here ((showing the book to me)). This has been ratified by the council ((Indonesia Medical Council)), also with the revised format**. So, in principle we will produce a professional**

> **doctor, competent|**. Who is able to compete in the international world, continue to improve the capacity of personal ability? These are all competencies listed here. Then later the doctor was in addition to a clinic ((professional related to clinic)) **also as a person who has managerial abilities, collaborators with other disciplines, entrepreneurs,** right. So that the competence of the field according to his education, this is a standard competency, this is now even 22 ((list of competency components)), because they are still divided into further smaller scales…previously were 19 ((competency components))" (MSTN2, SSI)

Another quote from an orthopaedics doctor:

> RSB: "OK, It was a good doctor, if suppose I change the question into a professional ortho specialist, is it the same as a good doctor?"
> RSP: "Yes it was yes ((mumbling)), because professional is what it is ((talking to himself)), **put yourself in place according to his profession's rules**. **Same, it should be the same**. ((It is just)) The problem of terminology and the habit of using like language anyway. **A professional doctor should be good and a good doctor should be a professional**."(MSTO1, SSI)

> RSP: "Yes in my opinion. Let's say he's nice. **But if the professional is, yes, he really does work according to the literature, meaning that the guideline** is like this. **So not all of it is left to the patient**. Then what is called not every case should be ended with surgical treatment, must be surgery, must be surgery. **For a professional, if there is an indication not to operate, it should not be operated, yes…** I think it is also unprofessional because there are some ((cases)) do not have to be operated on. ((for example)) just put a cast on or rested ((immobilization)) only and then finished. So, it's no exaggeration." (RESO3, SSI)

Critical discourse analysts suggest that most of the hegemonic discourse comes in a very subtle expression or is often partially invoked as a taken for granted assumption. An example of this taken-for-granted expression can be seen in the RESO3 statement "…according to the literature" assume a blanket statement for the medical literature and guidelines. This typical way of referring can also be seen in the following quotes, specifically, when the participants (MSTN4 and RESN3) refer to the standard or guides about patient safety and specialist education.

> RSP: "Education, **professionalism should be given also in the early days** when the resident started their training, then the second ee..((interrupted)). This professionalism is also actually given by the hospital. So, our resident at the time of new entry here, yes they were

> also introduced, what is its name, there is **an orientation yes, apart from FKUX from our teaching hospital, especially for patient safety**, yes."
>
> RSB: "How it was done doc, teaching or what?"
>
> RSP: "Teaching, then there is practice too. **I think it's good with the patient safety, it's good for us to be professionals. If it wasn't there, we wouldn't have been given knowledge of it**. If now it's actually with patient safety it's already one of the factors that make us professional too."
>
> RSP: "… at the time of the exam, we are also using Mini CeX ((Mini Clinical Examination)), right. there is a professionalism assessment, right? **This is further examination to the mentioned standards, regulations or guides** show that the current belief or quotes to these documents are frequently missed or inaccurate or worse the referral were not supported adequately with the coverage meaning of the referred documents. (MSTN4, SSI)

> No. Everything has its own indication. So, that personal assessment I have never seen it to date. So, if it has to be consulted, there must be an action, yes there are indications for that, there is this itself. **The standard of the profession is already existed if it is like this then we have to do cross-sectoral ((different speciality department)), consult to other profession or divisions, it's there it is**. So it's not because you are so fond of being consulted, I am a consultant, No, there is nothing like that (RESN3, ITTD)

In the excerpts above, MSTN4 tries to convey that I already understood about jargon around “patient safety” and its related guidelines, which indeed in some cases has become a tagline of Indonesian hospital accreditation practice in the last decade. Unconsciously, I just took this “patient-safety matter” for granted as it is a known conception at that time (or possibly because I am also one of hospital assessors). This way of referring also happened with some residents, for example RESN4, when he was referring that there is a professional standard for making consultations. Whilst I was at that time just accepting this, when rereading and reflecting further to the existing documents, I realised there is no such thing as a standard for making consultations. It was only a convention (a non-written acceptable custom) for making consultations. Therefore, I realised this typical way of referring has become a common practice among participants and me. As one addressed to be a doctor, I was possibly trapped into a self-belonging bias to this subtle hegemonic practice of “professionalism referring” so that I was taking for a granted that this standard or guide referral is indeed a part of professional practice of physician. Unconsciously we (participants and I)

have created an imaginary standard for our everyday practices and customs and then refer to it as professional standard because we thought it is what we usually do, and other people might not do like what we do.

Another example is on the “medical ethics” jargon. This was inferred when we were talking about ethics. At that time, it seemed that we already knew what this term did mean. In fact, there was a change in Code of Ethics guide of Indonesian Medical Association (KODEKI) which not every physician might have known about.

The conception that a profession is more than a mere occupation because of the standard they had and applied is hegemonic in participants’ conception of professional and professionalism. Although it is not necessary that the standard is applicable or even existed. For an example, MSTN3, a chair of College of Neurology, provided the ideal of compliance to the standard of physician and physician’s oath:

> “… I chose the profession as a physician, my job is that **I should take care patients** at the hospital, I became a lecturer, I became an educator, it is a job, but the profession is as a doctor. Which means … **a profession should have a certain amount of education and a set of ethics, right?** That we should uphold. So, I do not really care if it would be drawn to education, would be drawn to the problem of service, **but the point is how we perform therapeutic contract as a doctor. And if we talked about therapeutic contract as a doctor, the physician's oath** should drive how to make the patient survive, or if we use the current fancy language is ((the)) patient safety … actually, **in fact it was not a problem about patient safety. Truly, we should address how a doctor be able to do his physician’s oath properly. That is the essence.** (MSTN3, SSI)

In above excerpt, MSTN3 argued that compliance to the physician’s oath and code of ethics which both are in a form of written standard created by the profession’s community of practice (Indonesian Association of Physician). However, frequent inaccurate referrals to the standards among participants in representing the described professionalism, as featured in above excerpt, may indicate two possibilities. First, referring to standards is a preserved practice of medical profession to maintain its social identity and privileges. And second, a referral to standards or professional organisation works is a symbolic feature of social imaginary institution of professionalism among current medical professionals.

In regard to the first possibility, definitions provided by sociologists on professional are relevant to this finding. In sociologist's' view, a professional is defined as a member of a profession. Consequently, professionals are governed by codes of ethics and profess commitment to competence, integrity and morality, altruism, and the promotion of the public good within their expert domain. Professionals are always expected to maintain their accountability to those they serve (patients) and to wider society (Larson, 1979; Freidson, 1999; Evetts, 2003).

I argue that a referral to the practice standard found in this study is a discourse to maintain the professional privileges to perform a special function in society and therefore grant social advantages. This applies even when a referred standard is sometime as mundane as a trivial paperwork (e.g., a recommendation paper) of what peers wanted (contrary to a robust academic or legal work where standard is usually constructed).

> RSP: "… also, there would be a new regulation. It is being discussed because KKI ((Indonesian Medical Council)) will issue a consultant's STR ((registration for consultant)). So, it will be streamlined by collegium into 8 ((sub-specialities)). These 8 are in the process, so that **it can be immediately submitted to the KKI to be legalized...**" (MSTN2, SSI)

In above excerpt, the MSTN2 as the influential person in the college of neurology provided an example of how regulation made by Indonesian Medical Council could be a product of what being discussed and wanted by a few numbers of persons in the college of neurology, especially those at 13 teaching hospital that envisioned change for entire member of the neurology community.

> RSP: "PABOI, PABOI ((repeating to confirm that it is the National Association of Orthopaedic specialist called PABOI)). **PABOI will accommodate the development of science related to services**. As the counterpart, PABOI had a collegium to oversee from the educational side. So, with that, it, depends on the flexibility of the place where the centre ((the teaching hospital)) works, **using this to advocate to the policy maker and to the management of the hospital, whether something can be advocated** … And that form of advocacy is very much helped by the national ((the national chair of PABOI)). There's no way we're going to move on our own, because it's going to clash, we can't." (MSTO1, SSI)

In above excerpt from orthopaedic participant, MSTO1 provided an example of how "scientific evidence" has become a powerful mean to advocate and convince external stakeholder in one teaching hospital to approve certain

practice wanted by local orthopaedic community through a negotiation provided by the national chair of orthopaedic association (PABOI). This is an example of the second possible feature of “referral to standard” discourse.

Regarding to this second possibility, referring to a standard, guide, evidence-based practice or other professional organisation enactment could be regarded as a feature of social imaginary of professionalism among current medical professionals. I called it imaginary because the referral is bogus hence hegemonic and contagious. People outside the medical profession or specialist peers might already believe that any standards referred by the specialist are real and applicable; and therefore, establish their trust in the profession. However, this referral is only to convince people that the standard is there, or the profession have already fulfilled their obligation to create and uphold certain standards. In fact, the standard does not exist, or if it does, it is not applicable in the way it is verbally described. Once, it was possibly only a little incident, but later on, both parties (i.e., the profession and the public) believed that this practice existed. The professionals do practice because it is inherited as routine activities or embedded in the service organisation where public already took it for granted that the practice is standardized or evidence-based, yet it is not.

At least four discourses might influence and are being influenced by this “standardization referral” discourse. These includes: 1) the belief system and worldview, 2) education, 3) organisation, and 4) legal discourses. The explanation of how these discourses emerged in available data and their interdiscursivity (possible relational dynamics between discourses) will be described and discussed further in the next chapter which will extensively provide reservation to the interdiscursivity of MP in this research. However, indicating the influence of these four discourses earlier in this section is important to remind that the texts or conceptions I produced so far are never meant as a stand-alone theme or discourse, hence each of them is always interlinked with other discourses and more immanent social practices in the society (Foucault, 1972; Chouliaraki and Fairclough, 2002).

The representation of “standardization referral” discourse I found is unfortunately manifested as a Chimeric practice (one narrative, two different trajectories or heading). First, this imagination might be positive as it contributes to the establishment of the current “trust building” of the public in the

professional and as a control to the member of professions to provide an evidence-based or standardized approach. A standardized or evidence-based practice narrative conveys a comfortable feeling to the public that the practice would have been performed with the best way with an effortful spirit to find the best for patient's welfare i.e., *beneficence* and *non-maleficence* principle of medical ethics. With this trust, the public as patients, provide their consent to be examined, treated in a clinical process and at the same time give their shared fund to finance the service provided[9]. In a constructive way, the standardization of practice discourse provides more secure and accountable practice of medicine which raises the trust of public to the medical profession.

Secondly, which is in the opposite trajectory, the imagination at the same time serves as a contributor to resisting organisational change. This is because referring to standardization can become a trap for some members in the organisation who are unresponsive to change. Consequently, they tend to preserve a comfort zone of doing so-called good practice, sometimes labelled as evidence-based practice. In my case, while referral to guide, such as "we should refer to Code of Ethics or physician oath, right?" (RESN3, SSI) is a valid practice (protected by law), however, considering what being referred to be the old guide or old concept, this might lead to an absence of accountability and quality assurance mechanisms in professional organisation and practice. This can be seen in a case when college of neurology, who are entrusted to provide the updated professional guides or standards was felt not to be doing so:

> RSB: "If among the developments in FKUX compared to Perdossi and in the college of neurology, KNI, is there any update, or KNI is left behind compared to the development of education or discussion about professionalism in FMUX?
>
> RSP: " I think this matter, in the collegium, this issue has never been discussed."
>
> RSB: "Even never?"
>
> RSP: "Hmm ((with agreement nodding gesture)) Collegium is still very generic in my opinion. Sorry yes, just get to Doctor EA it's okay."
>
> RSB: "It's all right.
>
> RSP: "Still, it is really only the primary needs are being discussed. For example like SKS calculation equality, modules, and so on have not yet

[9] Most of speciality care in Indonesia are funded by out-of-pocket (private funds) financial system, except the services provided at the hospital which since 2014 have been partly funded through Universal Health Coverage system.

> been discussed. Moreover, as such detailed term like professionalism, I don't think it seems to." (MSTN4, SSI)

In above excerpts, based on MSTN4's account, the College of Neurology is described as a passive organisation, which depends on who leads the organisation (persons) rather than having an organized system to actively engage with the production of standards. This contrasts with the College of Orthopaedics which is perceived to be more active and engaging with the development of standards as MSTO2 says, Indonesian Orthopaedic has been involved actively in the development of ASEAN Curriculum for orthopaedic surgery education, and Indonesia is regarded as "… the most fulfilled and catch-up one" (MSTO2, SSI) among other ASEAN countries, especially in the implementation of the developed standard.

The next feature of how organisation situation contributes to the behaviour of residents and specialist is featured in the following excerpts, where education and hospital organisation is unable to be a guardian or a leading sector in promoting best medical practice. For instance, supervisor delegates residents to do an administrative activity that is not their main role (attending meeting):

> RSP: "After that, well, I'll do service. Can be to poly or to OK ((operation theatre)), It depends. If there is an interesting case, then to OK, if there is none and I have other tasks such as, say, **attending meetings in representing seniors** or there be a poly. Often to poly."
> RSB: "a meeting to represent your supervisors? what meeting is that for example?"
> RSP:" Various meetings (smiling))"
> RSB: "At the hospital or faculty of medicine?"
> RSP: "Often at the hospital. If for Faculty of Medicine, usually the senior himself would come"
> RSB: "Can you give me an example what kind of meeting it is at hospital, meeting about what?"
> RSP: "Socialization whatever."
> RSB: "Accreditation?"
> RSP: "Accreditation, yes once. Otherwise, socialisation like IT like that is often told to replace them usually. It's about hospital things, medical records or something." (RESO5, ITTD)

Another common example is the responsibility for teaching residents. RESO6 responded that he tends to learn more with other resident than with the

supervisors, especially in acquiring surgical and communication skills which he believed as two important components of professionalism in orthopaedic.

> RSP: **“Surgical skills yes that's it, I'm more with the resident.**, But once I operate with seniors ((supervisors)) or I end up in a guided surgery, guided by the senior ((consultant/supervisor)), it turns out, "oh that is it, that is the way doing that, or oh yesterday I was right, oh it turns out there is a trick like this". Because somehow our supervisor's flying hours ((experience)) are much more than the senior colleagues.”
>
> RSB: “Okay. What about the communication skills?”
>
> RSP: “**Communication skills** in my opinion are also **more with resident anyway.”**
>
> RSP: “With residents?”
>
> RSP: “Yes. Because sometimes the resident more goes down together and see the supervision of his junior residents of how they are doing it. Like sometimes in the poly **before the SPV comes we are there to see how our senior resident examines the patient,** how he makes a question, ask the patient or pace to the patient. There we can go down reminding or cut, "it's too long, just make it to the point!", or how it should be done. Before at the end, our SPV come down and show sometimes "oh this is missing at here, you're not asking this yet." (RESO6, SSI)

In the above excerpts, RESO5 and RESO6, residents at the same teaching hospital with MSTO5, disclosed consciously that practicing outside the teaching hospital during working hours is a common practice which is endorsed deliberately by their teacher, MSTO5. In fact, MSTO5 narrated different stories that supervisors had their duty well done:

> RSP: “**We have time, time to teach, doing service are not much here. For me, I am only until 12 o'clock being here**. **After that I go out** ((to practice outside the hospital)). Why? **There's not enough payment here**… if I'm here, I'm not going anywhere. Then the condition must be enough income ((the precondition)), that's one yes. So, this what makes us difficult to have any improvement. Even with Malaysia, we are losing. (MSTO5, SSI)

Above situation is different to what conceived by MSTO who works at other teaching hospitals. MSTO3 believed that having practice outside teaching hospital during working hours is an unacceptable behaviour

> RSB: "Okay, is there such as **delegating system still existed?**"

> RSP: "**You can't do it now, can you? I can't**. At the PN ((pseudonym)) Hospital that practice is not allowed now, so there must be a single SIP ((practice licence)), should not be delegated ((to residents)). You mean delegated to people, right? I can't. Uh, I'm also chairman of the medical committee also at the SA ((pseudonym)) Hospital." (MSTO3, SSI)

As highlighted above, the contradiction indicates that in the first hospital where RESO5 and RESO6 work, the hospital's control to the professional practice of the attending physicians was more lenient compared to the second one. It means that the first hospital had a non-accountable practice. In the first teaching hospital, the system let their specialists delegate most of their responsibility to the residents (not to other attending clinicians), while at the other hospital (at the hospital in MSTO3 case) there is a belief that an attending should mostly be responsible for their patient care.

> "That's from knowledge ((theoretical)) point of view. Later, on attitude, I think **it doesn't need to be taught.** Our senior consultants already showed ample examples, and they are already **being professional at all** in our opinion. And we are not only learning from consultants, but also learning from nurses, instrument-man… Yes, indeed it may not be equal to the real work-field in our future, here the hospital is a teaching hospital, so it must have high standards…" (RESO3, SSI)

The above excerpt indicates that the unfavourable behaviours shown by supervisors or former senior residents came to form part of the participant's personal daily life. Moreover, it is likely to continue to be transferred from one specialist generation to the next generations (residents or junior residents).

5.2.1.4 Threading MP through understanding professionalism lapses

The MP conception surfaced through discussions with participants about their most feared or concerned professionalism lapses. A great learning moment comes when I compare the lapses idea among the two specialities. Orthopaedic participants pay more attention to the arrogance, overconfidence, selfishness, money orientation and crossing other's boundaries as their main concerns. While neurology participants are concerned about losing empathy, losing their thoroughness when patient amount overloaded, and money orientation temptation as the main lapses. Table 5-4 below shows the concepts of lapses that concerned most by the participants.

Table 5-4 Professionalism traits applied to the most concerning lapses

Aspect	**Neurology**		**Orthopaedics Surgery**	
	Lapses	Professional is	Lapses	Professional is
Difference	a) Losing Empathy b) Losing thoroughness to the detail c) In hurry d) Close-minded e) Ignorance to responsibility (e.g., cannot be called)	a) Emphatic b) Thorough/attention to details c) Gentle, Present to patient, Time-efficient d) Open minded e) Committed	a) Arrogance b) Selfishness c) Over-confidence d) Crossing boundaries (other specialist's role) e) Surgically unskilled	a) Humility - Humble b) Collaborative c) Has boundary awareness d) Adequately skilled
Shared Lapses	Money orientation	• Paid proportionally • Peace-life balance • Compliance with service system	Money orientation	• Paid proportionally • Equity in the use of health resource

Although not every participant shared directly the reason why any particular trait was considered to be a professional lapse, further comparison and contrast through interdiscursivity analysis helped to find strong relationship of conceived lapses with personal worldview and multiple organisational influences, especially on the money orientation issue. The money orientation themes both in neurology and orthopaedic were related to the complex organisation and payment system applied in healthcare and academic organisations where the specialists are employed. This is where I realised that all specialists are working as employees, and this is shown by the texts they are using to express some concerning lapses which are related to certain norms that are applied within organisations in which they are employed. This can be captured through the following excerpts when participants are discussing their concern with money orientation:

> "Well, for the not good one (3s) yes, the first is with the current BPJS system. You know I also work in a small hospital that is not type A yes, that's in a day patient can be 30. So that's me, I also become less professional in work because given the limited time, patients might become impatient, if we examine too long, they can go home late night. Then the second one, as I said was mostly. there's also it's the name,

> doctor is a human being yes, at the ends it is about money, like I said. They afraid of losing patient if they refer to colleagues or to an expert. Even here I've met patients come to hospitals he previously treated at a special hospital well, a special hospital for nerve disease." (MSTN4, SSI).

The way the participants argue around money orientation indicates that their concept on professionalism is influenced by a taken for granted norm and routine that applies in day-to-day practice. This means that beside the concept of professional traits that tend to be defined cognitively (through elicitation and reflection of theory and daily practice), MP conception can also be related to traits or behaviours that inevitably occurred in daily practice, which I termed operationalised and conflicting /dilemmatic. Thus, the exploration of lapses has brought me to second order of discourse or Discourse (D) this text analysis which is related to how MP is conceived. Based on this Discourse, MP conceptions can be categorized as cognitive, dilemmatic, and operationalised texts.

5.2.2 MP as cognitive, dilemmatic, and operationalised texts

5.2.2.1 MP as cognitive texts

The MP concept as a cognitive text emerged when definitions or conceptions of a professional doctor were uttered directly by the participants. These discourses were mostly represented during SSI, especially when straightforward questions about definition or concept were asked (e.g., "how can you describe a good doctor", "what does be professional mean for you", etc). I used "cognitive text" to label this discourse because the conceptions were consciously created, and usually were followed by logical reasoning in SSI or they were already embedded as routine practices of the participants which were versed either in the SSI or ITTD.

The conceived traits grouped in this discourse represent the ideal conceptions of participant of the MP. They are ideals because many of the traits were mostly conformed with books, standards or guidelines related to the MP. This does not necessarily mean participants got them from any reading materials, it might also be an incognito process of reflection during the interview, or a product of reflection based on their sum of learning and experience as a professional. I am putting them as ideal definitions because the uttered conceptions were not necessarily factual, or consistent with the practice

in everyday life. The following nested excerpts from MST and RES participants (MSTO and RESO in the same medical school) represent this situation.

> So, if I am asked what are the hallmarks of orthopaedics? **Nationally since the beginning it's been high standard, since the beginning**. So now, our board exams are being benchmarked by others ((other speciality)). As a result, from the beginning we apply high standard, all of the staff were going abroad for fellowship. That's the difference between us and the others. Others are following us, oh nice place yes, some come now. But the board exams which are like ours, are there already ones? ((in other specialities))... I don't think so (MSTO5, SSI)

In his narrative, as Chairperson of College of Specialist, MSTO5 disclosed that only orthopaedic surgery community are applying the high standard in the practice and education. However, this statement about applying all good standards was contradicted by his residents as reported in the following RESO5 and RSO6 statements that MSTOs in this programme rarely visited their patients.

> RSP: Because at the centre of education like in our academic institution, **we are taught up to the standard in the books, we use the best implant**, after that the tools we were using also quite good. Only if we look at the current reality, the outside stage ((attachment to remote hospital)) for example, well it happens in the real world, with BPJS system and others.
> RSB: BPJS?
> RSP: That's ((about)) the tools we use, which are up to date standards in the books, but now that the price cannot be covered by ---.
> RSB: BPJS
> RSP: Yes, silly BPJS health care! So, we have to use that instead, sub-standard tools that we use only. The obsolete one to be frank.
> RSB: But were you adequately being prepared for it, to be adaptable to the resources with available resources so?
> RSP: mmm (5s) Less likely in my opinion. (RESO6, SSI)

> RSP: Honestly, **I did not find any role model how really, because here our seniors are rarely**, so may be about **once a month they would come and stand by in the polyclinic**
> RSB: The ward, how about to the ward?
> RSP: Hm?
> RSB: Visiting ward?
> RSP: **Visiting patient's ward mostly our job**. We were the one who giving them the daily report. So we reporting what happened, we reporting to them, maybe once or twice only communication to patients like "Oh yes Sir, so the planning will be like this and that", that's it. But the whole everyday work were all executed by resident.
> RSB: Aren't there a grand round visit?

> RSP: There is the grand round, **but rarely do they ((the supervisors)) talk to the patients**. This report only this and that plans. Because it is already clear plans of all sorts. (RESO5, SSI)

Thus, there are conceptions of professionalism told by participants that were made up cognitively, ranging from the real experience and also theoretical ones.

5.2.2.2 MP as dilemmatic Texts

In contrast with the first discourse is the dilemmatic text. It is a discourse where participants had tendency to conceal in the first instance conversation about the good or professional doctor, but it was later revealed or confessed as “a reality” or “difficult” matter in the discussion. Opposite to the cognitive text, to locate MP as the dilemmatic text requires a triangulation process between SSI and ITTD or between sessions in the same nest cases (within neurology or within the orthopaedics group). I also needed to iteratively move back and forward to the interview records, compare and contrast, both optimizing the use of collocates networking as well as consult my personal reflexivity. Some of the dilemmatic texts mostly appeared when we had discussion about “professional lapses” and/or “the most concerning behaviour” of the doctor. But, why use the word “dilemmatic”? Simply, because most of the themes and components in this discourse were dilemmatic conditions which positioned the participant in a difficult standing or in a dichotomic standing position, i.e., between shame or pride, acknowledgement or denial, hate or acceptance, etc. The texts were also mostly about performances that participants were hesitant to discuss, or they were commonly sensed as inappropriate to be talked about. Included in this discourse are; 1) Spirituality and religiosity in practice; 2) High Self-esteem; 3) Leading others; 4) Resilient; 5) Treating patient fairly regardless of race and social economical background; and 6) Masking personal interest or problems in the front of patient and related working networks

One example of this dilemmatic component is “high self-esteem” which is feared by one participant as a subtle form of “arrogance”. Different to a Western worldview that regards personal high self-esteem as a key success factor in careers, in the Eastern culture, especially for Indonesians, high self-esteem might be considered as arrogant which is culturally unacceptable if verbally or

physically manifested in the public domain such as public services. This narrative was boldly shown in the following interview:

> RSB: "If e (3s) Does the CHM FKUX institution, as an organisation, has a set of declared values that contribute to the development of neurologist's professionalism, doc?"
>
> RSP: "Yes. How you would say it, it is such **an unbelievable narcissistic** if for FKUX, meaning be the best, the greatest, the leading, the-, the- and so on. That we as a FKUX member should be the most-, the most- ((superlative prefixes)). It is intended not to pick up the arrogance, for the former Dean, when she visited the Department, we used to be asked whether we had position as a chair in college of specialty or specialist association, "Why the chair is not from us", that was the sense to articulate that all the good things should belong to us. It meant that, if we become the chairs, all the good things then can be shared to the other. That's what I mean by narcissistic."
>
> RSB: "But isn't it true doc? I mean, it is indeed that this hospital has already been the National referral site, already the best of all, then the good practices can be shared as well, right?
>
> RSP: "Yes. I mean we are being indoctrinated like that, but it's difference with being arrogant is almost nuance/subtle, right?" (MSTN5, SSI)

In the above excerpts, despite believing that the high self-esteem (labelled as "narcissistic" attribute) contributed to professional development, there was a tone of hesitancy and euphemism in participant's talk to fully acknowledge this trait. The hesitation can be seen in the last participant's response in the continuation of the excerpt when MSTN5 feel uneasy of being regarded as arrogant by others

> Nevertheless, when we get in touch with others in National scale ((national community)), the sense to show off, or giving the best ((while other can't)) seen by other like that. It is sometime making us shy, it should be fixed during the meetings, there was a feeling that "Why people of FKUX being like that?". We had a sense like that, but not for showing-off, but we were indeed feeling like that because we were representing our institutes, so that we should give the best shot. But indeed, it is what the lecture and the dean's job right to promote the-, the-, the- ((best)), right? he he ((laughter))"(MSTN5, SSI)

5.2.2.3 MP as operationalised texts

The third discourse I labelled as "MP as operationalised text", is something in between the two previous discourse poles. It is labelled to the sub-discourses (texts) that appeared to be "the current normal", "already acceptable" matter but they might be beyond the ideal-normative definitions provided in the cognitive

texts. When discussing these texts, participants might not initially think the topic is a significant/important matter that needs to be discussed. However, how they narrated the texts indicated that the texts have been an inescapable or inevitable part of their professional practice. In dilemmatic discourse, participants are aware and have choices as well as possible power to choose their stance and acts. In the operationalised discourse, in contrast, they tend to be unaware, or if they are aware, they usually have no choice or power to do something differently.

Most of the texts in operationalised Discourse, emerged in ITTD and partly appeared in discussions about any interesting topic after talks about the good and professional doctor in SSI. The examples of texts in this discourse are the ability to select diagnostic procedures and treatment modalities wisely and manage resources efficiently.

While in normative text, i.e., code of ethics book, this might be referred to as “beneficence” or optimum outreach for the sake of patient welfare. The current budget limitation applied across health care organisations has made optimum/ideal care difficult to achieve. Therefore, rather than practising the best evidence-based medical care, what has been done by the practising professionals is conditional guide-based medical care. It means that they adopt the standard or evidence gathered from the USA or UK, which fits with the available resources and financial schemes.

Participants might gain insight mostly from their “formal” past teaching-learning experience in the cognitive text. In the operationalised texts, MP mostly appears as the hegemonic influence of the multiple layers of organisations where the participant is currently involved. This condition possibly made them unconsciously embrace the concept of professional deeds or professional matters without criticism. The example for this instance is on the patient safety concept.

> RSB: "I became interested whether neurology specialist has a specific definition of patient safety doc?”
> RSP: "Patient safety?
> RSB: "Yes, that might be different from another specialist or a general practitioner?
> RSP: "**No, we just follow the general patient safety in the hospital**, when (.) such as the risk of fall ((patient's fall risk)) and so on, all of them just adhere with the rule here ((hospital policy))” (MSTN5, SSI)

> RSP: "Yes, the orientation is combined FKUX-CM Hospital. So now the new residents in the first semesters should not be disturbed with each study programme, he should not be given a task at all, so he must do the orientation of FKUX-CM Hospital. Well, we're also JCI accredited, yes. **That's where the patient safety is number one. Well so it's emphasized right to the resident**."
>
> RSP: "It does create an effect! And I think now the resident is more professional, yes. Because now it is required to write a medical record for the safety, safety for the patients as well as doctors. So later if there are legal problems or sort, all had been recorded. In the past, it used to be just writing carelessly, one line, now it's already a culture…" (MSTN4, SSI)

In the above excerpts, MSTN4 and MSTN5 agreed that what has been applied by the hospital, under JCI (Joint Commission International) accreditation standard policy, was conforming to the professionalism provision. They did not relate that this patient safety is also covered by their physician oath, bioethical principlism "*primum no nocere*" (the first do no harm) rooted in medical profession teaching tradition long before the JCI-patient safety campaign. They seem to identify the hospital enactment of the patient safety concept as much more potent in shaping the professional behaviour than the professional organisation code of ethics guide or recertification provision.

Up to this point, I have presented the sub-Discourses of MP as knowledge emergence which I summarize them as a list provided in Table 5-5.

Table 5-5 Three sub-discourses of MP as knowledge emergence.

	MP as knowledge emergence sub-discourses		
	MP as Cognitive text	**MP as Operationalised text**	**MP as Dilemmatic text**
Characteristic	Theoretic, normative, bookish, Ideologic	Pragmatic, normalized, embedded as routine, taken for granted realities	Conflicting thought between self, peer, organisation and culture, embedded in discourse about practice
Example of MP components	1. Thoroughness and comprehensive in the clinical process (anamnesis, physical diagnostic) o Altruistic and empathetic o Compassionate care o Trustworthy 2. Having self-awareness on professional ability and limitation and Open minded and cooperative with other 3. Being communicative, informative and educative to patient 4. Ethical compliance with professional standard and legal system	1. Prioritizing patient safety 2. Being communicative, informative and educative to patient 3. Selecting diagnostic procedures and treatment modalities wisely 4. Managing resource efficiently involving matching care with payment scheme 5. Understand patient background and perform appropriate act accordingly 6. Doing guide-based practice (as a translation of evidence-based practice) 7. Mitigating and surviving considerable amount of dilemmatic circumstance (Professional dilemma literacy) 8. Physical mannerism and attire	1. Spirituality and religiosity in practice 2. High Self-esteem 3. Leading others 4. Resilient – surviving and safe 5. Treating patient fairly regardless of race and social economical background - justice 6. Masking personal interest or problem in the front of patient and related working network 7. Personal Wellbeing-Work balanced

5.3 Chapter Discussion

In the above section (5.2), I have presented two Discourses as the results of text analysis on MP conceptions in the medical specialist context. These Discourses are: 1) MP as professional traits or the competence and 2) MP as knowledge emergence. Both Discourses have emerged from text exploration on SSI and ITTD interview data through iterative text analysis (intertextuality), supported by corpus-based linguistic software (LancsBox). A range of MP conceptions featured and conceived in both developed Discourses have been summarized in Table 5-3 and Table 5-5.

Considering the age-gap between resident and MST participants, initially I wondered if this gap would become the source of different themes on MP conception. In fact, as provided in the result of analysis, the age-gap did not contribute to notable discourse differences. It might be tempting to assume that MST conceptions offer more mature and comprehensive views but interestingly even a younger MST or resident could hold a more orthodox conception of MP, such as regarding MP as merely about applying ethics in practice (MSTO3; RESN3). This contrasts with the views of some residents and older MSTs who viewed MP as not just applying ethics, but also adapting to patient needs (MSTO1) and those of other stakeholders (RESN4; RESO5)

As a good-professional trait or competency Discourse, MP conceptions can be grouped into three sub-Discourses: 1) individual character traits, 2) peer-group traits, and 3) medical profession traits. These traits were interchangeably interpreted as personal character, abilities, and behaviours. The “personal character” is related to the generic traits and abstraction of the "good person". Additionally, the abilities and behaviours are related to tasks/responsibilities at the institution and the multiple roles they represent. Whether MP is understood as personal traits, abilities or behaviour, these conceptions partly share similar ideas with professionalism components and discourses found in some studies both in western and non-western country contexts. For instance, those grouped in personal characters (altruism, honesty, humility and self-awareness, etc.) are similar to the list of professional behaviours issued by NBME (AAMC_NBME, 2002; NBME, 2007), ABIM’s Physician charter (American Board of Internal Medicine, 2002), Royal College of Physician of London (Royal College of Physicians, 2005, p14) in western countries and some non-western countries

(Chandratilake et al., 2012; Pan et al., 2013). However, as a set of traits resulted from a study in post-graduate medical education in a south-Asian country, this study is the first to be done. Hence, these have some context-based conception as they are framed in a designated, Indonesian socio-cultural perspective (i.e., socio-materiality perspective).

Some MP components in the traits Discourse have identical themes or constructs with literature, however, in some cases, they have a different meaning. For instance, about humility and self-awareness. Hilton and Slotnick (2005) propose reflection and self-awareness as a trait involved in professionalism. In this trait, they elaborate on the importance of presenting worldview and mindfulness in the decision-making process to deal with complex health problems. They suggest this trait is one of the critical components of professionalism that should have been featured across levels in the medical profession. While Hilton and Slotnick argue their professionalism, conception is applicable in a western or global context (2015), in my case, self-awareness is a theme to exemplify participants' discourse on a provision of being humble or humility and mindfulness to keep on the expertise boundary. Therefore, as a discourse, humility and self-awareness can be regarded as both universal and local conceptions of MP. Possibly, the "humble" thing in my finding poses the oriental (eastern) value of Hilton and Slotnick's self-awareness occidental (western) version. These possible homonyms (same in spelling and writing but different in meaning and origin) might also apply to other traits such as prioritizing patient safety, spirituality, and religiosity, managing resources efficiently, guide-based practice, mitigating dilemmatic circumstances and being sensible to cultural background (cultural competence). I will discuss these in the next two chapters since they are related to the agency, power and ideology issue.

Nevertheless, some themes of MP conception emerged in this research are very contextual. For instance, the brotherhood sensibility in peer-group and compliance with physician oath in medical profession group are new in known literature and likely very local/contextual to Indonesian constructions. While the discussion on these discourses will be provided in more detail in the following chapters. I think it is important to highlight that the traits Discourse that resulted in this first phase had shared both universal MP conceptions and contextual

ones. This is how the framing of context as activity systems is critical in playing its role in the MP conception. In the following discussion of the second Discourse on MP conceptions as a knowledge emergence plays important role in framing how contextual MP will always exist in different activity systems which arguably made MP as an integral part of professional knowledge is always contextual.

In the second discourse, MP is conceived as knowledge emergence. From the language (i.e., texts) used in expressing the above positive traits conceptions, participants' conception of MP can also be categorized into three groups (sub-Discourses) named: 1) cognitive; 2) operationalised, and 3) dilemmatic text. The full list of traits in these three sub-Discourses is presented in Table 5-4. The cognitive text represents the ideal way of conceiving MP or "MP on paper", the operationalised and Dilemmatic texts were emerging as everyday life representations of MP, either "MP in action" or "MP in the hidden mist". Emerged across resident and MST, the cognitive, operationalised, and dilemmatic dimensions of MP have also featured the progression of conception from resident to MST and also toward the different phases of residency. The cognitive is most likely to occur in the earlier residency phase or at the junior phase of MST, while operationalised and dilemmatic occurred in the middle and the late phase of development. I found this knowledge emergence Discourse, which categorized how professional specialists conceive professionalism as a series of phases: cognitive, operationalized and dilemmatic, resonated with Engeström's expansive cycles (Engeström, 1999; Engeström, 2001). However, this finding has not previously been described in other literature on medical professionalism teaching-learning.

The expansive cycles model is a theoretical model of learning, more specifically professional learning in the activity system. Learning in an activity system occurs in collaborative and co-production processes where elements (human and non-human) interact in the activity systems to achieve a new (expanded) activity system (individual-system learning. Engeström (1999) proposes that internalisation and creative externalisation are two critical learning process occurred in the activity system's expansive learning. Internalisation is a process where the subject of learning deals with the multivoicedness (competing discourses) of the activity system's elements

(Engeström, 1999). It is the development of culture through everyday routine reflection (Engeström and Miettinen, 1999). Externalisation, on another side, is a creation of artefacts process that makes the transformation happen. In this sense, cognitive and dilemmatic might serve as internalisation. Operationalised MP, in contrast, is what fuels the transformation. If we could rethink elements of the activity system in CHAT as a binary human (subject, community, and division of labour) and non-human (rules and instrument) groups, the cognitive and dilemmatic MP would represent the interaction between subjects and human elements. Whereas operationalised ones represent the interactions of the subject with non-human elements. If it is redrawn based on Engestrom's early expansive learning cycle model (1999), the cognitive, dilemmatic and operationalised MP could be visualised like Figure 5-3.

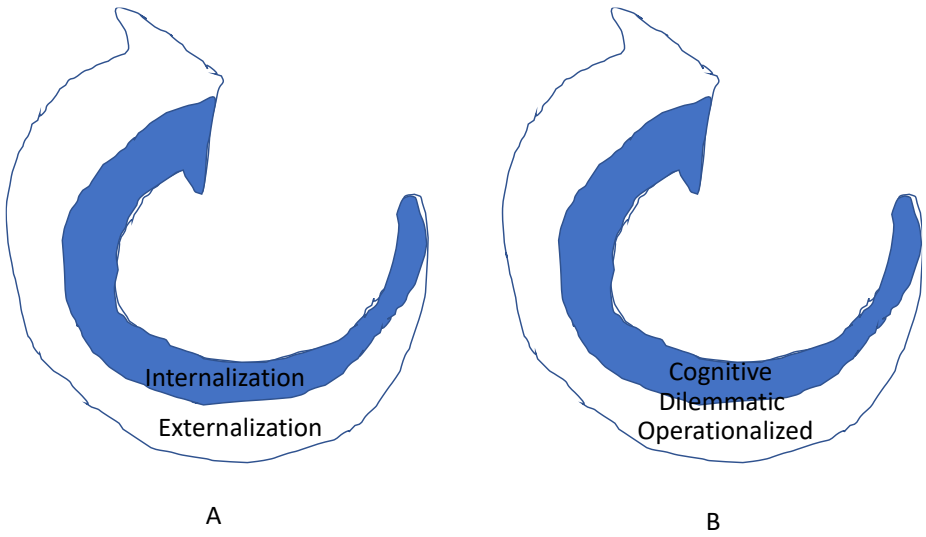

Figure 5-3 The Expansive Learning Cycle in Transformative Activity System

Notes: A Engestrom's initial illustration (1999, p.34), and B: how the Cognitive, operationalised and Dilemmatic MP could possibly be represented

Later, in the interdiscursivity analysis, I will describe how the combination of findings (MP as positive traits and MP as knowledge emergence) influences and is influenced by the situated and layered organisational learning contexts by taking examples in each specialist case. I argue this study is one of a few pieces of evidence supporting how institutional discourse shapes and is shaped by the definition of MP worldwide proposed by Hodges *et al*. (2011). I will later show how understanding MP conceptualisation in Indonesian medical specialists occurred in triple activity systems. This finding might serve as one possible answer to the challenge triggered in some papers which demand

further research to bring a new perspective of contextualise MP conceptions in different cultural or situational contexts.(Jha et al., 2007; Hodges *et al*., 2011; Burford et al., 2014; Jha *et al*., 2015; Hodges, 2016).

5.4 Chapter Summary

I started this chapter by providing features of the participants involved in the study and critical observations of their social role and expertise. This observation showed the trend of younger speciality residents recruited in specialist education, providing a wide age gap between current MST-residents, however this did not lead to an age-related difference in how MP was conceptualised.

After providing the information about demography, I then presented the result of an intertextuality analysis, which resulted in two Discourses of MP conceptions and their conceived sub-Discourses. A discussion on how the identified MP texts and discourses had relevance to postgraduate teaching and the development of the medical profession and further professionalism research in Indonesia have also been addressed. However, this chapter did not present and discuss the possible theoretical emergence of the proposed finding. For instance, in this chapter, the reader might be curious about the factors influencing the emergence of the conception. The discussion on this matter is critical to the further deployment of MP as learning outcomes in specialists' teaching-learning practice. In the next chapter, I will bring back some of the results from this chapter to dwell on the depth of possible discourses that influence the emergence of MP conceptions through interdiscursive analysis. I expect this interdiscursivity analysis to project the social practices that represent and influence the MP discourses in the medical specialist education practice. The analysis will shed light on both how MP can be brought further into Indonesia's specialist education and the wider transferable medical education context.

Chapter 6 Understanding Discourses and Social Actors behind the MP conceptualisation in two Indonesian medical specialist trainings

6.1 Introduction

In this chapter I will describe the second phase of Critical Discourse Analysis which is highlighting the interdiscursivity behind the conception of MP. This will then allow the exploration of power dynamic and the actors/agencies behind the discourses. Some themes in this chapter will overlap with topics discussed in the previous and also in the next chapter because interdiscursivity is about making connection to discourses.

6.2 Exploring the Interdiscursivity of MP

In my study context, the MP interdiscursivity can be approached by investigating the discourses within each specialty and across specialities. Drawing on the previous chapter, I will discuss interdiscursivity in relation to cognitive, operationalised and dilemmatic concepts of MP

6.2.1 MP Conception and Discourses in the neurology Specialist

Following themes and categories developed in the previous CDA phase, I tried to investigate discourses through intertextuality and interdiscursivity concept. This allows me to see whether there are congruences or differences between how the MST and RES in neurology conceive of MP and their perspectives on how they learn and apply it on everyday practice.

6.2.1.1 Cognitive conception of MP

Thoroughness and comprehensive in the clinical process

When conceptualizing a good and/or professional specialist, both MST and RES participants concur that being thorough and comprehensive, and attention to the clinical process' details are essential traits for a neurologist. This thoroughness is mainly built by the comprehensive data gathering process gained from complete consultation including general physical examination and specific neurology examinations. The thoroughness and comprehensiveness

involved other several personal traits such as being altruistic, empathetic, compassionate, open minded and also being communicative and informative to the patient. Three reasons come up of why participants highlighted that thoroughness is essential.

Firstly, it will lead the neurologist to choose selective procedural examinations. Government insurance scheme had outlined the budget limit for performing clinical investigation:

> "…but because of the limitations of the ceiling ((budget)), we must choose to perform the most valuable ((investigation)) first, for instance NCT ((nerve conduction test)) alone in the first visit, then the patient will need to make another appointment for EMG ((Electro Myelography)), which take time and delay the diagnosis." (RESN1, SSI).

To establish diagnosis and proper treatment, several procedural diagnostic investigations are frequently needed following evidence-based guidelines. However, participants conveyed that in many circumstances not all needed procedures can be performed because of budget restriction. That is why fulfilling comprehensive non-procedural data gathering through a comprehensive consultation and physical examination are critical for choosing the most valuable investigations to establish the diagnosis.

Second, it establishes the neurologist's core role to provide the correct diagnosis (determining the location of lesions in the brain) since the definitive procedural investigations are expensive:

> "… and the neurological examination is an examination that is quite complicated, a lot yes. From assessing consciousness, cognitive, assessing the existing 12 cranial nerves, motor, sensory ... So we have to have clinical abilities that I think, I think there is where we are higher than other fields. And secondly, why do we have to be skilled there? Because supporting investigations in the field of neurology are very expensive. For example, need CT-scan, MRI, then LP (Lumbar puncture examination), LP analysis now might cost millions ((rupiah)). So, supporting examination in the field of neurology is high cost…" (MSTN4, SSI)

In some cases, the definitive procedural investigations cannot be accessed by patient's financial scheme because the cost is too high. This high cost is not just because the machines (e.g., MRI, CT-Scan, EMG etc) are mostly imported, but also because the tools are not always available in every hospital. In this case,

patients need to be transferred and the cost for transfer is usually excluded in the insurance scheme. This situation underlines the importance of being professional by performing thorough clinical decision making based on consultation and physical examination.

Third, the thoroughness is perceived as contributing to the identity of the neurologist as one known trait that distinguished their speciality from others:

> “Being a neurologist in my opinion should be able to think holistically… because we're dealing with the brain, the controller. The brain is the chief of our bodies. So, the neurologist should be specific so that he can come up with a solution, problem solving, with spider web where, where we think of all the possibilities, that this possibility could be, this possibility-, but which one-. So, you can think systematically. Different to other specialist like orthopaedics. Orthopaedic, ((when)) bones are done he's done, no problem…” (MSTN6, SSI)

In the above excerpt, MSTN6 contrasts her reflection on interaction with orthopaedics to show how the neurologist-patient relation is different to the orthopaedic-patient relation. In this sense, MSTN6 conveys her pride, representing her neurologist community, to be known as the most thorough among specialists.

Reflecting on the participant’s reasoning and attitude during the interview, especially when they came up with the concept of “thoroughness in practice”, in my observation, most of neurology participants built their narrative of “professional being” by passionately relating their long-term relationship experience with patients. In their view, almost all neurological problems/diseases require long-term doctor-patient engagement. This is mainly because of the low healing rate of nerve cells if they are injured or damaged. Many neurology patients have to deal with chronic or lifetime disabilities/invalidism, which in turn makes the doctor-patient relation last longer or even a lifetime. Take an example of a stroke patient who suffers from lifetime speech problem after the first stroke attack. In this case, patients’ connectivity with the doctor occurred not just during intensive care while the patient had the attack but also long after they were discharged from the hospital.

In supporting this relationship argument some participants compared their experience with colleagues from the Orthopaedic, Neurosurgery or Eye Department. They reflected that colleagues in the Eye Department were

amazed by the amount of time needed by neurologists to take care of a single patient, even in the ambulatory clinical service. From the eye specialist's perspective, the time spent for consultation and examination of a single ambulatory neurologist patient could be used to handle several patients in the eye clinic (MSTN2, SSI). Neurology participants also compared orthopaedics, in which the doctor-patient relationship is portrayed as a time-limited encounter. It means the problem can be localized only for a specific problem, e.g., fixing fracture or replacing a knee:

> "…the relationship is then ended with a happy ending" (RESN3, SSI).

In the neurology context, the holistic first encounter is essential to maintain the long-term relationship with their patient and accurate decision-making needed to support selective procedural modalities and treatment.

Humility and self-awareness on professional boundaries and Open minded

The second feature of direct conceptualisation of a good and professional doctor among neurology participants is awareness of professional boundaries. Participants assert that being professional means they have to be aware of professional abilities, roles and limitation:

> "So, those who is called professionals are those who do the thing that has to be done and do not do the thing that shouldn't be done..." (MSTN1, SSI)

Participant asserted that the self-awareness is the key for being a reflective professional who is also open minded and willing to perform collaboration with others.

> "…so, when you are aware, you must consult, that's one of the qualities of professionalism. Don't hold the patient for yourself." (MSTN1, SSI)
>
> "…it means that we would never be able to work alone, but must working with others" (MSTN5, SSI)

Some participants also argued that the current provision of performing research-based care at the Teaching Hospital requires more interdisciplinary works:

> "And we used to involve other disciplines in research … So, we are collaborating more with other areas." (MSTN3, SSI)

Being communicative, informative, and educative

Communication, information, and education (CIE) is a terminology used by some participants to exemplify traits that are needed in the patient's education provision. Therefore, being communicative, informative, and educative are among ideal professional traits conceived by participants:

> "…Yes, that was, patient safety, patient comfort, then professional in terms of skills, if he is not skilled it means unprofessional, the skills ((clinical skills)) … then how he communicates." (MSTN4, SSI)

In some instances, participants argue that being communicative and informative is the means to gain trust from the patient and, therefore, comprehensive data gathering can be expected. Participants also believe that being communicative and educative is also required to maintain self-directedness to catch-up with the evidence-based knowledge and respecting patient's rights:

> "Well, we have to explain all sorts of evidence, right? If we do not update and do not know how to communicate is silly, right? … the decision for treatment is in the patient, not us. Our task is to give as many choices as we can, so patients can choose." (MSTN6, SSI)

This trait therefore embraces other interpersonal performance like being altruistic (putting others more than self), empathetic (ability to share another's thoughts and feeling into a set of respected behaviour) and trustworthy (reliable, credible and able to be trusted).

The summary of cognitive conceptualisation of MP in neurology is presented in Table 6-1.

Table 6-1 Cognitive conceptualisation of MP among neurology participants

Discourse	MP featured as
Cognitive	1. Thoroughness and comprehensive in the clinical process (anamnesis, physical diagnostic and positive 2. Having self-awareness on professional ability and limitation and Open minded and cooperative with colleague and other profession 3. Being communicative, informative and educative and other interpersonal behaviour traits such as: o Altruistic o Empathetic o Trustworthy

6.2.1.2 MP in neurology practice- operationalised and dilemmatic?

There are also features of MP that are not related to direct verbal conceptualisation. These features are embodied in the participant's response to certain things in their daily activities captured in SSI and in the ITTD. I conceived two themes called operationalised MP and dilemmatic MP to reflect how participants described the features of their everyday professional practice. It is "operationalised" because the traits are perceived to be the normalized traits which are primarily nurtured, endorsed, or legalized by the specialist practice authorities. It is "dilemmatic" because the traits are mostly perceived to raise conflict between participant-self and others. Consequently, this exhibits a dilemmatic situation for the participant in upholding their professionality in practice. The following sections will describe these two features in detail.

Operationalised MP

The traits under operationalised discourse appear to be a taken for granted performance that the doctor should do which are mostly not related to the earlier conversation about being a good or professional doctor.

Prioritizing patient safety

Patient safety is basically a different way of articulating the old ethical principle "*non-maleficence*" or "first do no harm". It means that the doctor's actions should not put the patient in a dangerous or harmful condition. Theoretically, patient safety is closely related to altruistic and patient care. However, in the participants' world, the term "patient safety" is also related to two specific discourses. Firstly, it frequently relates to hospital policy for achieving compliance with regulation, especially international accreditation that makes on patient safety a concern.

> "No, we just follow the general patient safety in the hospital, … such as the risk of fall ((patient's fall risk)) and so on, all of them just adhere with there ((hospital policy))" (MSTN5, SSI)

Another example is how a participant (MSTN4) conveyed that her obliged behaviour of wearing name tag is part of protecting patient safety as it was enforced by the hospital Director in a memorable incident:

> "…this is now become a culture, the current director dr.HR ((pseudonym)), which is the successor of Prof Akm ((pseudonym)), he is very much concerned about wearing nametag, because a lot of people wearing white clothes without wearing nametag can be a perpetrator right?" (MSTN4, ITTD)

And second, it relates to required performances for high-stake examinations.

> "Yes, I do. Hand washing is mandatory, it goes in one checklist for the exam yes. So, wash your hands well, that's six steps. Then how we greet the patient, introduce ourselves, then clearly yes, the procedure … may not be comfortable also for the patient in examining and need time, and it has to be explained in advance, ask for approval" (RESN4, SSI).

It is interesting to see that both discourses concerned with external factors are enforced and seemed to give participant no choice other than doing it as part of their everyday conduct. In the first excerpt, MSTN5 provided the reasoning behind her priority of wearing name tag that it is related to the hospital rules reinforced by the charismatic director, which she expressed as a "fierce person, but provides many breakthroughs" and "many people like him" (MSTN5; SSI).

Being informative and educative to patient

Despite conceived directly as the essential traits representing professional conduct, being informative and educative to patients has been repeatedly shown in the participant perspective when discussing any topic in SSI and also the sequence of activities in ITTD. It means that this trait is also part of the everyday conduct of participants because it is required by legal practice, such as the completion of medical record:

> "…There are extra again we should check regularly the back of the prescription sheet for any possible additional drug prescription, Doc. This sheet will inform how many times I should provide CIE ((communication, information and education)) to patient. There is also a dedicated sheet to perform CIE at the end of sheet, and this one patient's family should be witnessing" (RESN4, ITTD)

Doing guide-based practice

> "I think professionals start from attitude and knowledge. An updated knowledge, if he does not read much and he does not update his knowledge and he treats patients with knowledge that is not updated, it is unprofessional. I think it is. And if he gives the patient a choice of therapy

> according to what's good for him and not based on evidence, that's not professional in my opinion. (MSTN4, SSI)

In the above excerpt, the participant relates directly how the evidence-based and updated knowledge is a provision of professional conduct. The evidence-based medicine (EBM) is a movement and practice in medical profession that refers to the application of diagnostic and treatment procedures that have been validated through several studies, supported by empirical research or suggested by experts (Carter and Little, 2007; Sackett et al., 2007; Montori and Guyatt, 2008; Godlee, 2014). However, what is frequently meant and thus practiced by participants as EBM are the adopted evidence that is written as procedure manuals or guides produced by a professional body

> “If for EBM means by ((referring to)) guidelines, what we use is usually based on guidelines. Particularly, guideline in Indonesia … Because what I've noticed it's very different anyway, there are differences, there are some differences to the guidelines that have been implemented overseas and in Indonesia. So usually, we tend to use guidelines existed in Indonesia.” (RESN3, SSI)

Neurology residents, as the spearhead of neurology specialist service in the teaching hospital, assure their day-to-day practice follows the guidelines produced and endorsed by Indonesian professional organisations, such as the college of neurology.

Physical mannerism and attire

Performing and behaving elegantly during duty hours is possibly a standard behavioural norm among neurology participants. This is shown by the elicitation of the importance of arranging clothing neatly before participants go to workplace and the use of accessories, such as name tag and white coat:

> “After that, I made sure I was presentable in the mirror first, then I went out to the nurse station for ....” (RESN1, ITTD)

> “…then preparing clothes I want to wear, then yes, all the stuff I used to bring, I make sure laptop is already in my bag, the *sneli* ((white coat)) already in my bag, hammer reflex, funds ((fundoscopy)) and penlight, then also the important one: nametag…” (RESN6, ITTD)

Included in this physical mannerism is the strong obligation to perform an attendance check-log, either by using a manual sheet, or electronic login:

> "Sometimes my other colleagues are not fully there. So, I stayed for at least an hour or two for sign in, see for a while they went out to practice outside ((at private)), that's what I cannot do. Actually, I can do like that, but I don't want to. Maybe I had a little bit OCD ((obsessive-compulsive disorders)) yes ha ha ((laughter))" (MSTN6, ITTD)
>
> "… I used to be so busy as a HOD ((Head of Department)), right ... afternoon I had to be here, … then I had to go there ((ward)) for a patient visit then going back here again, because had to sign out for leave" (MSTN4, ITTD)

Both MSTN4 and MSTN6 regard doing check log is not just an obligation, but also a virtue of professional conduct.

Dilemmatic MP

Themes I conceived as the dilemmatic MP are mostly manifested in SSI when I invited participants to discuss lapses or describe the characteristic of unprofessional conducts. Within ITTD, the themes were surfaced in the participant's explanation or reason behind certain acts or behaviours.

Spirituality and religiosity in practice

Spirituality and religiosity (S/R) appear mostly as positive narratives and a frequent discussion topic among participant that relate to both situated personal worldview and social culture. Almost all neurology participants discussing S/R believed that S/R is an important matter in establishing professionalism of specialist either as individuals or part of community. There are several narratives brought by the participants when discussing the S/R issue. The most common one is that S/R functions as a source of motivation to be an altruistic, caring and compassionate person which transfers to professional life, especially when interacting with patients:

> "…So, if we are religiously good so of course would have a good perspective on the patient side. Looking good to the patient means we want only the good deal for patient for sure. But if we, say, have less in religion, our relationship with the patient might not be for the wellbeing of the patients and not for God's blessing, … but, for example, the pursuit of money, might be pursuing material. I am afraid it will turn like that if not balanced by the goodness in religion" (RESN4, SSI)

Another narrative is that S/R functions as a source of ethical principle to drive individual professionals to keep ethical and “sane” in the middle of “insane” task burdens.

> “Other than that, regardless of student’s religion background, please be closer to God. You are smart not because of your brain only, but also there are drops of *hidayah* ((guides)) from *Allah* which we never been able to realise. It is often I am being amazed with the cases findings, which is difficult in the beginning because of the complexities. But at the end I can recognized what the diagnosis for the case was” (MSTN1, SSI)
>
> “… There was a Professor from USA which said. You didn’t give this? No. They will close by themselves. Is it possible? It's possible (↑). How? I have God. And he said to the American professor “You don’t have God, do you?”. …The problem has been handled by *Gusti Allah* ((God Al-Mighty)). The fontanelle was unified/closed. Then the two babies were raised by Prof S and now they are pursuing Doctorate degrees…” (MSTN1, SSI)

A professor of neurology (MSTN1) in the above excerpt, argues the importance of S/R belief by providing lived examples of his patients. The most phenomenal one being the first successful separation of Siamese head-twins in Indonesia performed by an Indonesian neurosurgeon. This is an example of how a strong S/R belief helped to solve an overwhelming problem, the closing of the major fontanelle of the two separated babies.

The third narrative is that the nurturance of S/R belief in the reflective moment of professional life helps the individual professional to be aware of self-limitations and speciality boundaries, and therefore shapes their open-mindedness to collaborate with others in managing the patient.

> "The fortune is not from the patient, the fortune is from the God, isn’t it? If you are sincere, all will be flowing…this means you don’t have to keep the patient if you cannot solve the problem, refer it, your fortune will not be lost!” (MSTN1, SSI)
>
> "…everyone definitely needs money with all sort of difficulty. But we must be professionals, fortune can be from anywhere, right? if it is not our fortune it would not be our property, if we get it from ((incorrect way right way)) the loss will be a lot ... I still have such principles. But sometimes there are those who have such fears that it makes them unprofessional and that is shame to be seen by our own students." (MSTN4, SSI)

The fourth narrative, and the most subtle one, is that S/R becomes a means to control the behaviour of the peer community, especially to control the behaviour

of residents. An example of this is a case described by a MSTN participant where a religious preaching occurs and is informally encouraged in some specialist study programmes (i.e., neurology and internal medicine) and perceived to have an attitudinal impact on individuals' behaviour.

> "…at the Internal Medicine Dept, there is a professor with doctoral degree holds the preaching... Usually every Friday. Yes, later it brings a calmer attitude, better character yes, brings more positive manners …" (MSTN2, SSI)

Nevertheless, I found there is a degree of ambivalence in participant's argument when putting S/R as a practice in both educational and service context. This is why I describe this theme as dilemmatic. The first dilemmatic feature of S/R is how it is put in educational activities. In Indonesia, religious teaching is mandated by National Education Law to be delivered from primary education to undergraduate higher education levels. The normative teaching goal of religion in these education levels is to support national development in producing good citizens. As an enforcement, the student achievement of this religious teaching is mandated to be recorded in their academic transcript. However, this obligation is not applicable to the medical speciality programme and at other higher degree levels, even though I found strong views among participants that religious activities need to be empowered in residency training. More than that, in all neurology specialist programmes involved in this study, there were statements reporting the integration of religious practice in residency life. This took various forms, ranging from giving spaces availability for prayer (time and places), conducting weekly clergy sermon, and conducting collective prayer in Department before a batch of resident commence the national board exam. For some MSTs and residents these practices are productive in supporting their professional identity development. However, for some others, especially those with a minority religious belief, the activity is just another required activity arising from being involved in a peer-group where the majority of members shared a religious belief, and the activity was perceived as having nothing to do with professional development.

High Self-esteem

High self-esteem is needed to create professional confidence in performing independent care. The residency process is then perceived as a process not just to nurture knowledge, ability and competence of treating patient, but also to build professional confidence for independent decision making is required. In participants' view this can be achieved by conveying high self-esteem and the pride of being a knowledgeable specialist at the top tier in the referral system. Although they can still have discussion with peers, the nature of professional work often requires specialist to conduct expert decision making and judgement alone. Without high self-esteem this independence is unlikely to be achieved.

However, some participants worried this need for self-esteem might lead to selfishness and arrogance, which goes against the current campaign for more collaborative patient care:

> "Because we are facing arrogant tendency. Becoming specialist has possibility to be arrogant. Moreover, ((being)) sub-specialist. This is where a specialist think he/she already become the smartest one" (MSTN1, SSI)

This concern may not be too much. For instance, in an ITTD session, a resident participant provided an example of how she had interaction with an on-duty nurse:

> " If said to the nurse, Sis ((the participant said before that the nurse is used to be called "*kakak*" ((a calling to call elder sister)), actually she was not the nurse in psychiatry ward, ((participant showing how she said to the nurse)) I am a neuro resident for this patient, right?, This patient is referred to neuro, tomorrow patient is going to have this and that" (RESN6, ITTD).

In above excerpt, either read the original Indonesian language register or heard the record of this interview chunk, I felt that the instruction given by RESN6 was an example of how a person thought high of herself. This possibly an example of the arrogance like MSTN1 afraid of.

Leading others

This is possibly one of the consequences of self-esteem nurturance. Some MST participants assert that being a specialist mean always to be the leader in the healthcare team, especially in the context of referral. In this sense, some MST

reported that the current training programme endorses merit and excellence in achieving high academic performance.

> "Yes. How you would say it, it is such an unbelievable narcissistic ((teaching climate)) here, meaning be the best, the greatest, the leading, excellent, the most, the best and so on, ((superlative prefixes)). It is intended not to pick up the arrogance, … Yes. I mean we are being indoctrinated like that, but it's difference with being arrogant is almost nuance/subtle right?" (MSTN5, SSI)

However, some participants worry that this excellence and leadership endorsement climate might be falsely perceived as teaching the resident to be an arrogant professional. Moreover, some MSTs also expressed doubts about whether the current teaching climate contributed to the vision of interprofessional collaboration promoted by the hospital's international accreditation system, which requires doctors to work in multi-professional teams as a member, not the leader.

Resilient

The term resilient never came up in participant's word. This is my own interpretation to name the circumstances where the participant had to maintain mindfulness and work steadiness in any burnout and unfavourable circumstance especially those that happened in residency. One significant example is the enormous number of hospital patients, in ambulatory and ward, that residents are expected to handle l:

> "…was more physically tired anyway, we had to follow up a lot of patients during my younger stage, it could be 20 patients to be examined ((at ward))" (RSN5, SSI)

> "…That time, on Monday, 130 patients came in. It was in the morning between 9 -10 am, there were some calls to resident for this and that, which requires no one at ambulatory clinic. I had to stay alone. I could not avoid to treat the rest 70 patients. I already had 20, there should have been 5 residents, but there was only me left. At last, I finished them all, at half past 5. (RSN4, SSI)

Both MST and RES knew that this was far from the ideal circumstance a specialist should encounter. Even for MST, they could not handle lot of patients:

> RSP: "Usually till .. depending on the number of patients yes, if there are a lot it can be up to 3 or 3.30 pm, but the quickest one is perhaps at 2 pm it is already over."
>
> RSB: "If it is a lot, how much are they usually"
>
> RSP: "The most that I ever had ee (3s) 6 patients, but that's an already long time to perform neuro function examinations." (MSTN4, ITTD)

Unfortunately, unlike private hospitals, who can set the limit of patients, at the public, especially tertiary teaching hospital, limiting the number of admitted patient is impossible for two reasons. First, it is forbidden by law to refuse a patient coming to the public hospital, and second, residency education needs to have sufficient numbers of patients, as required by the accreditation process either for teaching hospital accreditation or residency programme accreditation. While MST could escape this circumstance by passing the mandate to provide service to the resident without losing the incentive, for the RES this is possibly the very top patient burden in their professional life.

I put “resilient” under dilemmatic discourse because it describes a burden that is known not to be ideal and which might harm the patient and residents’ safety, however, this is the only option for a resident to become fully registered specialist. They can do what they want once they have passed these circumstances:

> “…I personally cannot, within 5 to 10 minutes immediately spell out certain diagnosis, I need more time! So, when indeed there were many patients, I certainly was tired, and either tired or exhausted in mind. So later when I graduated, my ideal, my goal is to limit that, not too much ((having patients)).” (RSN4, SSI)

Personal wellbeing-work balance

When discussing everyday professional activity, participants reported performing hobby activity (e.g., golf, hiking, cycling, joining clubs, etc.) in order to maintain the balance of life amidst the intensity of work schedule.

However, in certain cases, this extra activity became a burden when it was endorsed by authorities in the workplace, such as senior residents or supervisors. A hobby, which should have been a joyous and voluntary activity, might become another item on a work schedule taking residents’ rest time.

The themes in the operationalised and dilemmatic MP discourse in neurology are summarized in Table 6-2

Table 6-2 Some Manifestations of operationalised and Dilemmatic MP in neurology

Discourse	**MP featured as**
Operationalised MP	1. **Prioritizing patient safety** – "required by hospital accreditation" 2. **Being informative and educative to patients** – legalized by provision to perform well recorded patient education 3. **Managing resource efficiently involving matching care with payment** - Selecting diagnostic procedures and treatment modalities wisely 4. **Understand patient background** and perform appropriate act accordingly – all hospital-based service are provided in class of care and package. 5. **Doing guide-based practice** (as a translation of evidence-based practice) – provision to create clinical practice guide which are mostly adopted from published evidence-based medicine papers 6. **Physical mannerism and attire** – provision of wearing presentable attire, white coat, name tag pin during work hours
Dilemmatic MP	1. **Spirituality and religiosity in practice** – resident are required to manage religious services outside working hours irrespective of their religion. 2. **High Self-esteem** – residents are taught as the top tier expert in the referral system and the owner of specialized knowledge; however, they also need to be humble in their everyday tasks with patient and colleagues 3. **Leading others** – Being specialist means always to be the leader in the healthcare team, but the current accreditation system requires doctor to work as a member, not a leader, of a multi-professional team. 4. **Resilient** - Mitigating and surviving considerable professional dilemmatic circumstances (professional dilemma literacy) while the source of pressure (e.g., organisation service and education, seniors, patients etc) remain unmitigated. 5. **Manage personal interest or problem** in front of patients and related working network – a professional needs to maintain mood (e.g., smile, calm, friendly) during patient care regardless of their own workload, burnout, distress etc. 6. **Personal wellbeing-work balance** – putting a personal hobby alongside peer activities (e.g., golf, hiking, cycling) both for self- and peer-wellbeing.

6.2.1.3 Social Actors involved in MP conceptualisation in neurology Specialist

The term social actors, as discussed in Chapter 3 refers to components of social practice whether human or non-human actors. In this section I will

highlight some social actors involved in the conception of MP through the interdiscursivity analysis.

As discussed in the previous section, most of the cognitive texts of MP come from participant's reflection of their professional engagement with patients, which are characterized by life-long disabilities and require long-term care. Therefore, being thorough and providing comprehensive care are the main repeated themes in the definition of a good neurologist. It is perceived that being thorough and comprehensive is the only way to alleviate the burden to the patients. In this case, MSTN and RESN participants reflected on their definition of a professional doctor, on patient's typical characteristic, and on the nature of doctor-patient engagement. This means that, from cognitive MP, the patient as the object in medical services also serve as actors from which the MSTN and RESN gain inspiration to develop their conception of MP.

Another way in which conceptions of MP developed was through the emergence of operationalised professionalism. Although there is a set (given) definition of professionalism in a specialist's life (i.e., written definition in standard, or perceived definition from their past training) there is a possibility that the actual and operationalised form of professionalism is still emerging and developing as a result of reflexivity from the individual physician and within the overall professional practice. This appeared in the data when participants shared their new ideas, inspired by the ITTD session, about pedagogic changes in teaching and learning professionalism. This provides insight that the conception of professionalism is emergent and individually constructed. This signifies two things: that the individual participant is the main actor of their MP conception, and ITTD mediated as a linguistic tool to generate insightful reflection and learning development.

Turning to residents, despite some similarities in their conception of professionalism ideas and a profoundly submissive role toward their supervisors in the training-service community at the study programme or teaching hospitals, residents' conception of professionalisms is not necessarily under the shadow of their supervisors. In some instances, residents' conception and the way they conceived professionalism were different from the MSTs. Being a reflective practitioner during everyday (multitasking) activities and learning professionalism from the influential role model (mostly from an influential

teacher), were significant in developing MSTNs' conceptions of professionalism. Among residents, in contrast, the significant inspiration for learning professionalism came from their patients, peer residents and a multiplicity of role models.

An interesting insight came from considering social artefacts in the development of MP conception. Nametag, pin, attendance check-log system, and white coat attire are some examples of matters being signified as critical in symbolizing or translating the concept of a professional doctor and professionalism.

In summary, reflecting on interdiscursivity in how participants conceive cognitive, operational and dilemmatic MP allows light to be shed on how participants in neurology generate conception of professionalism and how it is translated into neurology practice. Learning MP is both individual (reflective constructivist) and social (participatory) in which self, significant others and many social events and actors are involved.

6.2.2 Conception and Discourse in the orthopaedics Specialist

6.2.2.1 Cognitive conception of MP

There is a direct and strong articulation that professionalism, ethics and morality are understood as a unified concept, both among orthopaedics MSTs and Residents. These terms are commonly packed in a single statement, as the following extracts show:

> "... this is how it is**. Ethics, professionalism** that we-, from the entrance exam, that is a part of the interview being assessed, selection" (MSTO2, SSI),

or in RES's statement:

> "… the ethics, if it's **ethics and professionalism** it may already have a perception like the Civic Course at Senior High School, you'd find like the best answer that must be done…" (RESO6, SSI).

And this also appeared not just when the participants were directly asked about what they understand about professionalism, as below:

> RSB:" If suppose, I change the sentence like this, the professionalism of orthopaedic doctors is dot, dot, dot? What would it be?
>
> RSP:" Professionalism of an orthopaedic doctor is the professional behaviour of an orthopaedic doctor who does his work or daily activities

> according to the rights and obligations as a doctor based on ethics, ethics and any corresponding laws, I think that's it Doc." (RESO1, SSI).

But also, residents made inference to certain topics, such as when a resident discussed how teaching related to professional behaviour. The resident, RESO6, talked about a lecture they received at the start of residency that referred to idealised behaviours which were unlikely to apply in real professional practice:

> "Maybe ((humble with his view)) I was wrong. Because if the ethics, I mean if it's related to ethics and professionalism, we would have an image like we had the PPKN lesson ((the national ideology and civic lesson that obligatory taught at primary to senior high school)) where any ((known)) favourable best answer ((in the test)) must be chosen and done. Maybe because of this perspective then if it is related to teaching ((ethics and professionalism)), then it is what it is ((they take it for granted))" (MSTO6, SSI)

In some orthopaedic participants' statement, MP is reported as traits of an individual orthopaedic specialist. Most of these personal traits are concentrated on how to build more humanistic interpersonal relation with patient. However, unlike the neurologist's motivations to build strong relationships with their patients, developing doctor-patient bonding goal in orthopaedics is more often linked with legal provision in relation to patient safety and surgeon rather than patient welfare. This might be because, compared to neurologists, the doctor-patient relationship in orthopaedic service is relatively short and mostly contained in the surgical activity. One excerpt from an orthopaedics MST showed this reasoning:

> "The sequence is usually like this, patient usually already admitted 1 day prior the schedule, or in the morning, or 12 hours before the surgical schedule. I used to give explanation to them … I have to talk again to make sure he knows the diagnosis, ensure he knows what the available alternatives to surgery are, ensure he knows the technique I am going to do, ensure he understand agreed already. While waiting in the operating room, patients being called, I say hello to the patient, then anaesthesia work, making him sleep, working, finished, call his family, I explain what I'm doing, what the operating difficulties, then ensuring whether the results are satisfactory or unsatisfactory, finish, ((then)) go home" (MSTO2, ITTD)

Unlike neurologist participants, who emphasised comprehensive data gathering to capture a possibly multidimensional problem, in the orthopaedic context, a

problem is likely localized around the particular surgical intervention. This is possible because, in orthopaedics, the most intensive interaction with the patient occurs during the operation where patient is unconscious. While monitoring the course of treatment in neurology is performed through physician interviews and neurological examination, in orthopaedic, the monitoring is mostly performed by capturing technical data such as urine output, blood drain output etc:

> “Or suppose later he was at the level of OTL 1, has started to be an operator, that is, he must not only do the surgery alone, studying the operation, but he also has to do patient follow-up to their junior OTD, follow-up patients who are going to the operating theatre the next day, how is the lab result, how is the X-Ray, complete or not, or in post-op case, they should monitor patient's complaint, the drain, everything…” (RSO4, SSI)

From further exploration with the participants’ statements, this particular conceptualisation of MP, i.e., about applying ethics and regulation requirement, is closely linked to three discourses: continuous reinforcement during training course, standard enforcement and influential professional events.

First, the conception is a result of continuous reinforcement of certain concept through longitudinal residency training. For some residents, they perceived that “Ethics and Professionalism matter” has been reinforced in their residency programme, in lecture sessions.

> “It’s important, Doc. Here, we have an ethics division, it's Prof. A. So, Prof. A, every time we had a scientific meeting once a week, he always has taken over to do it, informing many experiences in the field of ethics Doc. So, we usually, at Saturday-Sunday, we discuss this, there is a case like this, what the moral ethics in this case and so on. So yes, that was also professionalism: how to choose implants, how to control costs but in accordance with the guidance, we still get it from Prof.A. Yes, we think it's a priority too Doc.” (RESO1, SSI)

or in a role modelling and apprenticeship process:

> “There is definitively no credit learning unit for this. Only thing we learned is when, what is called DPJP ((doctor responsible for patient care)), for example at spine ((sub-division)), which is often Doctor AY ((pseudonym)) says, "let's see the patient", go directly next to the patients. Well, every time with the patient, he always communicates with the patient, doing CIE ((Communication Information and Education)), especially to the patients who will be operated on next week or what, he will explain there. Yes, I learned it from there, Doc, from DPJP. Many

> DPJP are often going to the patients, … having a direct communication, yes I see it from there, the way they communicate." (RESO3, SSI)

The reinforcement of ethics and morality as the articulation of professionalism in the above excerpts is likely because most of the time, residents and practicing orthopaedic consultants, tended to pay more attention to the surgical technique and procedure than he patient. The following excerpts from RESO and RESN might give a direct comparison to this notion:

> "…So, when I watched YouTube, usually in the evening prior operation, I looked up to the techniques, how to perform soft tissue handling techniques, the operation procedure, like that" (RESO1, ITTD)

> "… So, for example, I don't worry about medical record completion, say it is already safe because friend already did it, but for getting in touch with patient, a direct interaction with the patient is definitely different. The way of doing education, giving information and communication and so on are different. That's for me I had to meet patient". (RESN4, ITTD)

Unlike neurology participants, who learn more by being in touch with their patients, orthopaedic participants preferred to familiarise themselves with surgical techniques by watching video recordings (e.g., from YouTube channel).

Second, the conception of MP as ethics and morality is a result of standard or professional organisation reinforcement featured by a written designated standard of conduct called KODEPOI (*Kode Etik dan Profesionalisme Spesialis Orthopaedi dan Traumatologi* (KODEPOI)/ Ethics and Professionalism Code of Indonesian Orthopaedics and Traumatology Specialist) and DEPOI (*Dewan Ethics - Profesionalisme Orthopaedic Indonesia* / Indonesian Orthopaedic Ethics-Professionalism Board). This is interesting, while in neurology, MST and RES reported that there should be generic rules or a code of ethics for every physician, orthopaedics, instead, set a separate, – specific code of ethics- guide. From one MSTO participant's narratives I understood that the reason behind issuing the KODEPOI is that it has functioned as an influencer for its peer-community members to behave differently in their professional practice:

> "…. Well, the motivations behind action without indication could be a lot. Most probably financial, and that's why the reason behind, right now, fortunately in every scientific meeting there is called DEPOI. DEPOI is the Indonesian orthopaedic Ethics-Professionalism Board. Where its president is changed every three years, and where at every scientific

> meeting, which is conducted in six months, everyone should sit down and listen. If we do not join, we could not get our STR ((renewal)), yes semi-forced. So every KONAS, every KONKER, every COE, there is a DEPOI session, where-." (MSTO1, SSI)

To make it known and applied, the KODEPOI has been enforced in a dedicated event during annual scientific sessions held by the orthopaedic association. From the excerpt we know that the event has a dual function. Firstly, it functions as a prerequisite for Continuing Orthopaedic Education (COE) credits which are required for license renewal. Secondly, it functions as an exclusive event to share and discuss critical incidents with peer members of the professional organisation.

The third explanation of how MP is conceived as medical ethics and regulation compliance is that it is institutionalized in residency assessment practice, which mostly takes the form of a summative assessment culture. This either manifested in the phase examination during the residency programme or in the final high-stake examination at the National Board Speciality exam (NBSE). For elite members of the Orthopaedic association, the elaboration of DEPOI topics in phase examinations (held by the study programme) and in NBE (held by College of Orthopaedic Specialist) encourages the new generation of orthopaedic specialists to aware as early as possible about the good and the bad shape of their profession.

> "… but orthopaedics became one of the most highly complained about specialities. Because the procedure is related to the cost, and that's a lot. … Alhamdulillah until now *naudzubillah min dzalika* ((I seek protection to God from that deeds)). *Alhamdulillah* ((praise to God)) until now no orthopaedic doctor graduated from this programme was included in the list of DEPOI, it was very frightening." (MSTO1, SSI)

> "…then we changed it. At the time we changed, MKDKI ((the committee in professional organisation that oversee disciplinary conducts among physician)) was full of ouch very high number cases ((lapses cases)), after communication ((being introduced in the NBSE and annual scientific meetings)) the cases dropped to 40%, so now we for this year there are no complaints, if in 2017 we had 20s, in 2018 it turned to 5 complaints." (MSTO2, SSI)

> "Well that sometimes there were case when an orthopaedic is still often judging their peers, while actually when we were at the board examination there is a test of ethics, it was stressed that this act ((Judging colleagues)) is not allowed, and each time during the congress there is always topic on ethics, like that." (RESO2, SSI)

In the excerpt from RESO2, a female orthopaedic resident, recalled her experience of unfavourable conduct by orthopaedics in her training, with a case brought in the DEPOI session about an orthopaedic specialist's act that went against the ethical principles endorsed in the NBSE and every DEPOI session as an act to be avoided by orthopaedics. This provides a sense that the DEPOI session has played its function for giving the expected insight to the resident about what is the utmost important in MP conception i.e., applying ethical practice.

Thus, among orthopaedic participants, the normative or cognitive conception of MP is more unified, localized in a discourse of application of prescribed medical ethics principles and professional organisational regulation of maintaining the good orthopaedics.

6.2.2.2 Operationalised and Dilemmatic MP In orthopaedics surgery

The data provides evidence that MP is also being conceptualised as an operationalised (a taken for granted routine) and dilemmatic discourse (disputed practice) which differs from the cognitive or normative MP.

Operationalised MP

In a similar way to the neurology participants, traits of MP that related to operationalised behaviour, as a taken for granted performance, were reported.

Prioritizing patient safety

Prioritizing patient safety has been a legal campaign in new hospital accreditation systems, especially targeting the surgical profession to implement stricter procedures, such as talking more to patient regarding the risk of surgery, outlining alternative treatment procedures before operating and doing more check-listed procedures before, during and after the surgical procedure. This patient safety provision also includes the emergent use of audio recording during operation.

> RSP: "from the beginning is usually like this, cervical surgery so, yes yes initially working as usual, like a surgeon listening to a time-out, then follow the preparations from the start."
> RSB: "Who will read the time out, the resident?"
> RSP: No, the "*om loop"* ((technician)) will
> RSB: Okay

> RSP: “Then we read, sorry, we listen ((to the time out)), we lead the prayer, then we start.
>
> …
>
> RSB: “Okay. If it is completed then, what do you do?
>
> RSP: “I left, yes. After completing report and the patient was awake (MSTO6, ITTD)

In above ITTD’s excerpt, MSTO6 should wait for the time out reading, and stay at the surgical theatre until the patient regains consciousness. This is a bit different from my experience when I was in medical school where these procedures were not done.

Being informative, communicative, and educative to patient

Being communicative and educative to patient is currently like a mantra for orthopaedic participants, and this was always related to legal provision and safety for both side:

> "I think I've started this ((being communicative to patient)) since the first time I practice. But It is now already like a habit, for me. In here ((teaching hospital)) patient has less bonding contact, so I am not quite comfortable operating here because I cannot untie the existing knots ((change habits)). I think it is important to create a bonding with the patient, if there is a problem, it would be much easier to handle ". (MSTO2, ITTD)

For a younger supervisor, this behaviour is needed to support the current campaign promoted by the College of Orthopaedic to internalize Ethical and Professional behaviour. Therefore, this behaviour is deliberately endorsed in teaching moments, especially during the ward round:

> “…I often typical, so typical I believe. I often asking ((to the resident)) about personal things of the patient, such as where patient home was, then how the present condition came about how many children the patient had, that was typical of me. I want the questions to trigger them ((the residents)) to understand their patients very well.” (MSTO4, ITTD).

Managing resource efficiently involving matching care with payment

Various criticisms have been expressed by participants on the current insurance payment scheme, i.e., BPJS. However, it seems the practice of matching care to available resources has already been normalized. MST and Resident

participants already know what to do to give the patient the optimum result (as completion of examination) and hospital (as revenue), although it may cause delay for the patient and require them to undergo many procedures.

> “So, the challenge **is resources are limited**, perhaps they were educated, well say, for an example at our place ((study programme)), because the implant technologies had been the same every day in our training. Then they come to **the rural area where they could not do it** ((because of limited technology)). So, they have to adapt to that ((challenge)) right? they must adapt to that! And finally, they should be able to sort out where they can do well, which they were inevitably to refer to. As if they are forced to do that, it would cause problems for them. That's the challenge” (MSTO3, SSI)

> “Sometimes it could be from the side of patient, sometimes from the side of the system. So, **the system doesn't allow optimal action to be taken** … It means there is a relationship between doctors, hospitals, with the payment system, the BPJS insurance system.” (RESO3, SSI)

Understand patient background and perform appropriate act accordingly

Orthopaedics participants are required to understand the socio-economic background of the patient and also the packages hospital could provide.

> "…The problem is now the doctor has to understand how patient can afford ((the healthcare expense)), using BPJS ((public insurance scheme)) or not, what package patient choose, how much the tool costs, and decide which procedure he can afford, well it's a hassle, isn’t it?,..." (MSTO2, SSI)

The understanding of patient background will determine whether the surgeon will give alternatives to the patient, including the operation package and procedure will be taken. This sometimes might mean a discussion of extra expenses if the patient agrees to and can afford them.

Doing guide-based practice

Repeated statements about the importance of standards and treatment guides were expressed. This is similar to what was captured in neurology that practitioners are pragmatically in favour of using adopted or endorsed guideline

rather than taking critics, evidence-based approach to their professional surgical task.

> “Yes, in my opinion. Let's say he's nice. But for a professional he should really do work according to the literature, meaning utilizing the guideline is like this. So not all left to the patient’s preference….” (RESO3, SSI)

> “… so at the type B hospital ((A is the top referral)) this ((surgical procedure)) is allowed to be performed as long as they have the C-Arm ((a portable X-ray)) device, usually used at the ER to measure the alignment of bone after orthopaedics' intervention) … we already put this clinical privilege in our ((college)) existing guidelines.” (MSTO6, SSI)

Physical mannerism and attire

Some participants reported that professional behaviour is perceived to be manifested in attire and physical habitus which determines the identity of the profession. This is a widely accepted norm in everyday professional practice. Some features of this belief is physical attendance, represented by attendance check-log, daily attire, wearing white coat or scrub at the appropriate place and wearing name tag and pin (for resident).

> “… we are in this University … has a rule on clothing, shirts should be tucked in, as Dr.RD ((a Head of Department)) requires, except for batik Doc yes. We are required to wear batik on Monday and Thursday, it's already the regulation in the orthopaedic study programme. And no resident allowed to pull his clothes out while he is on duty, when he is active as a resident, they must tuck in their clothes, must be neat, look neat, and residents must wear socks.” (RESO1, SSI)

For some participants, the way of talking also represents the professional identity of orthopaedic surgeon community:

> “…perhaps stereotypic sometimes can be a little much to predict whether somebody is a surgeon or not, from how he talks and the self-confidence, especially during conversation. Maybe that's what I think anyway. (RESO4, SSI)

Dilemmatic MP

Spirituality and religiosity in practice

Islam is the majority religion in Indonesia. Some MSTs report that religious belief affects their behaviour in practice. The religious ideology is perceived as a morality compass in performing professional decision making. Participants

spoke about the *barokah* (Arabic: *baraka*) concept, that is rooted in Islamic *sufism* :

> "…So, I'm just saying this, if your work orientation to find sustenance, you may get the money, but you will not get the barakah, … will get a lot of money, I'm sure a lot, and that's an example here. But his family was a mess, he has no friends. That's why the concept is the work as a worship. If you work as a worship means you are working as good as possible, because there you will get the best *barakah* ((blessing)) in life and hereafter." (MSTO4, SSI)

Although most of residency programmes in Indonesia declared racism as a serious problem to be prevented and managed in practice, some residents with minority religion felt that religion is still a hidden consideration in resident admission process (RESO5, SSI). Informal activities in the residency programme regarding religion are perceived to only facilitate the major religious belief:

> "…**we in the ortho are not very religious anyway**, to be honest. Maybe just once a year having religious preaching, inviting clergy for religious teaching together, that is for Department event yes… **That is a religious preaching for Muslim, but of course we have to help managing the event**." (RESO5, SSI)

In above excerpts, MSTO4 and RESO5 provide contrasting statements about religion, though they are within same institute. For MSTO4, religion would have been a source of spirit that inspired his professional practice and conduct. However, in RESO5's perspective, this religious belief is not incorporated so positively in everyday residency life, and might even cause unfair treatment, requiring her to facilitate a preacher for a faith she did not share.

High Self-esteem

There are two features where pride and high self-esteem are nurtured in orthopaedic life. The development of orthopaedics and the current sub-specialities is a representation of social process maintaining the distinctiveness of knowledge and placing orthopaedics as the top tier of referral expertise in bone and soft tissue problems. Since in the beginning of admission this pride has been encouraged:

> "…Then fourth is history. So, we understand that someone who loves an exact science must understand the history, the background of why orthopaedics originated, in real, must know. So, history. Then the fifth is on knowledge of our institution. So, knowledge of the school that he wants to enter. So, for example knowledge about Doctor T? If he did not know it means that he's not really going to get along with us…" (MSTO6, SSI)

In above statement, MSTO6 conveyed that two out of five core questions in interview process are about the history of orthopaedics and the institution they are applying to. This means that from the beginning of the selection process, sound knowledge of and pride in orthopaedics as a distinct surgical discipline and familiarity with the institute's distinctive achievements are impressed on the applicants.

The second nurturance is in the educational process. In all three orthopaedic residency samples, a hierarchical approach of task entrustment is acknowledged. This is comparable to military training where tasks are is differed based on the soldier's rank. One practice in educational process is that a high appraisal on an independent surgical task completion will determine rank and promotion to the next level. This is where participants established their confidence and speciality pride:

> "So that's how we believe, handing over the trust, … it means doing the task according to their respective levels. … "that's your level, you should've been responsible for that". That's how we build the confidence" (MSTO5, SSI)

However, the current campaign on Ethics and Professionalism, as well as the pressure on performing more collaborative work (interprofessional collaboration campaign in the accreditation provision) become a challenge for resident and orthopaedics practitioner. Despite taught that they are the top tier expert in the referral system and the owner of specialized knowledge, orthopaedic surgeons are also required to be humble in their everyday task with patient and colleagues:

> "… it may not be the same in the real world of workplace, let alone here, the hospital is a teaching hospital, so we must apply the highest standards. … not all medical personnel in non-teaching hospitals will be as professional as in teaching hospital. There ((at non-teaching hospitals)) we might also have to adapt our emotions as well," (RESO6, SSI)

Moreover, over-confidence is the most hated behaviours among supervisors and residents:

> "…well these usually weird people, yes, sometimes their friends do not talk to them, he ended up breaking himself, because he's over-confident, arrogant " (MSTO5, SSI)

Leading others

In their training and practice, as surgical operator, orthopaedics are taught to be the leader in the operating room. They decide everything relating to the surgical process, from admitting patients to the surgical theatre until discharging them from the hospital. To be fully entrusted as a surgical operator, the resident has had to gradually learn to bear responsibility from the lowest level of the resident. And when the entrustment come, it means they have full responsibility to lead a surgical team and bear the whole responsibility of the surgical result. The leadership nurturance in orthopaedic training grows along with the self-esteem development discussed in the previous theme.

However, in the current specialist healthcare, the process of leadership development should have been nurtured in an adaptive and situated context, especially in the sense that patients might have complex health problem that require interdisciplinary and collaborative care. There are moments where the leadership nurturance process becomes misled into arrogance and coercive behaviour. This might be the source of why some participants felt distressed when facing a new requirement to perform collaboration. Some of the participants felt powerless because their lead in the surgical decision-making process has the potential to be halted by others:

> "Once we consulted a patient which we planned to have a surgical operation in the next day. We had sent our consultation request ((to other specialist departments)) in the morning, but our request to cardio or to Internal medicine did not get any reply on time. They replied to it at the afternoon or at night ((which cause the postponement of the operation schedule)). We were not able to force them to immediately responding our consultation referral because are at different department and have a different work system which is *tap..tap..tap* ((quick action))" (RESO4,SSI).

Resilient

The word resilient is also not expressed explicitly by orthopaedic participants. However, like the resilient theme in neurology, it is an attribute inferred in the part of participant discourse on being a good orthopaedic specialist. Resilience is also a trait that emerged in dilemmatic discourse of both MSTO and RESO participants. In orthopaedic, the resilient trait refers to the personal ability to anticipate and survive a considerable amount of professional dilemmatic circumstances even at the situation where the source of pressure (e.g., organisation service and education, seniors, patients etc) has never been able to be mitigated. RESO1's statement reporting the gritty situation of R1 (Year 2 resident) represents this discourse.

> "So, at the R1 ((Year 2 resident)), they should have started to have multitasking ability Doc … So at R1, in one day they usually will get a lot of records and notes ((from chief and senior residents)). Well, it is where R1 is tested whether he is multitasking type or not. Even if he didn't multitask first, they have to have record Doc, I was told this, this, this, told this is this. The highest number, the priority task that must be worked on immediately is the supervisor request. This second is the role of the senior resident based on the tiered responsibility allocated in batches. So you have to sort out which tasks to do first…" (RESO1, SSI)

Manage personal interest or problem

In the front of patients and members of their working network a professional need to maintain their mood (e.g., smile, calm, friendly) and adapt to the situation, whether it is during patient care, with supervisor, or at home regardless of their workload, burnout, distress etc.

> "Because it is not good Doc if for example, we are angry in front of the patient, patient might not trust us…" (RESO2, SSI)
>
> So far, it's possible that if she ((wife)) sees or hears how I've been talking to a friend or my junior, …. But how to behave at home so far seems to have no problem because yes, I think I can do differently how to talk at home, how to talk in the hospital" (RESO6, SSI)

Personal wellbeing-work balance

In orthopaedics' residency life, putting balance between work and personal wellbeing is perceived to be important. Therefore, in some training programmes,

they put extracurricular activity as an integral part of residency programme. This includes facilitation of family gathering and encouraging personal hobbies as intentional peer activities (e.g., playing console games, running, golf, hiking, cycling etc). In some instance these activities might be seen as part of a peer-group mission to create collegiality. However, for residents, especially those at a junior phase who do not do such hobbies, this becomes a problem, because it extends their working hours, thus reducing rest time. For instance, arranging family gathering and doing sport:

> " … So the good thing is we're really given time in Saturday-Sunday. It is really the time to get along with the family. You know sometimes operation can last until 10 o'clock, 11 o'clock pm at night, when we went home, all ((family member)) already asleep. So we are really given a time on Saturday-Sunday time to be with the family, otherwise there will be a gathering event ((arranged by junior resident in resident organisation))." (RESO1, SSI)

There is hidden side to the family gathering event mentioned above. The event organizer for this activity is usually the more junior resident, who is already hectic with day-to-day tasks. Another example is institutionalized hobby, hobbies that relate to senior residents or supervisors:

> "…Because I am now in charge in nature loving division at ortho. Doctor T wants to go camping, wants to do mountain hiking. I was told to handle then I instructed my junior to prepare what is needed. Oh, my goodness ((Smiling while response to my eye curious gesture)), I used to join a student club on this matter Doc, when I was an undergraduate … among us there are hobby activities we're inherited from our former chiefs because they are related with supervisor's hobbies. For example, the chief has seen oh this kid ((junior resident)) seems to be told to do mountain hiking, and then they started to be recruited" (RESO2, SSI).
>
> "When there was futsal match ((among residents and supervisors)), I should join, even though I did not play but I came. Get ready for all kinds of things." (RESO3, ITTD)

In above excerpt, RESO2, without reserve is taking on the role as event organizer for any extra-hour activities that interest their supervisor. And since RESO2 is a Chief, he delegated the task to his junior resident who at that time was on duty. This approach contrasts with RESO3, a woman resident chief,

who felt obliged to attend the futsal[10] event just to make sure everything went well.

The summary of traits under operationalised and dilemmatic discourse in orthopaedics are presented in the Table 6-3 below.

Table 6-3 Manifestations of operationalised and Dilemmatic MP in orthopaedics

Discourse	MP featured as
Operationalised MP	1. Prioritizing patient safety 2. Being informative and educative to patient 3. Selecting diagnostic procedures and treatment modalities wisely 4. Managing resource efficiently involving matching care with payment scheme 5. Doing guide-based practice (as a translation of evidence-based practice) 6. Physical mannerism and attire
Dilemmatic MP	1. High Self-esteem 2. Leading others 3. Resilient 4. Masking personal interest or problem in the front of patient and related working network 5. Personal Wellbeing-work balanced

6.2.2.3 Social Actors in MP conceptualisation in orthopaedic surgery specialist

In analysing the possible way participants in orthopaedics surgery come to these operationalised and dilemmatic professionalisms, two social actors - namely multiple work arrangements and organisational structures and power emerged as significant.

6.2.2.4 Multiple work arrangement

I am using “multiple work arrangements” to describe a feature that participants referred to as “work schedule”, “on-the job tasks”, “responsibility” or the “tasks assigned to the residency phase”. For most MSTs, the multiple work arrangements is usually expressed as work schedule or task and responsibility. While for RES, the multiple work arrangements is manifested mainly in the tasks and responsibility assigned in their phase role.

[10] Futsal is a football-like game sport. It is usually played on a hard (non-grass) field, smaller than a football pitch, and mainly indoors. The size of the field is around 38 x 20 m, and therefore, usually played by 5 players on each team.

Most orthopaedic residents perceived that their current conception of MP had been established in the OTL2 (orthopaedics Advanced Level 2 in the beginning of year 3) phase of their residency, which is associated with the assigned responsibility and assumed abilities in that particular phase.

> “In semester ((academic term)) 1 to 4 that's where residents focus on working to instructions … their jobs are according to the instructions, … The semester when they are able to decide what's best for the patient is usually at the 5th semester, when they have started to have rights…” (RESO2, SSI)
>
> “Yes, because in OTL2 ((early of year 3)) it is where he's been exposed to all the cases, so he should have known and he should be able to handle all, all the patients. So, let's say his junior asked him: what is the diagnosis? He should know, What's the plan, sir? He should already know”. (RESO5; SSI)

The responsibility and roles of the resident will be expanded gradually. The chief level is where all the complex responsibilities of a “real” specialist are assumed to be achieved, including responsibility for the performance of their junior:

> For those whom I trusted I usually only see at the end, oh it's okay, okay start. If I don't trust one, step by step I will follow, and advise: this needs more of this and that. However, I think excessive supervision can decrease one's creativity and flexibility in work.” (RESO6, ITTD)

The resident also has a role in managing other residents’ handling of patient care as well as extracurricular activities,

> “…. the *parade* ((not translated in English but the closest meaning of parade is possibly the ‘rounds’, one of clinical teaching practice introduced in the western medicine)) is where all residents gather in the same room to discuss patients, to discuss the mistakes of juniors… At this parade I ensure all residents come, slides per-stage were ready. So, each stage will present their patients, the course of the disease, what is the current treatment and what is planned.” (RES2, ITTD)
>
> “Among us there were, like hobbies derived from our former chiefs. For example, the chief has seen ‘oh this kid seems to be in favour of joining mountain hiking’, and then they started to be recruited ((by senior residents and teachers who love doping hiking)).” (RES2, ITTD)

Additionally, in one institute, a resident was expected to deputise for their supervisor at meetings held by the hospital organisation.

> “Yes, if there is a meeting invitation at the time I had a resident’s activity, a meeting that requires me to come out, then I should be finding somebody to replace the resident’s activity ((and attend the meeting)).” (RESO5, ITTD)

6.2.2.5 The organisation structures and power

The “organisation structures” names the different organisational structures that influence the multiple roles assigned to MST and RES which are either symbolised in a certain functional role or by material objects, such as “identity collar pin” (enamel collar pin), “name tag” and “decree letter”. These are means to represent organisational structure in symbols.

The power is the authority that is linked with organisational structures and established roles that requires people, or the functional structure underpinning the role, to do or not do something. For example, a hospital director has power because he/she is mandated by the law to manage people in the hospital organisation structure. The second example from this study is a chief resident who has authority to order their junior resident to come to the ward earlier in the morning to perform patient visit, while he/she might come a bit later just to receive the report of patient visit from the junior residents and not vice versa. Another subtle one is found in the doctor-nurse relationship, a consultant is more likely to ask for a nurse’s help than the opposite, and a head of nurse would have power to order a resident to do something, but the resident cannot order the head nurse. In the last example I would say, a consultant has power to order nurse, and a head nurse has more power than a resident.

However, in a text, identifying power is harder that identifying organisation structure. It is relatively easy to recognise organisation structure in the texts from given available organisation chart, symbols or the name of role. For instance, chief, senior resident, junior resident are names of resident organisation and the level of hierarchy in the resident organisation. However, it is more difficult to capture power in text because we have to see the relation between the structure and the existing organisational symbols. The last example in previous paragraph would explain this difficulty. I would not be able to recognise that a head nurse has more power than a chief resident in the ward for patient care if I do not get the sense of relation between a head nurse and chief resident. Critical discourse analysis scholars provide a clue that power is usually able to be identified in the texts or speeches by the way speakers use the “subject” and “object” in their sentence. The most powerful agencies are usually expressed by the use of a hidden subject or the use of a passive

sentence, where the speaker assumed their counterpart understood who or what party was being discussed (Van Dijk, 1993; Baker, 2006). Recognising the organisation structure and power in the texts is a critical step in conceptualising social practice in CDA (Phillips and Jorgensen, 2002; Rogers, 2011), and specifically in 3D-CDA (Fairclough, 1992; Fairclough, 2015).

Thus, during the identification and formulation of cognitive, operationalised and dilemmatic discourses, many social actors are involved in the emergence of ideas about professionalism that create a discourse. These actors involve, but are not limited to, a number of human actors such as 1) the individual participant, 2) the role model picked up by the participant; 3) the professional organisational represented by the extension of specialist organisation as medical specialist teacher figure; 4) peer resident, especially the senior resident figures; 5) significant others in operating theatre; 6) influential family member. There are also non-human actors the influence how the MST and/or RES conceive MP, such as: 1) surgical knowledge and technology; 2) work arrangement; 3) organisation structure in the teaching programme; and 4) legal provision of practice and service organisation.

There are subtle differences between how ideas about professionalism are conceived among neurology and orthopaedic MSTOs and residents. While neurology residents tend to freely express their different understanding and approaches to their supervisors, orthopaedic surgery residents seem proud to continue the legacy of their supervisors or senior peers. It seems that role modelling, either by supervisors or senior residents, is the preferred way of learning professionalism within the orthopaedic specialist. This makes sense because the core basic and major training process is apprenticeship where the surgical techniques are referred and taught from the supervisors or senior resident to their juniors.

> “…After the pre-parade they have to report again to the chief residents, "Sir, asking permission today I want to operate this patient, male, age, diagnosis, I would plan this technique and that”. We, the chiefs listen to them, and sometime provide corrections if there are some mishaps, statements ((made the juniors)),” (RSO3, ITTD)

The multiple work arrangement and organisation actors presented above shed light on a possible third activity system - the professional organisation as a context in which MP is conceived. is.

6.3 Summary of analysis and discussion in this chapter

6.3.1 Similarities and differences (unique) conception of medical professionalism across specialist communities

From the above discursive analysis in each speciality, we can infer that there are similarities and differences in conceptualising MP as well as factors that influence the conceptualisation of MP in each speciality, either in cognitive, operationalised and/or dilemmatic discourses.

One similarity is that the three themes of MP conception developed in the first stage of CDA (cognitive (normative), operationalised and dilemmatic) can be applied. This means that there is a unified situation in which MP is conceptualised and applied in everyday practice of both specialist training and services that is oscillating (move back and forward) between idealistic discourse (cognitive), operationalised (institutionalised MP) and dilemmatic (contested MP). However, the dominant feature of conceptualisation, and the influencing factor (agencies and ecology), related to the emergence of MP conception are different.

The discursive analysis revealed some differences in MP conceptualisations, mainly in its nature and the agencies/actors influencing the different conceptualisations. In neurology, participants tend to conceptualise MP from reflection on their interpersonal relationship during practice with patients, therefore, MP in neurology is more elaborated in the cognitive, especially interpersonal, dimension. In contrast, orthopaedic surgery participants tended to conceptualise MP from a prescribed or operationalised concept situated in daily surgical successes; therefore, the elaboration of MP was heavy on ethical and legal aspects of MP.

6.3.2 Identifying specific MP in neurology and orthopaedics

When drafting the list of potential explorative questions in the SSI, I was interested in knowing whether there was a specific MP in different specialist communities. This intriguing question was triggered by current practice in Indonesia where each specialist Association or College of Specialists are keener to produce their own version of competency and education standards

rather than extending the existing physician competency standards issued by the Indonesian Medical Council. Another reason why this question is interesting is that it will have consequences for teaching-learning MP in post-graduate medical education. As a medical educationalist I have frequently been consulted but could never provide a satisfactory explanation because research-based evidence has been lacking.

In order to explore this MP specificity theme, I found the intertextuality analysis in CDA worked well in synthesising data from SSI and ITTD. This might be because the combination of interview methods also provides a form of data triangulation. Mostly, the ITTD provided a more natural representation of everyday professional life so that to some extent it played a dual function in confirming and confronting the theoretic or normative narratives of participants in the SSI. Furthermore, the indirect conversation about professionalism in the form of instructions to the imaginary “double” of everyday professional life in ITTD provided evidence of consistency or inconsistency, which helped to establish whether statements uttered in SSI were genuine or rhetorical. Table 6-5 shows two examples of both genuine and inconsistent statement from participants

In regards of specific MP, I found participants were divided in perceiving a “specific professionalism” within their speciality. Most residents and a few MST participants believed there was not, and should not be, a speciality MP. In contrast, the majority of senior MST participants, who had more extensive leadership roles in their professional organisation, held the view that their speciality had a specific MP. Those believing MP should be common across all specialities argued that the “Physician Oath” and “Code of Ethics” should be the guide unifying them. In this view, “whatever responsibility a speciality physician might bear, the core professionalism should be the same (MSTN3, SSI). Themes such as patient welfare, compassionate care, and taking into account *esprit the corps* among colleagues (treating colleagues as a brotherhood) come up as the essential shared elements of professionalism. This referral to the physician oath and medical ethics in conceptualizing MP is not a new thing and predictable. In the Indonesian context, it is probably a normative and conventional way of conceptualizing MP. Before the first national competency standard (SKDI), the Good Medical Practice for Indonesian Doctor guidelines,

which became prescriptive, were enacted in 2006. These two guides were the main references used in most Bioethics lectures in medical school where medical students were being taught about the profession and morality principles which to some extent was the conventional way of teaching professionalism.

It was interesting how participants referred to professionalism as a shared conception. Rather than mentioning a clear description of professionalism, the participants were more likely to indicate the name of a document (material) than the description (virtues).

> “Truly, we should address how a doctor be able to do his physician’s oath properly. That is the essence. Because patient safety is only one dimension of the physician's oath, right. But now, people might not realise what the physician's oaths is, so we need a common language. Therefore, currently the patient safety has been surfacing. But truly, the patient safety has already been included in the oath. Well, unfortunately among us sometimes forgotten (the oath) and then we are really trapped in situations where we cannot fulfil our oath well. For instance, the condition under BPJS influence.” (MSTN3, SSI)

Later, in the third phase, I will describe that the referral to physician oath discourse is socio-historically related to the religious-belief and legal system in Indonesia. Many Indonesian people with religious belief (mostly Islam) believe that an under-God’s name oath cannot be broken unless the oath caster offers the expiation redemption [11]. Moreover, in the medico-legal system, the Medical Ethics and Nobility Committee (MKEK) powerfully oversees and punishes to any physician who breaks the Code of Ethics. These religious and legal discourses might have strongly influenced the participants when they refer to the physician’s oath as a source of professional ethical values. In Indonesia, the physician oath is more than ceremony. It is a combined legal and religious practice. As a legal practice, it has been mandated under an unratified 1950 presidential decree which obliged every single medical school to hold a ceremony and issue a certificate that their graduate had already taken an in God’s name oath in the front of the Dean of the Medical School. It is regarded as breeching the law if a medical school did not do the ritual or issued the oath

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[11] (in Islamic jurisprudence, a muslim should choose either freeing a believer slave, fasting 3 days consecutively or giving food to 10 people if they broke a single oath verse (al-Munajjid, 2007).

evidence. The other half is the oath as a religious contract. In every physician oath taking ceremony, symbol of religious matter should exist i.e., the presence of a religious scholar and/or religious scripture (e.g., Quran, Bible, or Veda). Breaking an oath matters when people still believe that it will be considered shameful and punished.

Participants holding a view that their specialty, either neurology or orthopaedics, had a specific MP, asserted different opinions. Orthopaedics participants held a perspective that the commitment to comply with updated international standard of practice and advanced-technology deployment were distinguishing professionalism traits. This is shown by a senior orthopaedic, affirming that “the establishment of orthopaedic surgery has been nurtured by foreigners” (MSTO5, SSI). This senior teacher and chair of Indonesian College of Orthopaedic and Traumatology meant that the inception of orthopaedic in the country was distinguishing quality of the orthopaedic because, “the standard has been high since the conception and the birth of the speciality”. (MSTO5, SSI). Not just limited to the inception period, in support of the reason that orthopaedic is above average quality education, MSTO5 provided a series of arguments such as: 1) “continuing updating international standard in education”; 2) “so many of us, the teaching staff, had overseas training fellowships” which differs from other specialist programme (e.g., Internal Medicine); 3) PPDS ((residents)) had opportunity to have a clinical rotation at foreign country; 4) Indonesian orthopaedic surgeons have been taught in English for a long time (MSTO5, SSI).

Another view from orthopaedic participants on the distinctive feature of MP conception is on their attention of interpersonal communication skills. Regarding this, MSTO1 provides an interesting case that because of communication skill introduction in NBSE and orthopaedic training curriculum,

> “the ((national disciplinary lapses)) cases dropped to 40%” (MSTO1, SSI) and in the subsequent years the cases that arrive in Disciplinary Court and Honorary Council for Indonesian Medical Profession (MKDKI) decreasing drastically: “, if in 2017 we had 20s, 2018 5 complaints, and for this year (2019) there are no complaints ". (MSTO1, SSI)

In contrast, in neurology, participants are prouder of their commitment to perform comprehensive data gathering and communication (MSTN3, SSI;

RESN2, SSI); approach to thorough clinical examinations (MSTN4, SSI), and religiosity (MSTN1, SSI; MSTN2, SSI; RESN4, SSI) while at the same time having concerns about technological advancements (MSTN3, SSI; MSTN4, SSI). Regarding this, MSTN4 provides an example of how she relies on thorough clinical examination and uses MRI as a confirmation of this manual clinical process.

> "… In neurology we still depend on thorough anamnesis ((consultation)), and I gave the examples of this important matter, and *alhamdulillah* ((praise to God)) this approach mostly went right". If the anamnesis is right, the physical examination is right, people say 80% ((of the problem will be solved)), it's true! it's real indeed! When it was fitted with the MRI result. It turned out correct, accurate!" (MSTN4, SSI)

The specificity of MP also emerged when participants were discussing their most feared or concerning professionalism lapses. Orthopaedic participants pay more attention to arrogance, overconfidence, selfishness, and crossing other's boundaries as their main concerns. While neurology participants were concerned about lapses such as losing empathy, losing their thoroughness when overloaded with patients, and hurrying. Interestingly, both specialities identified money orientation as a common problem which cause significant lapse. Table 6-4. below shows the lapses that most concerned participants.

Table 6-4 Most concerned professional lapses

Neurology	**Orthopaedics**
Losing Empathy	Arrogance
Losing thoroughness to the detail	Over-confidence
In hurry	Selfishness
Close-minded	Crossing other boundaries
Money orientation	Surgically unskilled
	Money orientation

Although not every participant shared directly the reason why any particular trait was considered to be a professional lapses, further comparison and contrast of the intertextuality analysis helped to find strong relationships between the lapses with personal worldview and layered organisational discourses. The detailed explanation of this interdiscursivity will be elaborated further in the next chapter.

In a number of publications discussing medical professionalism and its elaboration in teaching and learning, there is an assumption that in order to teach MP, whether in the classroom at medical school or learning workplaces for residents and practicing physicians, a set of learning objectives (LOs) or description of intended learning outcomes (ILOs) have to be set out in advance (Arnold et al., 2001; Lynch et al., 2004). Consequently, to construct these ILOs, consensus-based studies should have been conducted, leading to the production of a set of MP descriptions, characteristic, or traits. This assumption is valid from the perspective that MP education is a way to nurture the future generation of “good physicians”, but it is also problematic. This because of a tendency amongst educators to produce ideal descriptions of LOs (Freidson, 1999) In fact, in the core of MP discourses, ethics and morality have become the dominant discourses (Martimianakis et al., 2009). This means setting MP as formal teaching learning and assessment activities creates a designated (latent) gap between the ideal image of a professional doctor and the reality of professional life (which is frequently non-ideal). Consequently, the elaboration of MP in teaching-learning is frequently seen as artificial and inauthentic.

This research was not intended to create a set of LOs like many other research studies into professionalism in Undergraduate Medical Education (UME) have done. This study intended to better understand how medical specialists are constructing their conceptions of MP and how that might best be taught and applied in their education/training. However, during study I found that participants, especially the MSTs, took ideas from the discussion during SSI and ITTD to improve their teaching or training.

This experience brought me an insight that there could be a model of research on MP that functions both as scholarly activities and as an agent of change in both the medical speciality practice and education as many developers of professional learning theory envisioned (Eraut, 1994; Fenwick et al., 2012; Hafferty et al., 2016; Sawatsky et al., 2017; Engeström, 2018; Hays et al., 2020). When consulting the literature, this insight is just what CHAT offered in its expansive learning concept. In expansive learning, learning and knowledge development (which could be in a form of inquiry) are not just about transformation of expertise for learning subjects (people), but they are also a form of co-production between subjects, their activity network, including non-

human objects (which might include rules, organisation structure of work function, and learning tools, and various other non-human entities) (Engeström and Miettinen, 1999; Engeström, 2001)

6.3.3 MP discourses as a diffractive means of representing self and professional identity in social actors' network (activity systems)

Understanding three similar but different ways of MP conceptualisation in neurology and orthopaedics, participants suggest that conceiving MP in everyday practice is diffractive due to different source of influential powers. The term diffractive is used intentionally to describe that it might have different ways of expression and conceptualisation though it comes from a single source. This diffractive nature is interchangeably portrayed in the three textual discourses previously discussed (i.e., cognitive; operationalised and dilemmatic text), especially when participants elaborated different source of powers. These powers might range from their personal reflection; institutional and standard referral (organisational power); and societal or ecological influence (ideological power). The following paragraphs will further discuss these issues.

As a product of personal reflection, there are some moments that participants confidently expressed their own version (reflection) of professionalism that may be lexically different to the majority of their peers or teachers. However, their conception is still part of the known standard of conduct, such as competency standard or Ethical guides. This type of conceptualisation is mostly the product of critical reflection of moments in their past professional experience. This can be found in some of the cognitive definitions of MP. One example is the conception of MP as being compassionate and empathetic to patient.

The second feature of conceptualisation is the way that participants refer to the definition brought by the existing standard, or organisation where they belong. Participants are representing themselves as part of a certain community such as specialist community (professional association or college of specialist), physician community, as a member of their university *alma mater* or as the inhabitant of the hospital workforce. This can be found in either cognitive or

dilemmatic traits. For example, conceptualizing MP as compliance to physician oath or as compliance to Ethics and Professionalism standard.

The third way of conceptualisation is where participant convey MP as a way of conduct due to certain inevitable forces from actors external to the medical organisation or wider ideological sources of power. In this instance, participants convey the traits in their MP definition as taken for granted behaviours and normalized ways of conduct which is embedded in the routine activities. Most of the traits in the operationalised discourse represent this MP conception. In this discourse, participants tend to unconsciously suppress their existence as an individual self to appear and be recognized as holding a particular form of professional identity or as an integral part of service organisation. The example is featured in the stance and behaviour regarding patient safety issue at the Hospital. Most participants agreed on a definition of patient safety which originated in the hospital accreditation standard. These prescribed professional conducts, such as frequent hand washes (steps recommended by World Health Organization), prevent and managing fall risk, emergency evacuation awareness, interprofessional collaborative work etc (WHO, 2011 adopted in National Standard of Hospital Accreditation) are perceived as new norms for those working at hospital. In fact, the patient safety concept has philosophically been rooted in the old-time Bioethics Principles, “first do no harm”. However, the influence of accreditation is likely to make the prescribed conducts appear refreshed.

6.3.4 Making sense of the fluidity of professional-workplace with socio-materiality perspective

The interdiscursivity analysis of the operationalised and dilemmatic discourse has also shed light on a fluidic existence of the professional workplace from participants which led to two type of influential social actors in CDA which I termed work arrangements and multiple organisational structure.

Because of the limitations of 3D-CDA in theorising objects of observation and the learning context it is important here to reinforce the analysis with a socio-material theoretical perspective, such as CHAT. As previously discussed in Chapter 4, CHAT has a designated conceptual framework for theorising context and learning which is bounded in an activity system. An activity system consists of interactive elements which are categorised as tools and signs, rules,

community and division of labour. These elements are interwoven along with subject (learning people) in order to create new mode of learning (object) (Russell, 2009; Engeström, 2014)

When we reanalyse the work arrangement through CHAT, it is clear that work arrangements can be understood as a boundary crossing between tools/sign and rules between activity systems. Work arrangement in my observation is a feature of how professional activities are set in working spaces (e.g., workplaces, rooms, offices), working aids (e.g., medical tools, social media, attire, identity label) and working time (e.g., work schedule, priority agenda). Working spaces and aids are products of human artefacts which used to be categorized in tools and sign, while working time is part of rules made by the subject and community of practice and professional hierarchy (division of labour) to making sense of how to interact with working spaces and aids (tools). In the real life of activity systems, work arrangement is no longer able to be distinguished separately from rules or tools anymore because it has been realised through mobilization or boundary crossing of the subject between multiple elements within activity systems (Engeström et al., 1995). I argue in this study that work arrangement play a significant influence in the emergence of MP conception from both resident and medical specialist teacher. One prominent example is the conceptualisation of professionalism as compliance with professional guide or professional standard. For instance, if an orthopaedic surgeon says “your practice should comply with professional standard!” (MSTO2, SSI), it might mean local professional standard, hospital professional standard, national professional standard, or even international guideline. Because the applied professional standard has always been contextual, dependent on which workplace the surgeon is referring to and whose priority is at stake.

Another example of the interdiscursivity of elements across activity system (AS1, AS2 and AS3) is an ability to manage resource efficiently. Ability to manage resource efficiently is one of the MP traits in the operationalised discourse which is influenced by both work arrangement and different organisation structures in specialist professional activity. This ability is related closely with the current Indonesian Universal Health Coverage policy-based health financing system (called BPJS) in financing patient expenditure while

having patient care at the healthcare institute such as public hospital. This financial scheme has been modified by the teaching hospital authorities through the enactment of technical rules applied specifically in the particular hospital (MSTO1, SSI; MSTO2, SSI; MSTN3, SSI). It means different teaching hospitals might apply different procedures leading to a different availability of aid and tools. Consequently, this might influence the ability and wisdom of the specialist to use the available tools, which are mostly different to the guideline set by the professional organisation (MSTN1, SSI; RESO5, SSI). In this instance, a practicing specialist should adapt with three different activity system institutions (e.g., BPJS, hospital authorities, profession organisation) and possibly one work arrangement (the procedure, aid and tool installation and availability).

The elicitation of the influence of multiple organisational structure on MP conceptualisation is also better to be framed with CHAT in the sense that there are multiple activity systems taking part in the MP development, as indicated and identified by Engeström, Engeström, and Kärkkäinen (1995) as polycontextuality:

> In their work, experts operate in and move between multiple parallel activity contexts. These multiple contexts demand and afford different, complementary but also conflicting cognitive tools, rules, and patterns of social interaction. Criteria of expert knowledge and skill are different in the various contexts. Experts face the challenge of negotiating and combining ingredients from different contexts to achieve hybrid solutions. (p. 320)

Considering the discourses that emerged in interdiscursivity analysis, especially on multiple work arrangement and organisation structure, I argue there is a possible third social-actor that fulfils the criteria for an activity system. This activity system, along with the two identified before, University-based education activity system (AS1) and hospital-based specialist service activity system (AS2), together influences the emergence of MP conceptions and their related discourses. The third activity system is the medical professional organisation. In neurology, specialist AS3 is represented by neurology association and the College of Neurology, both at national and local levels (i.e., local study programme/hospital) , while in orthopaedic surgery it is represented by the Indonesian Orthopaedic and Traumatology Association (IOA) and its College of

Specialists, also both at national and local levels (e.g., province, town or hospital). The illustration of AS3 utilising CHAT is shown in Figure 6-1.

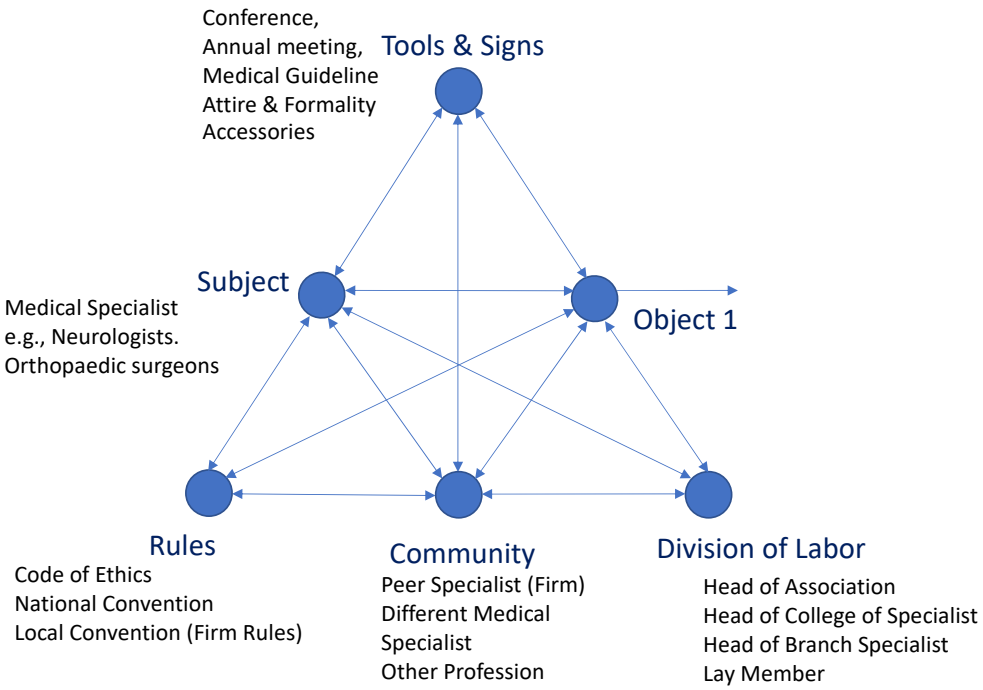

Figure 6-1 The specialist professional association as an activity system and its elements

The subject in AS3 is medical specialists themselves. The instrument elements (tools and signs) are represented in conferences, annual meeting, neurology guidelines, attire and characteristics related to peer identity. Rules in AS3 might be in form of specialist code of ethics (created by Indonesian Orthopaedic Association), national convention (such as an obligation to attend the DEPOI event during annual meetings, collecting CPD credit to maintain licensing), and also local convention (e.g., rules set by the local specialist firm). Community of practice in AS3 might involve peer specialists, multi-specialist task force (such as neurology and other neuro-based specialist in creating a grey area practice guideline), or multi-professional community (such as non-cancer operating team, surgical cycling club etc).

The three activity systems collectively form the polycontextual boundaries which contribute to the development of MP conceptions, as illustrated in Figure 6-2. The summary of identified and possible elements of activity systems are listed in Table 6-5.

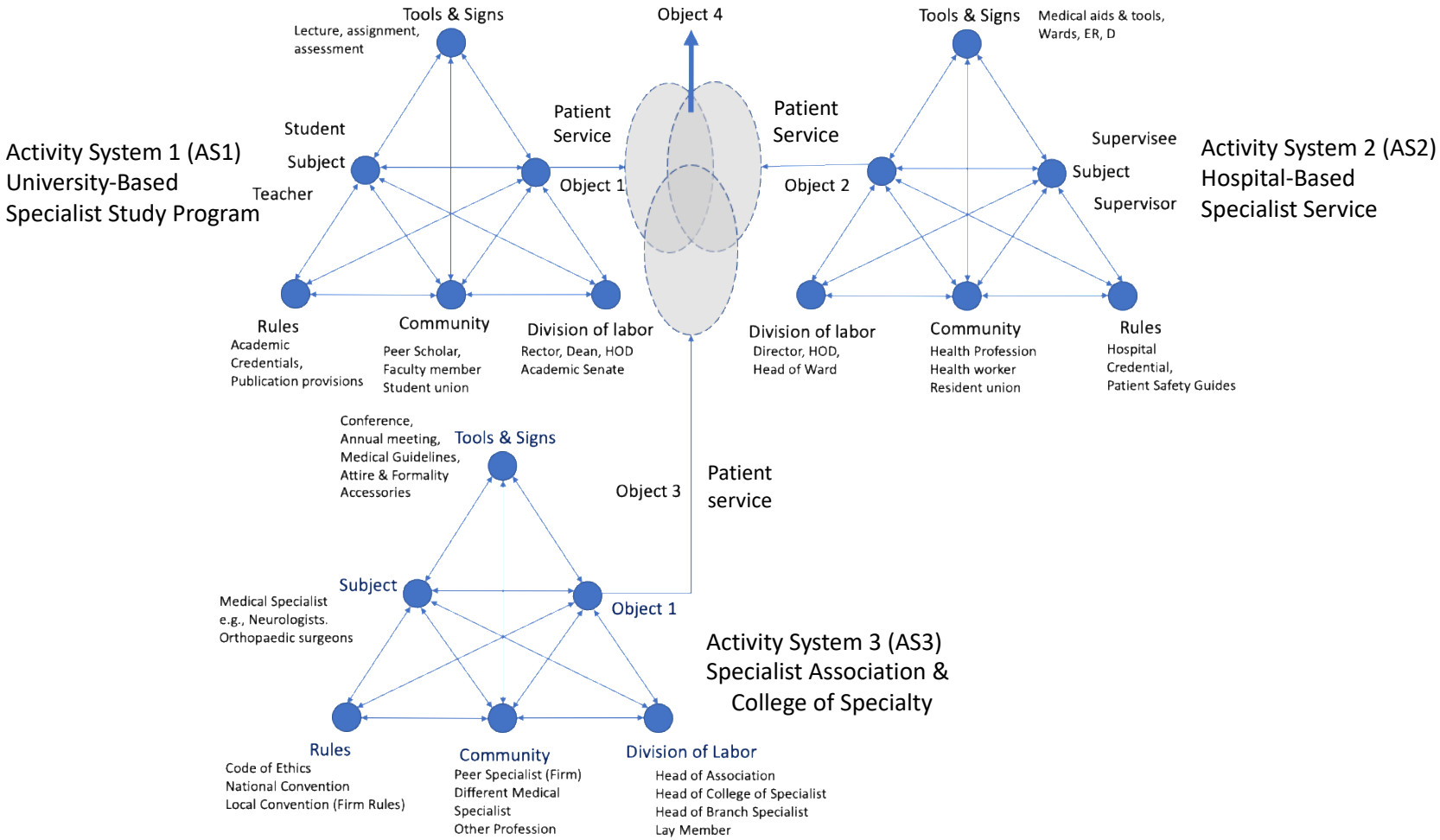

Figure 6-2 Polycontexturality of Activity Systems (AS1-AS3) in MP conceptualisation

Table 6-5 Organization /institute as social actors/ activity system in MP conceptualisation

Organizational Social Actors as activity systems	Identified discursivity and elements of activity system
Educational organisation Example: Study programme, Faculty of Medicine, University, Ministry of National Education	Tools and Signs: Teaching-Learning events, classroom, assignment, assessment Rules: Education Curriculum (prescriptive Learning outcomes), academic credential Community: Academic meetings, student union, faculty member Division of Labour: Rector, Dean, HOD, Academic senate Object: cognitive - Idealism and Ideological (MP conception)
Healthcare organisation Service organisation example: ambulatory clinic, ward, ER, stroke unit, surgical theatre structure, public and private practice organisation	Tools and Signs: surgical tools, neurology test machine, examination room, surgical theatre Rules: BPJS law, practice guidelines, Legal obligation of Physician in the healthcare Community: Health professionals (nurse, dietitian, pharmacist etc), health workers, hospital administrator Division of Labour: Hospital authorities, Medical Committee (CMO), Head of Department, Ward Chief officer Object: professional community identity within organisation (MP conception), supervisory process, specialised care
Professional organisation Example: local peer group, resident organisation, competing guild in department	Tools and Signs: annual meeting, medical guideline, speciality attire and accessories (e.g., white coat decoration) Rules: specialist code of ethics, national convention, firm convention, norms or regulation (local), religious/spiritual norms Community: Hobby club, inter-sub-speciality care club (cancer team) Division of Labour: sub-specialities, senior-junior specialist, chair of association, chair of college of specialty Object: peer identity preservation (MP conception)

6.4 Chapter Summary

In this chapter, I have extended analysis of the second Discourse identified in chapter 5, which conceptualised MP as a cognitive, operationalised and dilemmatic text. This chapter's analysis focuses on the interdiscursivity of the traits grouped in each discourse across speciality contexts, i.e., neurology and orthopaedic surgery. From this analysis, similarities, and differences in the conception of MP are identified, leading to the elicitation of the uniquely situated conception of MP in speciality contexts.

I also identified the diffractive and fluid nature of the professional workplace in which they conceive and apply MP conception in their everyday

practice. This fluid professional workplace then led to the elucidation of multiple social actors and their influential power in developing MP conception. Using CHAT to frame this finding, the elicitation of multiple social actors helps to identify the medical specialist association and its college of the specialist organisation as the third activity system. This specialist organisation activity system (AS3) and other previously identified activity systems (University-based study programme and Hospital-based speciality service) are critical in setting the context of MP conception.

The next chapter will further analyse and discuss the possible ideological discourses that characterise medical specialist education as social practice. Finally, following the third phase in 3DCDA, I will discuss possible consequences and speculations concerning the two identified Discourses and three activity systems in MP conceptualisation of two specialist medical practices could nurture the further development of MP in relation to teaching-learning practice.

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Chapter 7 Understanding social practice through MP conceptualisation in Indonesian medical specialist education

7.1 Introduction

In the previous two chapters, I have discussed how the idea of MP is conveyed through many discourses (chapter 5) which are interconnected and also competing in how it may be applied and practiced in everyday professional life (chapter 6). This chapter covers the third part of the 3D-CDA, framing discourses in conceiving and applying medical professionalism as a component of social practice, at the same time as dialectically representing current and emergent Indonesian medical specialist (social) practice. In the 3D-CDA, the concept of social practice functions both as a framework and as an object of analysis. As a framework, it provides criteria and a guide to analysing discourse. While at the same time, as an object of analysis, it deliberately becomes a space to observe, describe and criticise discourse as a form of social practice (Fairclough, 2001; Chouliaraki and Fairclough, 2002; Fairclough, 2011). In this framework the critical discourse analyst is able to explore the power and agencies that influence the emergence and the replication of discourses in the society. This power and agencies influence on social practice conception is the feature distinguishing Fairclough's 3D-CDA from other critical discourse analysis methods (Wodak, 2001; Phillips and Jorgensen, 2002; Rogers, 2011). The three stages of analysis in 3D-CDA provide a more prescriptive and staged-framing of analysis compared to other CDA approach (Rogers et al., 2016; Liu and Guo, 2016). In this view I believe, the framing of social practice into three dimensions in 3D-CDA helps beginner analyst like myself to construct the social practice of the Indonesian medical specialist from discourses about MP, and how this social practice influences their conception of MP.

The chapter starts by summarising Fairclough's point of view on the underpinning theories of social practice. This provides a common background of how the third phase of 3D-CDA is performed. From this point of view, I then describe the social practices that MP represents and how MP is also influencing

and influenced by the agencies/institutions in the society through competing ideology and power discourses. This elaboration is pivotal to my study because it offers a critical realist perspective on MP in a situated context of medical specialist education and, therefore, leads to a discussion of how workplace education in specific contexts, such as specialist training programmes, could support professionalism development. Seminal reviews of MP in medical education practice performed by Hodges et al (2011) and Birden et al (2014) argue that research within this critical realist perspective is rare. Hence, it is essential to describe how MP is taught in the context-specific ecology of specialist and continuing professional education, especially for developing countries, like Indonesia. Following this discussion, before summarizing and closing this chapter, I offer speculation on how this understanding of context-specific MP could benefit the local teaching-learning practice, particularly in the Indonesian medical context, and further study about MP.

7.2 Discourse as social practice: a 3D-CDA account.

Many discourse analysis scholars argue that what makes a critical discourse analysis (CDA) “critical” is the conception that discourse is a representation of language use, and thus becomes one critical component of social practice (Wodak, 2001; Gee, 2011). The CDA as a theory and research method has been credited to a British linguist, Norman Fairclough, because of his contribution to include the critical theories (Wodak, 2001; Phillips and Jorgensen, 2002; Rogers et al., 2016), social practice theory and socio-linguistic in a form of analytical framework which he initially named as Textually-Oriented Discourse Analysis (TODA) (Fairclough, 1992, p.37). However, scholars renamed this version of Fairclough’s CDA as three-dimensional critical discourse analysis (3D-CDA) because it involves three analytical stages (Phillips and Jorgensen, 2002). In this section I briefly review some critical concepts that Fairclough repeatedly elaborates about CDA. These are social practice, the dialectical relationship of social practice’s elements, order of discourse and genre and style.

Fairclough conceptualises social practice as a “relatively stabilised form of social activity (e.g., classroom teaching, television news, family meals, medical practice etc)” (Fairclough, 2001 p.3). Every social activity includes social elements, such as: subjects and their social relations, instruments,

objects, time and place, forms of consciousness, values, and discourse or semiotics (Fairclough, 2001). Every social practice is, consequently, also an articulation of relatively stable form of various social elements, where discourse become its essential (always present) component. In Fairclough's view, professional learning practice, such as specialist medical education practice, can be regarded as a form of social practice. Consequently, as discourse becomes the essential element in social practice, in the context of this study, analysing discourses within specialist medical education becomes the means to approach and characterize the social practice of specialist medical education.

Reinforcing Harvey's social theory of semiotics (1996) and Foucault's genealogy (1972), Fairclough argues that the social practice elements have a dialectical relationship. This dialectical relationship means that each element 'internalizes' and influence the others without being reducible to them. Thus, it requires an understanding that even though they are distinct elements, they are not fully separated. For instance, social relations, social identities, cultural values and consciousness are in part semiotic (presented as discourse), but that does not mean that we could theorize and investigate, say, social relations (such as interaction of resident-supervisor) in the same way that we theorize and research language (e.g., the grammar of resident report to supervisor during morning report presentation) (Fairclough, 2001). This dialectical relationship, on one hand requires understanding that discourse is shaped and constrained by social structure. However, on the other hand, "discourse is also framing practice; not just representing the world, but also signifying the world', constituting and constructing the world in meaning" (Fairclough, 1992. p.63).

Another area which Fairclough describes as applicable in 3D-CDA is a conception of order of discourse, discourses (with "s"), genre and style. Fairclough has theorized that discourse arises in three ways in social practices: 1) discourse present as the social activity within a practice; 2) discourse appears in representation; and 3) it appears in ways of being (Fairclough, 2001.p.2).

As a social activity, discourse represents a genre. Genres are distinct ways of acting, of producing social life, in the semiotic mode / linguistically (Fairclough, 2003). Some examples of genres are everyday conversation, doctor-patient consultation, business meetings, forms of interview, journal

article, popular health magazine etc. Genres structure texts in specific ways or rules (Fairclough, 2001). For instance, in doctor-patient communication there is a specific way doctor guides the patient information (e.g., starting with greetings and introduction, asking patient data, patient chief complaint and so on). These rules make the doctor-patient consultation differ with business meeting.

Discourse in the representation and self-representation of social practices constitutes discourses. Here Fairclough highlights the difference between ‘discourse’ as an abstract noun, and ‘discourse(s)’ as a concrete noun. Other DA scholars, such as Gee, use Discourse (with capital “D”) to represent the social abstraction and discourse (with small letter “d”) to explain the way of uttering in this different type of representation (Gee, 2014). In Fairclough’s account, discourse (the abstract) are diverse representations of social life, value and hegemony which are inherently and differently positioned by social actors which allow them to ‘see’ and represent social life in different ways, different discourses (the noun). For instance, the struggling life of a poor and disadvantaged medical student (an abstract discourse of a social reality in university life) could be represented through different discourses (the real way of talk in communicating poverty) in the social practices of government (e.g., national priority for budget allocation), politics (e.g., disadvantages and underrepresented voter), medicine (e.g., scholarship receiver), and social science (e.g., working class society, identity transition of the poor in medicine).

Hegemony is a critical concept in 3D-CDA. Reinforcing the concept from Gramscian Marxist school of thought, Fairclough (2003) defines hegemony as:

> “a particular way of conceptualizing power which amongst other things emphasizes how power depends upon achieving consent or at least acquiescence rather than just having the resources to use force, and the importance of ideology in sustaining relations of power” (p.45).

In relation with ideology, Fairclough asserts that seeking hegemony is a matter of seeking pattern of discourse where social actors or conflicting forces attempt to universalize particular meanings in the service of achieving and maintaining dominance (Fairclough, 2003, p58). In this notion, hegemony is no other than manifestation of ideological works (Fairclough, 1993, 2003).

Finally, the third aspect, discourse is how ways of being constitute styles. Some examples of styles are styles of the head of department, managers in an

organisation or company, political leaders or how teachers engage with students. A summary of these concepts is presented in Figure 7-1.

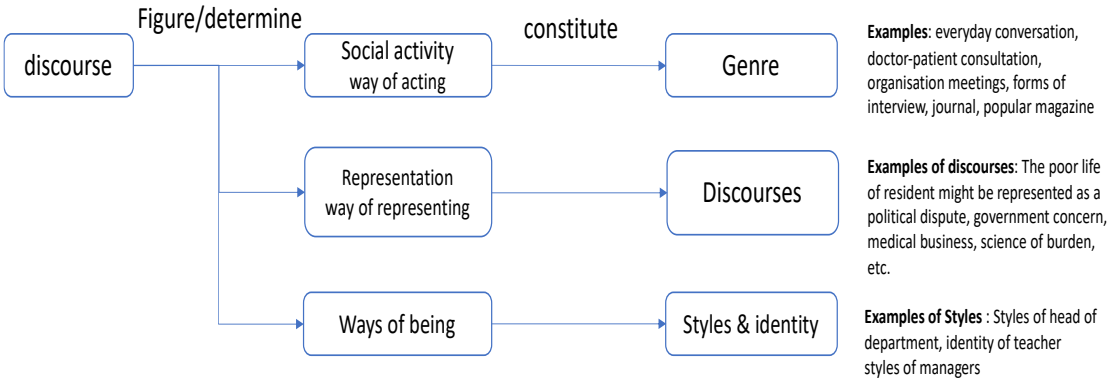


Figure 7-1 Illustration of Fairclough's account of genre, discourses and style

A further critical account given by Fairclough is his view on the order of discourse. Fairclough defines the order of discourse as the discourse/semiotic aspect of a social order. This is where various form of genres, discourses and styles are enmeshed together. Consequently, an order of discourse is a social structuring of semiotic differences and therefore represents a particular social ordering of relationships amongst different ways of making meaning, i.e., different discourses, genres and styles (Fairclough, 2001; Fairclough, 2015 p.24). In this understanding, the order of discourses concept has similarity with the socio-material theoretical perspective of activity systems or network concept in Cultural Historical Activity Theory (CHAT) (Engeström, 2001; Russell, 2009) and assemblages in Actor-Network Theory's (ANT) sensibility (Deleuze and Guattari, 1987).

However, compared to ANT, CHAT is much closer to 3D-CDA in conceptualising the relation between elements of social practice in meaning-making and knowledge generation. Both CHAT and 3D-CDA theorize 'difference' as the internal mechanism in which social actors (in CDA) or elements of activity system (in CHAT) produce emergence knowledge (CDA) or new learning object (CHAT). In 3D-CDA the mechanisms are identified as ideologies and power, while in CHAT these are conceived as contradictions and multivoicedness. In contrast, ANT uses more appreciative and optimistic term

which is called co-production or co-creating, which assumes a social and political neutrality which make ANT gives a further distance to 3D-CDA.

The difference between CHAT and 3D-CDA is that in an application of analysis to an object of interest, CHAT requires a set of principles to be applied (5 principles as discussed in Chapter 4). Specifically, we have to determine the activity systems we would like to analyse in advance. The 3D-CDA, in contrast, as for other linguistic or semiotic-based methodologies, can be used as simply as: we have a newspaper to read and digest. The 3D-CDA is powerful in locating practice in relation to ideologies or power gap discourses. However, the boundary of social practice analysis is freer in 3D-CDA compared to CHAT. For instance, in analysing the following excerpt:

> "If for the girls ((female resident)), she is more emotional in facing any unexpected condition. Less calm, more alike panic attack" (RESO5, SSI).

In 3D-CDA, this may invoke the gender bias that exists in the current Indonesian orthopaedic surgery education and representing how female residents are a marginalized community in orthopaedic society, and therefore need to be advocated for. However, 3D-CDA may fail to see this phenomenon as a part of learning that leads to transformative process in orthopaedic surgery education. In CHAT perspective, while this would be acknowledged as a contradiction (social conflict), CHAT also see this as a form of multivoicedness where a social actor (male resident) is in a process of learning how to accept their female colleagues as a part of new orthopaedic society. Collins (2008) criticise this exaggeration of advocation toward minority representation as a problem of why 3D-CDA had difficulty in situating social activity (phenomena) as learning context.

In activity systems, the transformative process occurs through multivoicedness, and contradictions across long term historical cycles of expansive (development) activity systems (Engestrom, 2016). In the later development of CHAT, by studies conducted in medical profession context, Engestrom promotes the boundary crossing idea to explain the mechanism of how contradictions enable elements in activity system interact and mediate learnings across different activity systems (Engeström, 2018). However, CHAT is still unable to theorize the assimilation of intercultural Discourses as brave as

3D-CDA (e.g., multinational discourse exchange in the mobilization of transnational fundamentalism across different cultural context), which is presented in the third phase of 3D-CDA. Considering the drawbacks and the power in each approach, I contend combination of these two approaches in this study will complementarily reduce the drawbacks and give both academic and pragmatic benefit.

Therefore, analysing hegemony and agencies in discourses offers new ways in to analyse and understand professional social practice, such as medical specialist practice and its training. An illustration for making sense of this difference is the situation of family order in Indonesia. The dominant family order in Indonesia is patriarchal in which husband become the leader and main income generator. There are cases (also found in this study) where male young married residents could not function well as the leader nor main income generator for his family due to a burden of education and clinical service. In the order of discourse perspective, the patriarchal belief is seen as the product of social mechanisms that become an area to critique and deconstruct. Meanwhile, from am activity system perspective, it is seen as a way out of the contradictions between the interactional agency (husband and wife) to resolve social tasks and responsibilities which do not have win-win resolution. In the order of discourse perspective, the different phenomena of this social reality could be a way to create a social critique. While in socio-material perspective, such as expansive learning in CHAT and assemblages in ANT, the resolution (e.g., task shifting in supporting the financial source in a family for resident's family) is framed as a way to create new opportunity, new balance or new social norm.

In the following sections, as the title indicates, I continue the analysis with the third steps of 3D-CDA and discuss how CHAT provides its pivotal contribution in conceptualizing MP in the discussion section. Informed by these theories, in the third phase of 3D-CDA I suggest that CDA could become a means to analyse the dialectical relationships between discourse (mainly expressed in participants' language but also other forms of semiosis, e.g. body language, and visual images) in conceiving MP and other elements of medical specialist practices. This phase is concerned with how discourse determines processes of change, and with shifts in the relationship between semiosis

(discourse) and other social elements within networks of professional practices (Fairclough, 2001; Chouliaraki and Fairclough, 2002). For example, the referring to standard of conduct can be expressed directly by participant “we had a professional behaviour code in this hospital” (RESN1, SSI), or as “I always make sure that my clothes are clean and ironed … and we, woman resident should wear skirt” (RESN1, ITTD). Additionally, this statement is also triangulated in participant’s way of wearing the white coat and skirt during the interview.

Therefore, using h 3D-CDA’s underpinning theories and assumptions, in the following section I chart the social practices through the identified discourses revealed in the text analysis (chapter 5) and discursive analysis (chapter 6) and identify the ideology and power agencies that interplay in the identified discourses. This will include a discussion of the system of knowledges and beliefs, social relations and social identities of the agencies or actors/actants involved in the production and discursivity (influence) of the MP discourses. This discussion is critical in that the discourse may be more or less salient in one practice or set of practices than in another because the contested ideology and power of agencies and, therefore, discourses may change in importance over time. For instance, promoting medical ethics in practice and education has been seen as a priority in improving professionalism for Indonesian orthopaedic surgeon, therefore there is always a dedicated forum to discuss about this issue in the orthopaedic annual meeting. However, in the neurology specialist community, medical ethics is better integrated into practice and assumed to be an important element of professionalism. In this instance, it is important to carefully not to take the role of discourse in any social practice for granted and be patient to follow on the iterative process of intertextuality and interdiscursivity as the core technique Fairclough advocated. This is the key mental process that constructs researcher reflexivity in CDA. I have attempted to visualise these cognitive-reflexivity process in Figure 7-2 .

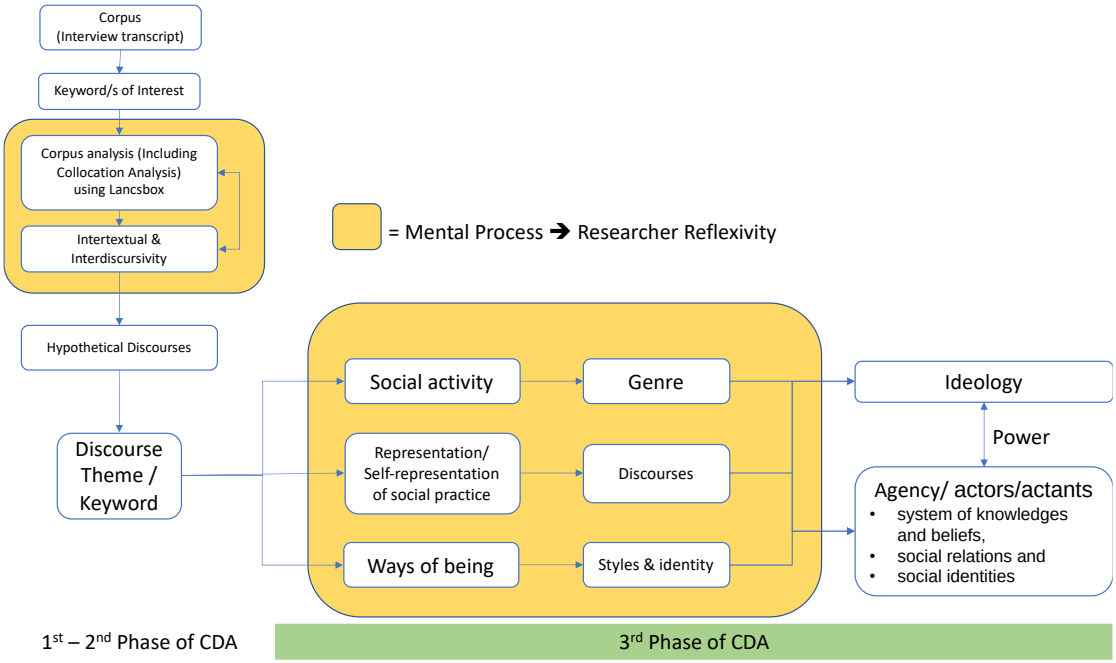


Figure 7-2 A cognitive-reflexivity process of performing 3D-CDA

7.3 Charting medical specialist practice through MP discourses

The first step in this third phase of 3D-CDA is performed by re-interrogating the identified discourses either grouped in traits or knowledge emergence discussed in chapters 5 and 6. The re-interrogation processes were done iteratively by identifying what discourses are latent with inter-agencies conflict (Fairclough, 1992) and what kind of power (influence) and hegemony (Fairclough, 1994) are being exercised. At the end of this iterative and intuitive-reflective reasoning, I came up with seven ideological discourses. This process is illustrated in Figure 7-2

These discourses are 1) competency and competency-based education; 2) professional responsibility and accountability; 3) evidence-based practice; 4) interprofessional collaboration and education; 5) medical ethics, medical and health regulation; 6) spirituality and religiosity; and 7) family institute and brotherhood climate. As explained before, for this third phase of 3D-CDA I apply Fairclough's key concepts of social practice (outlined in the previous section) to the seven discourses in the following sub-sections.

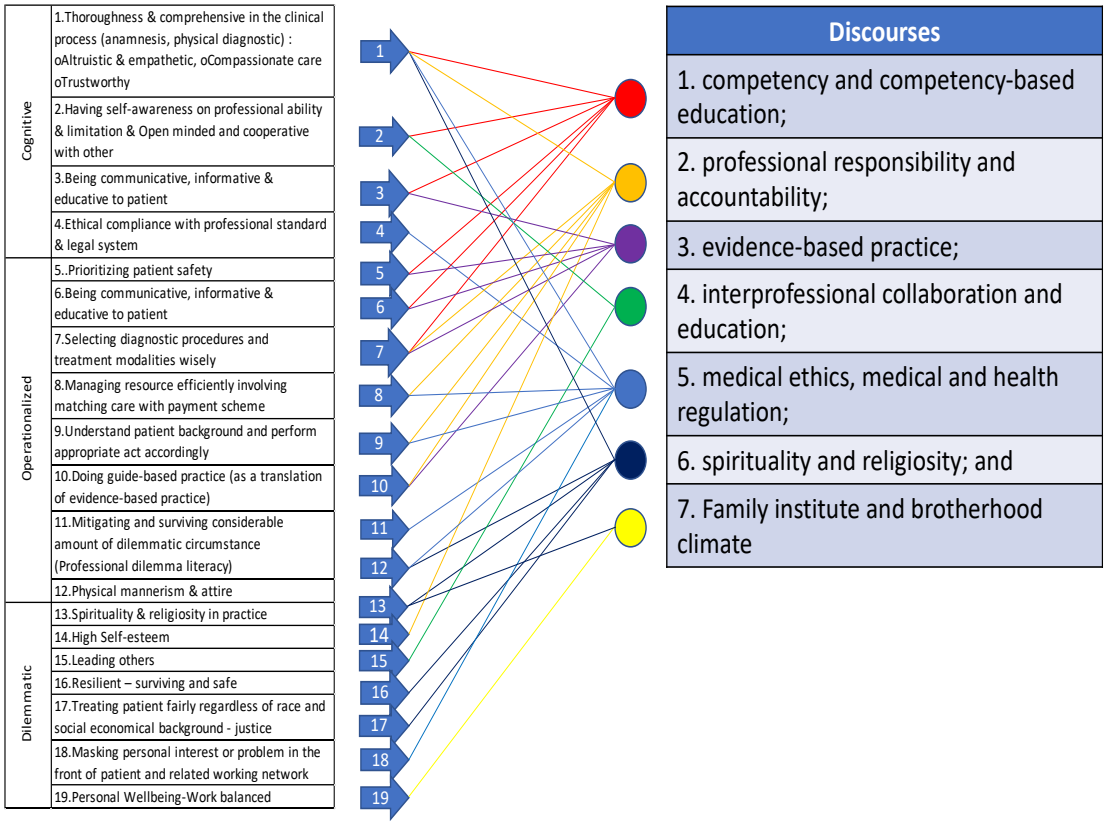


Figure 7-3 Identifying Ideological Discourses from knowledge emergence discourses

7.3.1 MP, competency, competency-based education, and professional learning

In chapters 5 and 6, I have shown that in both specialities, “competency” comes up as a discourse to articulate the idea of a good and professional doctor, and thus professionalism. There are two narratives conveying the relation of professionalism and competence. First, professionalism is conceived as a representation of all competency attainment, and second, professionalism is part of a certain competency framework (Chapter 5, p.16-17). In the first narrative, participants conveyed the idea that the professional doctor or professionalism is a result of all expected ability and traits needed for doing practice. Here, professionalism is conceived as the end condition of competency attainment. This can be seen in MSTO1’s statement when inferring that a good doctor should perform well cognitively, psychomotor and ethically (MSTO, SSI) which is the core component of competency. A similar statement is uttered by MSTN2 during a SSI session in which she refers to professionalism as attainment of competency both in training and in a competency exam:

> “So, the professionalism is after we have completed our education yes, a stage-based education … and then there is the acknowledged professionalism, it is that we are at that level of competence…and there is one more stage to work as a professional doctor, … of being a neurologist, the SpN. Specialist doctors are obliged to take a competency test prior graduation” (MSTN2, SSI).

Furthermore, MSTN2 is also directly referring to the notion that being professional is about attainment of the necessary clinical skills or mastering clinical process (history taking, physical examination, order supporting procedural examination, making diagnosis, decision making, and providing treatment) in specialist services which are already prescribed in the national competency standard:

> “Oh yes, a moment please, there is a book on this ((showing the national standard competency book for neurology specialist)) … So, in principle we will produce a professional doctor, competent, who is able to compete in the international world.” (MSTN2, SSI).

In this explanation, MSTN2, working for many years as a chair in the college of specialist, firmly asserts that the professional doctor is the same as a competent doctor.

On the other hand, some participants conceived that competency is an umbrella term for all the abilities expected of a doctor, with professionalism as one part of this. This means professionalism as a virtue or moral conduct and a humanistic attitude, which is expected to be present in individual doctors when performing their professional duties. The example of how participants convey professionalism as part of competency can be seen when a participant identifies veracity and excellence as features of a professional doctor. Veracity (meaning accuracy, reliability in doing things) refers to comprehensive, accurate, and objective transmission of information, as well as to the way the professional fosters the patients’ or subjects’ understanding (Beauchamp, 1999, p). Additionally, excellence is seen as the highest performance, stressing the “possession of abilities to an eminent or meritorious degree” (Royal College of Physician, 2005 p.17). Some participants report this as: “a thoroughness or comprehensiveness of performing clinical process” (MSTN3, SSI) or “… what we choose to investigate should really make sense …, then “afterwards provide the best management and advice to the patient” (RESO2, SSI). This illustrates

veracity and excellence and composes the ideal discourse in the conception of MP.

Nevertheless, the different conceptions of competency is not our concern in this study. Hence, I would like to expand the discussion on why and how participants offered the competency discourse when asked to reflect on good and professional doctors and professionalism. This is how I identified the nature of professional practice and how professionalism is learned in this form of social practice. To do this, I utilized the intertextuality and discursivity analysis technique on how participants use the term ‘competency’.

The first step, I used LancsBox again to explore the whole corpus (data from MST and RES transcript both SSI and ITTD) how the word “competency” (Bahasa translation: *kompetensi*) is collocated among participants’ words. I found that terms and phrases “national test”, “national standard” and “professionalism” collocate closely with the word “competency” (see collocation graph in Figure 7-4). Figure 7-4 shows the words ‘test’ and ‘standard’ collocate strongly with the term competency which is indicated by the darker node and close proximity with the competency (red node) in the central. This close collocation-proximity (distance) can be interpreted that, during interview, the use of these terms appears significantly more compared to other keywords and therefore forms a particular discourse (McEnery and Hardie, 2012; Brezina, 2018). The calculation result from LancsBox of all interview records, presented in Table 7-1 shows the frequency and statistic measure of the words that collocate with competency.

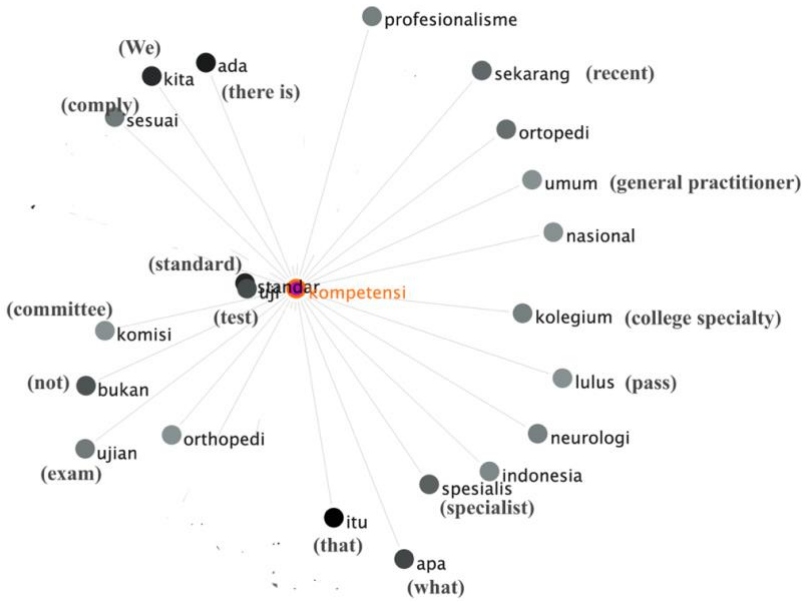


Figure 7-4 Collocation graphic (GraphColl) of '*kompetensi*" (Competency)

Table 7-1 List to show the frequency of words collocating with 'kompetensi' (competency) in Interview corpus**.**

Collocation Position	Collocates	Freq (coll.)	Freq (corpus)
L	standar (standard)	39	123
L	kita (our)	35	4857
L	**uji (test)**	19	28
L	**sesuai (comply)**	8	221
L	**ujian (exam)**	8	294
L	**komisi (comission)**	5	31
R	itu (that)	72	12864
R	spesialis (specialist)	13	456
R	sekarang (recent)	11	838
R	ortopedi (orthopaedic)	10	449
R	kolegium (college)	7	111
R	neurologi (neurology)	7	309
R	**profesionalisme (professionalism)**	7	317
R	umum (general)	5	104
R	**nasional (national)**	5	111
R	**lulus (pass)**	5	155

Note for Table 7-1: Position: L (Left) or R (Right) is informing where the location of the word is to the word competency. For instance: Uji (test) is L, means that the word uji comes before (left) the word competency (uji). Specialist is R, means that word specialist comes after (right) competency; **Freq (coll)**: the frequency of word collocated

with competency; **Freq (corpus)**: the frequency of the word in entire corpus (interview record); bold words in Collocates column are those related with hight-stake exam practice.

Next, I examined each statement and made sense from the meaning and context of how the words are expressed and conveyed to identify the social practice behind the discourses. From this reiterative process, I found that the most frequent discourses on the use of "competency" are about application of competency standards, translating competency-based medical education and national competency examination. From the statement by MSTO1 quoted earlier "…he must be good cognitively, psychomotor, and ethically…" MSTO1 is basically referring to the definition of competency as an educational learning outcome, which is usually presented three outcome domains (i.e., cognitive, psychomotor and affective). This means that some medical specialist teachers who held this particular view had, at an earlier stage of their career (MSTO1 is aged 37 years old), internalized that professionalism and competency are both associated with the implementation of competency-based medical education (CBME) policy, marked by the introduction of the National Competency Standard for Indonesian Medical Doctor (KKI, 2006). Additionally, since both medical specialists (neurology and orthopaedic surgery) are conducting their education alongside their professional service, it can also be said that the understanding and application of competency idea and competency-oriented education has become a critical feature in the development of professionalism and professional learning of Indonesian medical specialist education.

But how is the implementation of competency-based education now being internalized among participants, and how does it influence their conception of professionalism? Two responses which appear in the participants' discussion can answer this question. Firstly, because CBME is a global trend in the global medical education society: developed countries are already applying it. Secondly, because it relates to the issue of professional accountability.

The first reason that global trends and western medical education practice is important might be best represented in the statements from MSTN1 and MST05:

> "… I was invited to Seoul to talk about neurology education in Indonesia and I made a presentation there. This is the curriculum that I built; frankly, I am using references mainly from the United Kingdom…" (MSTN1, SSI)

> " … From the very beginning the orthopaedics was nurtured by foreigners. Foreigners not in the context of ((physical)) colonization yes…So the standard has already been high. Yes, it was fortified from abroad. Nurtured by overseas experts. From Australia, America, and others…" (MSTO5, SSI)

> "…In developed countries, I dare to say, that the cases ((orthopaedic clinical cases)) are mostly simple. Here ((in Indonesia)) we had a lot of advanced cases…once, while doing a fellowship funded by ASEAN in the USA, I had a presentation about a massive tumour reconstruction surgery. They were shocked and made some calls, telling their friends "Hey, here we had an Indonesian presenting a really difficult tumour case. You have to learn from them!" That's what he said." (MSTO5, SSI)

MSTN1 and MSTO5 are referring to western countries as the source of high-standard references to be adopted. These statements are not just referring to the texts in the standard, they also refer to the concepts and practice of western medicine's neurology and orthopaedic 'society' which has been embedded in the adopted standard. Typically, a professional standard, such as an educational standard, is a representation of philosophy, concept and practice produced by a particular professional society. In Fairclough's view, a standard or printed text is a feature of the genres in which it represents the way of acting (Fairclough, 2011, p.121) or represents a product of social life in the semiotic mode (Fairclough, 2001, p.2). The participants are producing a discourse that wester medical education practice is a benchmark, and therefore the standard that applies in western society should be adopted and implemented in developing countries, such as Indonesia.

The statement by MSTO5 regarding the comment from an American orthopaedic surgeon "…you have to learn from them" (MSTO5, SSI) infers a desire for recognition. In this narrative, the adoption of the standard is conveyed not just as a way to scale up the quality of practice in Indonesia but, more importantly, it is also a way that professionals in Indonesia can be recognized in the wider international specialist community, which has been hegemonically influenced by the Western professionals.

Additionally, at the same time, following the discourse about ability to comply and adopt western standards, participants also state that adopting Western standards per se is not sufficient or, indeed, can be problematic in the Indonesian local context. This is because "patients, resources and systems ((health and socio-political system)) in Indonesia are different to western"

(MSTO5, SSI). In his interview, MSTO5 wanted to explain that the professional community in Indonesia has considerable ability linked to the specific presentation of clinical problems amongst their patients. These differ from their western counterparts, for example, the size of the tumour mass they have to operate on. Despite arguing that the example of the advanced tumour mass might be due to the failure of health system to find the case earlier, or due to the limited health resources in the primary health care, MSTO5 contend that the ability to treat the problem has to be an expertise worth acknowledging.

The narrative that the western standard is the benchmark for other (non-western) societies or the desire to be recognized by western society depicts a mindset frequently found in post-colonial societies and developing countries (Hammer, 2005; Bleakley et al., 2008; Ashcroft et al., 2014). The post-colonial mind is even stated explicitly in MSTO5's phrase: "Foreigners, not in the context of ((physical)) colonization, yes". This emphasises that being nurtured is not a form of colonization, the statement itself is even critically confirming that colonization is occurring (i.e., in a non-physical form). MSTO5's statement about the ability to treat difficult cases in Indonesia in comparison with the western situation also features post-colonial thinking. In these narratives, the discourse conveying professionalism as competency is a representation of the current social practice in Indonesian medical specialist education which is influenced by post-colonial ideology.

The second reason why competency is frequently elaborated is because of the accountability. It is evident in participants' narratives that professional accountability relates to two discourses: 1) legal mandate (legal accountability) which is influenced by power external to the profession, and 2) moral obligation (moral accountability) which is influenced by intra-profession power. In the legal accountability narrative, participants agreed that competency attainment should be measured through the national competency examination because it was mandated by a set of emergent Indonesian laws. These laws (e.g., Medical Practice Laws enacted in 2003; Higher Education Law enacted in 2012; and Medical Education Law, enacted in 2013) have brought an emergent regulatory framework to Indonesian medical practice and education and a stricter legal court process for those who do not comply with medical regulations. In contrast,

a few participants advanced the idea that being competent is part of realizing the public's expectation of a good doctor.

The public's expectation of the competent doctor is driven by a sense of moral obligation to secure patient safety. Two participants from neurology (one RESN and MSTN) referred to this moral obligation as "… a realization of a physician's duty to patient" (RESN3, SSI), "realising patient safety (RESN4, SSI) and "a translation of physician oath which had been recited prior granting authority to practice" (MSTN3, SSI). Reciting the physician oath is a ceremony required by the Indonesian Medical Association in order to grant new graduates membership of the association. This second narrative differs from the previous narrative because the elaboration of competency is influenced by the ability of professionals to self-regulate their conduct in order to comply with surveillance system or public accountability (e.g., competency exam, hospital credentialling process, and hospital accreditation). This is a phenomenon indicating that the medical specialist community is currently maintained by external rather than internal regulation.

Prior to the establishment of InaMC and LAMPTKES, there were no publicly available national competency standard and national education standard for Indonesian medical specialists. The accreditation of medical specialists programme was performed internally by specialists' peers in the college of speciality. This was the time when the medical specialist community had the privilege to self-regulate both the medical specialist education and medical specialist practice. Self-regulation is one characteristic of a professional society in which the individual member believes they have an authority and mandate from society to regulate their education and practice (Freidson, 1970b; Larson, 1979; Evetts, 2003). However, after LAMPTKES was established, fortified by a series of government laws and acts, the medical specialist education community was driven to create their public competency and education standard and to run the educational programme and grant degrees. While the competency standard is still exclusively created by the medical specialist community, the education standard, is set by LAMPTKES, involving many stakeholders. The current LAMPTKES accreditation also involves an external assessor (non-specialist background) while the competency examination is still conducted exclusively by the specialist community through

the college of specialist. Since LAMPTKES run the accreditation for the medical specialist study programme (2014), it took almost 5 years for all specialists to produce both competency and education standards, mainly due to enforcement of the accreditation regulation. The study programme cannot take residents or produce specialists if they are not accredited by LAMPTKES. This is interesting because while the number of high-profile malpractice cases of poor patient care and patient safety issues (e.g., unseen patient, manipulating patient data, inadequate medical consultation due to overcrowded patient queue.) precipitated scrutiny from non-medical professionals, the development of competency standard documents and a specialist study programme, which exemplified the quality of the specialist, was so slow progressing. This could be seen as a feature of collective diminishing ability to perform self-regulation among the medical profession.

This diminishing pride in self-regulation due the increased power of an external regulator creates anxiety, and this may be the most plausible explanation for the different tone among participants, especially MSTs, when referring to competency and accreditation. This self-regulation issue also explains why the majority of participants linked professionalism to competency and competency standard rather than compliance to public provision or responsibility to society. Here again, the politic of identity is influencing how participants conceive of professionalism.

Thus, in summary, through examining the competency discourses, a discourse of politic of identity, represented as post-colonialism mindset and collective professional self-regulation anxiety, influences the conception of professionalism among participants in two specialist communities. In 3D-CDA such influential discourse is also called as hegemony. These discourses represent the constant structural internal versus external conflict, known as contradictions in CHAT (Engestrom, 2001) where some cognitive, operationalised or dilemmatic conceptions of MP related to competency discourse are the result of expansive learning of medical specialist subject (participants) toward these contradictions. While arguably these discourses become hegemonic in conceiving MP, as a knowledge product of activity systems, the discourse and conception of MP are dynamic.

7.3.2 MP and formalization of professional responsibility & accountability

In some participants' narrative, professional conduct or professionalism needed to be symbolized into a form of legal acknowledgment. The current practice of a high-stake exam where: "… the acknowledged professionalism is that we have a measure of competence level..." (MSTN2, SSI); and institution accreditation (e.g., teaching hospital accreditation) like in: "… so we have an assessment called OPPE ((Ongoing Professional Practice Evaluation)), … it is part of KARS ((the name of accrediting body)) hospital accreditation" (MSTO1, SSI), are two examples of these narratives. There are two possible explanations as to what might influence the surfacing of this discourse. First, the formalization of professionalism is perceived to be a means of producing tangible evidence for recognition of a profession's existence nationally and internationally and therefore protecting the niche of practice. And secondly, it is a feature of social change in Indonesian medical regulation. I discuss each below.

First, formalizing professionalism as a means of producing tangible evidence for getting recognition, either nationally or internationally. In the neurology specialist context, it is represented in the formalization of the national competency exam. The competency examination is a way to produce tangible evidence to preserve the specialist authority of certain skills and abilities, thus protecting this niche of practice in a health care institute from other competing specialists. For instance, for the neurologists, in managing neuropathic pain (MSTN1, SSI), or rehabilitating nerve injury (MSTN6, SSI). Thus, the elaboration of tangible and legalized professional practice is also a collective agenda of the neurologist community (and possibly other specialists too) to protect the interests of their specialist community.

Another feature of seeking recognition, especially international recognition, can be found in the orthopaedic narrative of holding and preserving the National Board Specialist Examination (NBSE) for orthopaedic surgery residents with the involvement of foreign examiners (MSTO2, SSI; MSTO5, SSI). While this kind of practice also applies to other member of ASEAN Orthopaedics Association (AOA), such as Malaysia and Philippines (AOA, 2021), there is no reciprocal practice, whereby an Indonesian orthopaedic surgeon becomes an examiner in

Singapore, Japan, United States of America, Australia or New Zealand, who supply the foreign examiners . There could be various explanations for this uneven practice. Perhaps it arises because the “Indonesian orthopaedic community is the young one” (MSTO5, SSI), as it was established in 2002 (IOA, 2020), and therefore there is a need for support and mentoring from surgeons from stronger orthopaedic cultures, such as Western nations (MSTO5, SSI). Possibly it is evidence of postcolonial mindedness, where being a developing (oriental) nation encourages the need to adopt standard from developed (western) nation. This can be seen in MSTO5’s statement (see p.14) who comments that orthopaedic educational practice has been nurtured by western surgeons (MSTO5, SSI). This infers that the accountability issue of high-stake exam practice is not merely a professional accountability for the national stakeholder, but also an accountability provision for the specialist community to be recognized by the standard-producing nations.

Additionally, the formalization of professionalism is also a feature of the shift in medical regulation from self-regulatory to external regulation. In the past, the practice of high-stake exams and accreditation of study programmes and hospitals were self-regulated by medical specialist organisations and therefore the result of exam and accreditation was not made public (MSTO5, SSI). However, the current practice of high-stake exams and accreditation (such as hospital accreditation which requires a credential portfolio of practicing specialists) has to be done because it is required by law or the organisation’s regulations (e.g., hospital, Ministry of Health), and therefore the exam and accreditation are made more accessible to the public. The formalisation of professional accountability is more likely to produce a feeling of safety in the public but also means that professional organisation is steadily losing its exclusive right to regulate the conduct of its members (self-regulatory).

Thus, examining the professional responsibility and accountability discourses from participants has revealed the current situation of the professional community’s governmental accountability. This involves showing how a knowledge-based expertise discourse emerged as a narrative to secure the niche for practice amidst the tight competition of the service market and the development of new medical specialities and sub-specialities. Examining the professional responsibility and accountability discourses has also again

revealed the decline of Indonesian medical specialist self-regulatory privilege through the more powerful effect of external regulation on medical specialist practice. The examination of professional responsibility and accountability discourses in both neurology and orthopaedic surgery specialist enable us to surface the role of an influential medical teacher as role model, medical specialist professional organisation (both college and specialist organisation), Indonesian Medical Association, medical regulation and medical and health regulatory bodies as agencies involved in the emergence of conception of medical professionalism.

7.3.3 MP and interprofessional collaboration and education

One emergent feature of professionalism is the ability to work and communicate with other professions in a healthcare team. (Cooke et al., 2010; Frenk et al., 2010). Therefore, in all SSI sessions and ITTD I tried to prompt discussion about this issue. However, unlike other issues such as competency, morality and ethics, issues about collaboration with other professions were limited to the provision for working with other medical professions (other medical specialists) and this is possibly the main discourse of how participants related professionalism and collaboration with other professions. There is a sense that the majority of participants struggled to see the benefit of realising interprofessional collaboration in practice, possibly because of a perceived social hierarchy within the binary medical and non-medical professions. In turn this contradicted the promising hopes about the importance of collaboration with other health professions presented in some Indonesian studies on interprofessional collaboration (Findyartini et al., 2019; Sari et al., 2020).

Reflecting on one MSTN participant’s statement, "you were taught to be the leader of others" (MSTN3, ITTD) or "you are trained to be leader (MSTN4, SSI), reminded me of my own experience in a private clinic where the doctor was perceived to be the one who had to know everything about health, including the false perception that we could do everything, and better, than other health professionals. The truth was, we never had an opportunity to even know in detail what other professions did do due to the burden of achieving our own tasks and responsibility. So, in the workplace, doctors tended to ask for help from others only if they needed help. Other professions might think they are not needed if they are not asked. In fact, the burden of patient care has

increased due to the rise of patient beds and hospital services, while the number of medical doctors and other health professionals stays the same.

Some participants asserted during SSI that collaboration with other medical specialist professions is important to achieve optimum benefit for patient welfare (MSTN5, SSI; MSTN4, SSI), and therefore this would be able to "…reducing the amount of ((individuals)) working burden" (MSTN6, SSI). However, in practice, disclosed during ITTD sessions, the issue about inter-professional collaboration, especially between medical specialist (residents) with non-medical professions, such as nurses, dietitians, or pharmacists, has not been well established and nurtured. This inconsistency of idea and practice of inter-professional collaboration is found in both neurology and orthopaedic surgery participants. The lack is greater compared to the sense of intra-professional collaboration (i.e., working with other medical specialists). The narratives conveyed in ITTD among residents give succinct illustrations of what happened. Residents asserted in ITTD they were not used to perform a designated collaboration services while there should have been a chance to do this. Excerpts from neurology and orthopaedic residents reported that interaction with the nurses responsible for caring for their patient was not a routine and mandatory activity in their residency task. This phenomenon happened across different study programmes / teaching hospitals (Note in the following excerpts, RESN5 and RESO1 are residents from different study programmes / teaching hospitals):

> RSB: Yes. Is that the typical pattern for your patient follow-up? Aren't there nurse being involved?
> RSP: Only if we were going to add therapy or if for example, we wanted to ask for something to be done ((by the nurse)) then we will coordinate with the nurse later on.
> RSB: So, during patient follow-up time, it is not common to ask nurse to join along?
> RSP: No (RESN5, ITTD)

> "The nurse, if we are doing patient visit usually ((they)) do not involve…They are not joining us. They are usually staying in the nurse station. It is us alone that used to go to the patient or patient's families" (RESO1, ITTD)

A nudge by the researcher towards the area of interprofessional collaboration (IPC) and interprofessional education issue did not elaborate much discussion among participants about how residents and other health professionals interact.

Participants were mostly aware of the importance of collaboration with different profession in the patient care, however in everyday practice, interaction with different professions seemed not to contribute to conceptualisation of professionalism in the specialist professions except on two issues. First, the emergent provision to assess professionalism among residents requires an assessment to be made by a health professional, usually the head nurse. Second, the vision to develop collaboration with health profession (other than medical profession) among medical specialist mostly still positions medical specialist in the dominant social roe in the healthcare team. This is surprising given the campaign in national and international hospital accreditation inspired by WHO Patient Safety guideline (WHO, 2009; WHO, 2011) or what is advocated by CAIPE (The Centre for the Advancement of Interprofessional Education) in its guidelines (CAIPE, 2015) which stress the importance of IPC and demand more horizontal relations between medical and health professions.

One frequent feature of the discussion of professionalism among participants in relation to other health professionals is the application of 360-degree multisource feedback (MSF). This assessment method requires residents to have a formal (written or scored) evaluation from superiors, colleagues, and different health professions. Some participants reported that the health professional completing the 360 is frequently and solely represented by the ward head-nurse. This made the relationship between the nurse and resident formal, especially when MSF in some study programmes functioned as a requisite for passing and upgrading the level of residency and entrustment.

> "…but actually, the judgment for that ((attitude)) assessment are two. One is formal marking, and another one is the annual assessment that we are judged through the three-sixty (360). So, this three-sixty we are evaluated not only by seniors ((supervisors)), but also from nurses." (RESO5, SSI)

While this activity is seen as a positive endeavour for compliance with patient safety provision in hospital accreditation and an international trend in professional assessments, in everyday practice, residents see this as no more than a formality to pass their residency. In the following excerpt, RESN5 did not even take into account this collaboration, since the supervisor's evaluation of the patient interaction carried more weight than that of the nurse:

> RSP: Hmm, well, I think everything, since one of the supervisors also see how we interact to them, and during round they also see how we interact to the patients, and also usually ((getting information)) from the nurse. They (the nurses) will provide reports on our performance during daily life.
>
> RSB: Daily life?
>
> RSP: I mean all of the things in everyday working life, possibly. but I do not much know and care about this ((things that nurse is reporting)) … the most fatal one is if we got bad evaluation while we interact with patient from supervisors (RESN5, SSI)

Furthermore, in the keyword exploration (using LancsBox) of the elicitation of the existence of other professions during all conversation in SSI and ITTD, only nurses appeared as the significant other profession in participants' discourses. This did not mean that other professions were not mentioned in the conversation, it is just the discussion about other professions (dietitian, pharmacist, surgical assistant, etc.) did not create sufficient meaning (absent discourse) related to professionalism. This discourse might indicate the strong power position of the medical profession and therefore creates a typical vertical inter-professional communication between medical profession and other health professions, which is mostly represented by nurse in this study. This is even represented (unconsciously) in the use of language of one sympathetic resident when describing the nature of everyday relations between doctor and nurse:

> RSB: "That time, when supervisor doing patient visit, will the nurse join the visit?
>
> RSP: "Yes. Usually, we performed patient visit with the supervisor, there would be nurse who brought supplies, reports, medical record folder, request forms, signature forms, ((the nurse used to say)) "Doc, the medicine for this patient need to be reordered…" (RESN3, ITTD)

RESN3 unconsciously provided the feature of a common practice where the nurse is providing assistance to doctor. This is represented by an acceptable role of the nurse to bring the medical record folder, medical equipment (stethoscope, fundoscopy), while performing patient visit, especially with a consultant. This indicates that, even for the resident, the role as leader /master in the healthcare team is the normal role of the medical specialist either as supervisor or resident in everyday practice.

> "Remain important skill, in my opinion anyway, is the leadership Doc. So for example, when we graduated, we will be the leader, mainly in the operating theatre. Even there we gain help from nurse, anaesthetist,

> instruments, and others, still, we are the leader of the team. This is also applicable in front of the patient's family ((ambulatory care)), for example if our assistant nurse made a mistake or treated wounds badly, it is our responsibility as the leader." (RESO4, SSI)

In the context of the medical and health profession in Indonesia, this lack of inter-professional collaboration l among resident practice offers a different view from the literature on inter-professional collaboration. However, those studies were performed in undergraduate medical education, general practice or other health professional contexts (Findyartini, et al, 2019; Sari et al, 2020; Hastuti, et al, 2020). Considering the explorative nature in this study, the result on IPC theme needs to be further investigated, especially on how it affects undergraduate student learning during the clinical phase and about the importance of interprofessional collaboration in effective healthcare delivery in the country.

Thus, in this section, examining the interprofessional collaboration discourse in the participants' narrative helps to identify the dominant view of the health profession's role in the current specialist services. While the relation to other medical profession tends to be horizontal / mutual, the narratives to non-medical health profession tend to be vertical, putting the medical specialist over the health professions through the leadership discourse.

7.3.4 MP and evidence-based practice

In chapter 6, I argued that evidence-based practice is a desired and operationalised / institutionalized trait of the professional doctor. It is operationalised through multi-layers of regulatory frameworks of the Indonesian healthcare system and medical services, thus representing the emergent hegemonic discourse in medical specialist practice. There is a good reason why this becomes a hegemony: the 'governmentality' practice. In his book, Foucault (1973) indicates that governmentality is a mentality of rule, or a logic governing the conduct of health professionals that is shaped by broader socio-political relationships (Foucault, 1973) and this type of governmentality seems to be global phenomena affecting health profession societies, with a possible difference in agencies involvement and power gap circumstance (Martimianakis et al., 2009; Martimianakis and Hafferty, 2013). I found this governmentality discourse existed in participant's narratives of evidence-based practice, and

there is an indication that this discourse occurred both internally within the profession and external to the professional community.

Inside the profession, evidence-based practice as a governmentality discourse manifested through the way the specialist profession association developed to protect the subject-based expertise and at the same time mitigate conflict among specialists who shared the same expertise. This narrative surfaced in the creation of academic white papers of particular skills or expertise:

> "We are currently preparing the competency standards, education standards, what else, the sub-specialists, and all are coordinated by KKI, the Indonesian Medical Council. They (in KKI) are the guards to prevent internal clash between specialties. So, it turns on what we called the white paper. The white paper contains academic and evidence-based elaboration of what we can do and later this will be used to discuss with other conflicting departments ((speciality)). It is already regulated by KKI and one of the models is neuro intervention."(MSTN1, SSI)

This type of internal governmentality also appeared as a control mechanism by the elite members of the specialist professional association on the ordinary members. In neurology, this narrative surfaced in the case of creating a national standard for performing neurology examination for practicing members and residents. The standard or book was drafted by a group of specialists working at the same institute of the college's chair, who thought that the skills' teaching at other specialist programmes had been below standard. Therefore, an evidence-based guide was needed to scale up the quality of the majority of college members, who mostly worked at town or rural hospitals.

> "…after that, a book on physical examination was also made. You know physical examinations in neurology are a lot really. Many of our staff have been involved in the College as examiners, and we saw every centre of training had taught a different method to perform the physical examination including the interpretation. We felt sorry for the candidates. That's why we decided to create a book for minimal standardized techniques of physical examination. It turned out, at one of the College meetings, this idea evolved to create a national reference for all" (MSTN4, SSI)

By contrast, in orthopaedic surgery, this narrative of governmentality is to maintain the balance of service between the primary and referral hospital because of the lack of regulation of private practice by orthopaedic surgeons practicing new advanced techniques that were learnt from individual courses abroad.

Evidence-based practice is also presented as governmentality of specialists, represented by specialist associations or colleges of specialists lobbying the external agencies of the profession organisation (e.g., hospital authority, insurance agency, non-medical health profession, etc.), especially to protect their authority to perform certain medical expertise or intervention modalities (e.g., specific medical prescription, diagnostic or treatment procedures, etc.) in the health-service organisation. The importance of this is to secure the financial income from the knowledge and evidence-based ability:

> "… the development is greatly influenced by BPJS ((*Badan Penyelenggara Jaminan Sosial* - The government agency responsible for managing public health security or insurance)). Yes, ((BPJS requires)), if it's not like this then it ((the health service fee)) won't be paid… Finally, yes there is this external factor, how to say it, the pressure from BPJS, they demand that the education should ((have evidence)) that it already taught this and that" (MSTN1, SSI)

> "PABOI ((the association of orthopaedic surgeons)) will accommodate the development of science related to services. As the counterpart, PABOI had a collegium ((college of specialty)) to oversee from the educational side. Depending on the flexibility of the hospital authority, they ((PABOI)) use this science review to advocate to the policy maker and to the hospital manager, whether something ((new procedures or technologies)) can be deployed. (MSTO1, SSI)

Thus, evidence-based practice discourse across neurology and orthopaedic participants might indicate two possible existences of self-regulatory practices. First, this might indicate the form of governmentality of a profession's association to its member through creating stratification in internal specialist peers. This is because the guideline is also about who has rights to do what under sub-speciality expertise. Second, this might also depict the defensive practice of the specialist community to retain the privilege of its specialist knowledge and skill and preventing others from entering and sharing the fruit of secure specialist practice.

7.3.5 MP, medical ethics, and medical & health regulation

Exploration of MP inevitably brought up the medical ethics discourse which is addressed both by neurologist and orthopaedic participants. In many instances of participant's narratives, medical ethics is conceived as a component of MP. The majority of orthopaedic surgery participants even conceived that MP is exclusively about medical ethics (chapter 6) while this is a rather more nuanced discussion with neurology participants. Analysis with LancsBox supports this

difference by showing that the collocation of term ‘etika (ethics) and ‘profesionalisme’ (professionalism) is more frequent and closer in orthopaedic (15 collocations) participants than in neurologists (2 collocations) illustrated in Figure 7-3 and Figure 7-4 This collocation analysis result suggests that “medical ethics” is systematically more associated with the term “professionalism” and more elaborated in orthopaedic surgery participants than in neurologist participants.

Figure 7-5 The collocation of ethics (etika) and professionalism (professionalisme) in a corpus from orthopaedic surgery interview

Figure 7-6 The collocation of ethics (etika) and professionalism (profesionalisme) in a corpus from neurology interview

When discussing medical ethics, most participants refer to the “code of ethics” document issued by Indonesian Medical Association (IDI) which has been written mainly under the four principles of medical bioethics (principlism) of

Beauchamp and Childress (2011) - *beneficence*, *non-maleficence, autonomy, and justice*. The IDI's code of ethics consists of statements that are unchanged since its first version in 1969 as internal regulation of medical doctor society, including forms and mechanisms of disciplinary punishments for members who transgress the code of ethics. This is possible because IDI is the only professional organisation for medical doctor authorized by the Indonesian government. Protected by Health System law, it is mandatory for all Indonesian doctors to be an IDI member in order to be granted their licence to practice. This means IDI, especially the chairs, hold huge political influence in the Indonesian medical society in which the code of ethics has become the major governmentality tool for the professional organisations for decades. This at a glance seems to be the understanding that is conveyed cognitively by most of the interview participants.

However, as many participants further elaborated, the compliance to medical ethics (enacted in IDI code of ethics) only is not enough to shape the professionalism of medical specialists. This is conveyed by many conflicting statements of participants commenting that despite the adequacy of the current teaching-learning on medical ethics, this did not lead to conformity to the expected professional conduct of residents nor practitioners in everyday practice. Among residents, the education rules, hospital rules or applied professional organisation rules that directly applied in their everyday professional life are seen as a much more powerful driver of their conduct than a set of ideal medical ethics prescribed in the code of conduct:

> "There should be a relevance. Because by studying it we would know our limitations legally and ethically. Well, that is, maybe it is that we are lacking, very lacking. Honestly, I also had forgotten. Because the last time I was studying about the medical ethics and law is at S1 ((Undergraduate)). (RESN, SSI)

> RSP: "…because if the ethics and professionalism, we may already have an image that it is like in the Civic course ((at primary school)) when we just choose the best deed answer for what must be done. Maybe because of that, when it turn to the question of teaching, roughly it is what it is."
> RSB: "and that's different from the real conditions in the field, it does not like what it teach?
> RSP: "yes"
> RSB: but there are events during orthopaedic annual conferences about ethical matter or ethics course, aren't there?
> RSP: "That I still haven't come along and really delved into it.

RSB: “Why?”
RSP: “There are many other things I need to prioritize” (RESO5, SSI)

This is possibly why, in orthopaedic surgery, a formal reinforcement during practice or training through frequent exposure to and reflection on real critical incidents or seminal events has been thought to be a more powerful way of raising awareness and learning events for residents and participants to understand the importance of upholding ethics and professionalism in practice (MSTO1, SSI; MSTO2, SSI). Additionally, in neurology, this reinforcement has been sought through the implementation of a professionalism checklist in residency levelling up assessment and in high-stake assessments (national competency exam) as “ …a requirement for getting certificate of competence” (MSTN2, SSI). This gives an insight that a direct oversight from external agencies, such as current multi-layered surveillance regulations (i.e., school, hospital authority, senior specialist and resident organisation’s regulation) are more powerful to nurture professional conduct than the internal self-regulatory mechanism of an individual. This phenomena reminds me of Prof. Jordan Cohen’s statement from the preface of *Measuring Medical Professionalism*: "They don't respect what you *expect*; they respect what you *inspect*" quoted in (Stern, 2006, p.v). In this statement, Prof Cohen highlights the importance of assessment (continuous performance measurement) to nurture professional conduct.

The view of medical ethics and code of ethics as a governance tool (governmentality tool) of the medical profession, which was frequently expressed by participants, has long been discussed in academia, especially among sociologists. In the sociologists’ view, a code of ethics has been an internal regulatory mechanism for individual medical professionals to “internally” guide their conduct (autonomy) which in turn characterizes their communal identity (Freidson, 1970a; Larson, 1979; Starr, 1984). However, this mode of governmentality practice which long has been guarded by the political lobbying power of the medical profession, has been spoiled by the conduct of chairs or renowned members of the organisation themselves (Larson, 1979; Evetts, 2003). These high-profile cases of misconduct have caused distrust to the code of ethics as well as the erosion of self-belonging of its members to their organisation. Consequently, some physician members seek guidance from

stronger organisations, such as specialist groups, or just rely on more powerful external regulatory mechanisms, such as legal and care organisations or other independent multidiscipline health-professional group. This is one of the reasons identified to explain why membership of medical associations in Western countries, such as the American Medical Association in the USA, declined significantly in recent decades (Collier, 2011). In the Indonesian context, given that resigning as IDI member is an impossible choice due to the national practice regulation that requires all medical practitioner to be active member of IDI, discussion about the diminishing power of IDI's code of ethics as a single governing guide of conduct is profoundly present in participants' view.

> "…but now, people don't understand what doctor's oath is, right? So there we needs for a same language ((to deploy further)). That's why now patient safety has become a prominent issue. But actually the patient safety things were already included under the doctor's oath, right? Well, unfortunately between us ((medical doctors)) sometimes have forgotten or then we really have a situation where we cannot live the oath of our doctor well. As ((a situation)) with the BPJS ((national health insurance scheme))." (MSTO3, SSI).

In speaking about this insufficiency of internal regulation, participants looked to the immediate and more tangible governance of conduct, such as specialist's convention or in-workplace regulation such as hospital or health authority regulation.

Thus, the medical ethics discourse has brought to the understanding that there is a shift in how specialists maintain and uphold their professional conduct from self-discipline governance of code of ethics to a preference for more external and tangible surveillance brought by external regulatory and legal framework.

7.3.6 MP, spirituality and religiosity

In chapter 5, spirituality and religiosity (S/R) theme appeared as a characteristic ascribed to a professional doctor. The text and collocation analysis through LancsBox showed S/R keywords such as *Tuhan* (God), Allah, *ibadah* (worship), agama (religion) and *pengajian* (religious lesson) were used by both neurology and orthopaedic participants. However, in contrast to ethics, the S/R keywords are more elaborate in neurology compared to orthopaedic surgery. Among the

four keywords, keyword ‘Ibadah’ can be traced only in orthopaedic surgery (see Table 7-2. Tracing further these S/R keywords in both SSI and ITTD, they are clearly indicating a critical discourse that influenced the conception and practice of medical professionalism.

Table 7-2 The S/R keywords to and its collocation with professionalism

	Ortho			Neuro		
	Freq	**Fr**	**COP**	**Freq**	**Fr**	**COP**
Tuhan (God)	0	0	0	13	0.64	2
Agama (Religion)	1	0.06	0	50	2.47	12
Pengajian (religious lesson)	4	0.24	0	21	1.03	7
Ibadah (worship)	7	0.44	0	0	0	0
Spiritual	1	0.06	0	13	0.64	5

Notes on Table 7-2: **Freq**: frequency absolute entry in corpus; **Fr:** Relative frequency; **COP**: collocation with professionalism.

The S/R manifested from individual-informal to communal-formal discourses in the medical specialist’s life. It is an individual-informal because it appeared as a personal worldview and a communal-formal because it also appeared as a form of governmentality to rule the conduct of individuals in the specialist community of practice. This section describes and argues that that S/R discourse is grounded as social practice and also formed the identity of an Indonesian medical specialist community that influences the conception of medical professionalism.

As a personal worldview, S/R has inspired the conception of good and bad conduct that influenced professionals in performing medical practice (i.e., treating patients). This has been conveyed by participants through the concept of *ikhlas*, *ihsan* and *tawakkal. Ikhlas* means doing things just to seek the afterlife reward from God, thus putting aside any praise or material reward from human beings. This appeared in this participant’s narrative:

> “…but if we, say, have less sense of religion, our relation with the patient would be chasing, not for the wellbeing of the patients and not for God's blessing nor for the safety of the patient, but, for example, the pursuit of money” (RESN3

Ihsan/ehsan means seeking the perfection of deeds for seeking love from God and thus wishing a promise to see the God in hereafter (Al-Eraky et al., 2014).

This is beyond Ikhlas which is still about seeking promised virtual reward. The concept of Ihsan is conceived directly by prophet Muhammad p.b.u.h as it is narrated in an authentic hadith “doing worship as if you can see Him (God), if you cannot see Him, then pretend He is seeing you” (Muslim, 2007. p.76). From this transcendent nature of action, it is expected that God’s spirit will accompany, guide and provide happiness for life in the world (baraka/barokah) and in the hereafter life. These Ihsan and baraka are among popular concepts of esoteric spiritualism (*sufism*) in Islam (Nasr, 1977; Schimmel, 1994; Schimmel, 2011). This was expressed in the following participant’s narrative, which regarded the professional life as part of worship:

> “But I'm sorry to say, we've had doctrines from the beginning, work is a worship. Every step of our life is worship, not work for sustenance. That's ((sustenance motive)) wrong. So, I'm just saying this, if your work orientation to find sustenance, you may get the money, but you will not get the *barokah*, because of what? If the orientation money you may hit your own friend, can step on ((exploiting)) the patient. Will get a lot of money, I'm sure a lot, and that's an example here. But his family was a mess, he has no friends. That's why the concept is the work as a worship. If you regard work as a worship means *you are working as good as possible*, because there you will get the best *barokah*, blessing in life and hereafter.” (MSTN5, SSI).

Additionally*, tawakkal* is submitting all deeds and efforts being done to the Almighty (God), usually in any uncertainty or risk taking circumstance. The *tawakkal* also means a commitment to an unreserved acceptance of what happened next (good or bad situation) after a best effort or decision-making. This surfaced in a participant’s example of the closure of fontanelle after the first separation operation of a head Siamese-twin case in Indonesia. The MSTN1 who told the story highlighted how the confidence of the Indonesian neurosurgeon who did the job was due to a strong transcendental belief -*tawakkal*- to God.

> “…I told that I have Gusti Allah ((Javanese words to praise the name of the Islamic God)). The problem has been handled by Gusti Allah. Gathuk ((the fontanelle was closed)). (MSTN1, SSI)

As a public discourse, elicitation of God and religious virtue has been incorporated into social activity or medical specialist and residency daily life. This practice is most likely the one that triggers a conflict about whether S/R is a

personal issue or a *public* aspect in professional life. Among the majority of Muslim teachers and resident level participants, holding religious-based activities along teaching and service activity is perceived to be a common thing, and even, in one instance, participants felt obliged to hold and attend it because S/R is an integral part of life and therefore critical in developing professionalism and balanced-services (MSTN2, SSI; MSTN3, SSI; MSTN3, SSI).

> "…At the Internal medicine Dept there is also my colleague, a professor with doctoral degree is holding the lesson ((routine preaching))…Usually every Friday. Yes, later this brings a calmer attitude, better character yes, bring more positive manners to us ((staff) and residents." (MSTN2, SSI)

> "We don't have it ((a formal religious teaching like in undergraduate)) here, in specialist training this is not present. But if in order, for example during Ramadhan month, we encourage residents to hold religious preaching and other religious activity…That's what it is, yes for any religion, I'd say religious education is important." (MSTN6, SSI)

However, for some Muslim and non-Muslim minority residents, this activity is seen as a voluntary matter and not related to professionalism teaching. This is possible because there seems to be informal religious-based discriminatory practice in some medical specialist programmes as indicated by some participants (RESO5, SSI; RESN4, SSI).

> "Neurosurgery is really religious. **Those that are not Muslim, are usually a bit difficult to get in** ((to be accepted as resident or staff member)). Here ((in orthopaedic surgery department)) it is still okay, though they prefer the Muslims, but it's good that non-Muslims could still be involved" (RESO5, SSI)

Following a participant's recommendation to read the specialist competency standards, I found that in these particular standards S/R has been conveyed as one or two competency descriptors because it was mandated by national education standard. Interestingly, while there is an explicit mention of religious keywords in orthopaedic surgery and national qualification framework document, there was no entry nor an explicit statement about S/R in neurology national education standard. However, I found that S/R descriptors have been enacted in the study programme as an educational standard, as detailed in Table 7-3:

Table 7-3 Competency statements depicting S/R discourse

Neurology	Orthopaedic surgery	Indonesia National Qualification Framework level 9
No mentioning about S/R in national education standard but present in Competency Standard in Study Program level such which adapting IQF level 9: The specialist neurology graduate is expected to: a. Be pious to the God Almighty *(Bertakwa kepada Tuhan YME)* (Competency Standard of Neurology Study Program of Faculty of Medicine Brawijaya, 2017,p.15)	Providing a professional medical practice that is in accordance with values and principles of **spirituality**, noble morality, ethics, law and socioculture. *(Melaksanakan praktek kedokteran yang profesional, sesuai dengan nilai dan prinsip ketuhanan, moral luhur, etika, disiplin, hukum dan sosial budaya)* (Indonesian Medical Council decree No.67 Year 2020, about Education Standard for the Profession of Orthopaedic and Traumatology Specialist, page.90)	General Description: a. Being pious to the **God Almighty** *(Bertakwa kepada Tuhan YME)* e. Respecting culture diversity, view, belief and **religion** and also other original view / finding of others *(Menghargai keanekaragaman budaya, pandangan, kepercayaan, dan agama serta pendapat/temuan original orang lain.)*

This legal enactment of S/R allows medical specialist education organizers to recognize S/R discourse as a means to empower a vision for specialist training, and thus professional development. All of this practice phenomena demonstrates that S/R is not just a local phenomenon captured during interview sessions but part of the wider national culture and belief system that influences the social practice, such as professional medical specialist education.

Thus, whether it is an individual-informal discourse or communal-formal discourse, S/R has influenced medical specialist individuals in conceiving and practicing professionalism in their professional practice. The absence of a unitary interpretation of legal practice in specialist educational practice, and the flexibility of competency-based education, let the influential medical teachers and medical specialist training organizers and also the standards of specialist education become critical agencies in exercising S/R as a mean of reshaping professional conduct of residents and other specialist (governmentality).

7.3.7 MP, family institution and brotherhood

A discourse on the importance of family institution and the creation of a brotherhood climate to support professionalism development has emerged in both neurology and orthopaedic surgery participants. I am using “family institution” to refer to the common social institution used in sociology to articulate the relation of an individual with his/her nuclear family, which typically consists of husband, wife, father, mother and first line generation children. Additionally, the term “brotherhood” is to articulate a wider family-based relation, or kinship, mentioned with particular meaning by some orthopaedic surgeon participants. There are three discourses on family institution and brotherhood that related professionalism and professional conduct.

Family institution: welfare as a goal of life

A common narrative highlighted that family matters are personal issues that must not interfere with professional duty:

> “Patient is always number one ((priority)), but on the other hand, for example, we have kids. I mean as a female doctor, I think that the burden for a female specialist is much heavier than for the male. For a male doctor, treating the patient as the number one will not matter because there is his wife who will take care the kids and so on…” (RESN4, SSI)

However, it is interesting to note that some participants were strongly asserting that the family institution is one of the important goals in their life and, therefore, conflicting with professional duty – fulfilling demands from the family institution might be prioritized over professional duty.

> RSB: “For example, there is a conflict between family and task at the hospital, what is the priority, then?
>
> RSP: “Family. We gained success in the hospital but our family is broken, what’s that for? Family, first. Any problem, solve it first. How can we serve good care if our family is in a mess? For hospital task, if it is in a mess, we still have next semester, can be fixed in the next term. But if the family is broken, how we will fix it? It cannot be repaired, …For me, family is everything, it is all started from the family, ended up in the family. (RESN3, ITTD)

Moreover, due to the importance of the family institution, it has been a core topic for discussion and consideration in the resident admission process.

> **During the admission interview, I was asked about this thing ((family dilemma))** … In fact, this is applied in real resident life…((once)) Another supervisor said “That's okay, the reason we're all here is for

> family. If anything happens, I will be your back up, finish your concerns with the family. After all, family affairs like this do not happen every day, don't they"? He thought this is not just about giving support, this is even a duty, "you must make your family happy!" (RESN3, ITTD)

Family and brotherhood as psychological support for balancing workload burden

Family and brothers (peers) are frequently expressed as the first reference where MSTs and residents are seeking support or balancing their professional burden. For example, MSTN4, a female senior neurologist, asserts that functioning role as a wife sometime felt more oblige to her to balance the wellbeing.

> RSB: "To reduce boredom from your routines, are there any tips and tricks in order to not get bored? "
>
> RSP: "Yes, it gets boring sometimes, but we have an on-leave, right. So, my husband often went out of town or going abroad as well, ... well, he is a lecturer as well, but not a physician. Anyway, having a presentation abroad, in that case he frequently wanted to be accompanied, … as a wife I am obliged to accompany my husband … And actually, I am the one who is happier being with my family, so what makes me happy is if my family are pulling together, compared to a meeting at a reunion event. I don't know what would you call that, anti-social or what, ((laughter))... But, my feeling, I am happier if I am with my family, I already had grandchildren, so I am with my grandchildren, it makes me very happy, anyway." (MSTN4, ITTD)

The same views are also shared among orthopaedic participants:

> RSB: "I'd like to know what it was, all this time, that makes Doctor Rz able to balance and survive the burden of work?
>
> RSP: "For me personally, yes, it is my family, Doc! I go home and there is a family. (RESO1, SSI)

Another orthopaedic surgery participant also argue that family support influences the quality of professional works of the resident:

> "Maybe in my observation, some of my friends, yes, they have family, say their wives are supportive, they tend to work professionally compared to those with demanding ((emancipated)) wives (RESO5, SSI)

Family and brotherhood as a governance of conduct

The term family and brotherhood are referenced by participants to indicate an intention to establish a friendly and positive training climate.

> “So, every PPDS, resident, has an academic mentor in which we always emphasize: “they ((teacher-mentors)) are your parents here. That means if you have a problem you go to the PA” (MSTN6, SSI)
>
> Brotherhood, yes brotherhood. So, we're a family. So as if a gap, not the gap eh yes, what is it, the barrier between those very seniors and junior, like Prof. H, and me for instance, is thin. Or for example, like doctor I ((senior)) and doctor E ((junior)), they are equal and égalité. So, this is what happened with the resident too … So, with such a pattern we expect them to share more problems either in studying or working…” (MSTO4, SSI)

However, this is also how the training director and teachers establish authority and hierarchy as a specialist community in training, where parents and elder brother – senior specialist / senior resident, show respect to the younger brother – junior resident/junior specialist. This can be seen in participant’s statements about how a response from or method of communication with a resident needs to be shaped.

> “There is a resident that every time we gave any input, he answered, he replied, he argued … When we asked every staff member about this resident? “He is stubborn, bla-bla-bla, if we advised him, he kept answering continuously.” (MSTN6, SSI)

The governance of conduct behind the family and brotherhood discourse can be understood because commonly the interaction between members in Indonesian family institutions is more vertical than horizontal, and in most cases in participants’ view, is also patriarchal. This is portrayed by how parents and older members in a family have more authority and are respected by the younger members. Some participants refer to these values as a part of an internalization of Javanese culture: “… this Faculty of Medicine is in Java, and mostly inhabited by the Javanese, therefore those ((residents)) from outside Java originally had to adjust to the culture here.” (MSTN4, SSI).

The Javanese culture has long been studied as the dominant and hegemonic culture in socio-politic of Indonesia (Geertz, 1979; Koentjaraningrat, 1985). In a dominant Javanese tribe culture, vertical interaction is symbolized by different language use (e.g., from younger to elder) (Koentjaraningrat, 1985) and physical mannerism during interaction such as kissing hand to the parent and elders (*salim* or *sungkem*) or bowing or putting hand together in the front (*ngapurancang*) (see figure 7-6 for a clearer illustration).

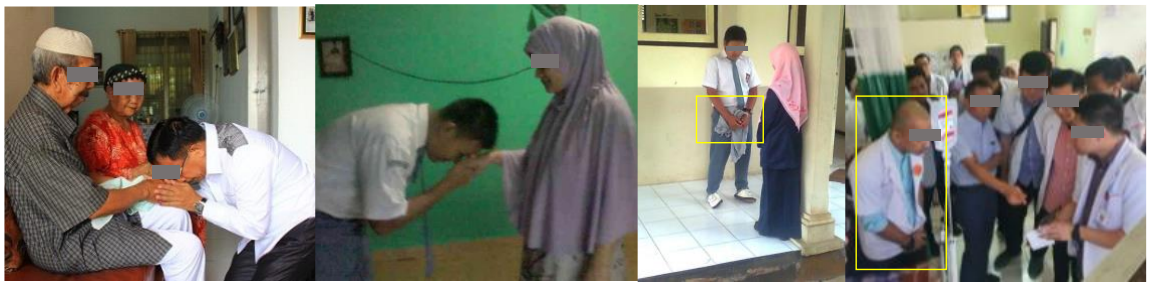


Figure 7-7 A visual depiction of *salim* and *ngapurancang* customs

Notes of Figure 7-6. A1 & A2: *salim* or *sungkem* position; B1 & B2: *ngapurancang* stand, both are usually performed when younger person or people with lower social position meet the elder or more respected person. Note that in B2 a resident (inside the yellow rectangle) is in a submissive gesture (*ngapurancang*) to their senior resident and supervisors.

The patriarchal hegemony is also seen in the views of the majority of participants as the study mostly took place in medical schools in Java Island. In this patriarchal view, husband-male has major responsibility in family society and wider society compared to wife-female.

> "a wife has to accompany husband while doing this overseas trip, while this is also as a refreshing for me…" (MSTN4, ITTD)

This patriarchal issue can become a source of conflict in residency life or medical specialist practice. MSTN4 frames the refreshing from specialist life by spending time doing her obligation as a wife by the verb "has to". This can also be seen in the female orthopaedic resident who conceived that professionalism is a balanced life. She said:

> "As **a family leader male residents might think about their home**, right? I think being resident you should be able to put it at place, where time for family and time for your work. … He should be able to educate the couple themselves." (RESO5, SSI)

However, this patriarchal and male-dominant influence is being shifted since more woman residents are entering specialist programmes, even in surgery, which has had very few women in the past ten years. Some male orthopaedic surgery residents even give more respect to female resident colleagues due to their superior management capability:

> Sometimes, even my female senior colleagues or the one in same level, I thought more amazing. Because, she can come early in the morning and

> have already made up with the maximum makeup ((good looking)), compared to us, come to the ward still in a mess ((bad looking))" (RESO6, SSI).

Thus far, revisiting participant discourses while discussing medical professionalism and everyday professional life has shed light not just on how medical professionalism is conceived, learned and applied. It also opens a window into understanding the ideologies and socio-political context of medical specialist practice that influence how participants frame their professional practice and medical professionalism. Moreover, analysis of these discourses also led to identification of the agencies that are involved in exhibiting power and ideological contestation. In the following section I will describe and explain the critical agencies involved in the particular emergent ideologies.

7.4 Agencies and MP discourses

Identification of ideologies and hegemonies in MP discourses have brought recognition of agencies dispersed through discourses, genre and style which become a feature of the analytical task in the third phase of 3DD-CDA. But, what is the significance of identifying agencies in this context? Agencies inevitably are the source of power in which discourses are constituted and influence other discourses and other agencies through hegemony, and therefore together construct social practice (Chouliaraki and Fairclough, 2002). In a complex professional education, setting such as specialist education, understanding agencies and hegemonies are critical to enable the educator to design the most appropriate modalities and strategies for developing such a complex learning outcome as professionalism. This is where identifying and discussing agency is critical to the project agenda for a possible deployment of MP into teaching-learning strategies.

From analysis of the seven discourses from the earlier (or initial) data analysis I was then able to link them to agencies and the power they exercise in influencing how professionalism is conceived. I categorized the agencies in the MP discourse production into two big groups: human agencies and non-human agencies, inspired by sociological and socio-material concepts such as activity theory and assemblages in actor-network-theory (Engeström, 2001; Fenwick and Nimmo, 2015) which inform my approach to this study. The list of identified

agencies and their role in the studied medical specialist practices are presented in Figure 7-7 and Table 7-4

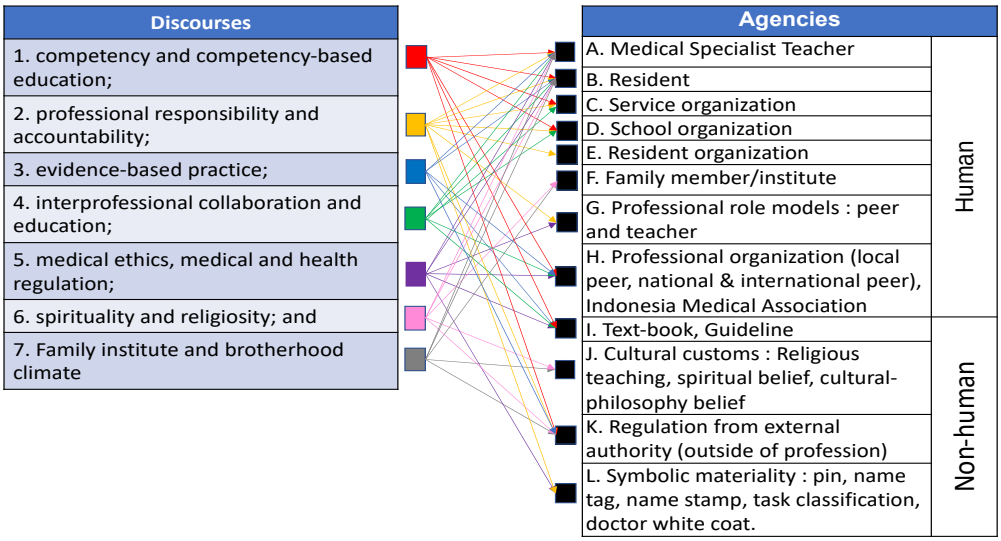


Figure 7-8 MP discourses and agencies in Indonesian medical specialist practice

This human and non-human agency categorization emerged because of how they presented among participants. Human agency is used to represent the group of individual and social organisations which have been assigned a societal role in the participant's narrative and therefore responsible for the discourse production and influence (e.g., their role as a resident). The non-human agencies represent the object that is not directly related to particular individuals (e.g., governmentality). This non-human / materiality might involve an abstract societal product, such as social structure, culture, social values, procedure etc., or more tangible social artefacts / human products such as attire, medical tools, regulation documents, medical guideline etc.

Table 7-4 Identified agencies and their influential role in Indonesian medical specialist practice

Agencies		The role of agency in context	
		Neurology	**Orthopaedics**
Human Agencies	1. Medical Specialist Teacher	The most powerful source of knowledge acquisition and knowledge translation in practice which are mainly exercised through resident-teacher encounter and feedback session	The most powerful source of power in determining promotion in a dominantly hierarchical residency training
	2. Resident	Resident plays important role in running MST responsibility at the teaching hospital	Resident plays important role in running MST responsibility at the teaching hospital
	3. Service organisation authority	Service organisation authority determines the infrastructure availability for profession in running their practice.	Service organisation authority determines the practice through infrastructure availability
	4. School organisation authority	School organisation is the local power who determine the curriculum and thus determine how student is taught and assessed. This is seen as the “formal” burden for residency training while doing service is seen as the real burden of professional life.	School organisation is a symbolic power of legitimate professional knowledge applied in a set of service activities. Service at teaching hospital should be the example of evidence-based knowledge and practice.
	5. Resident organisation	Resident organisation is one source of professional development	Dominant influence of resident organisation in professional development
	6. Family member of resident/professional	Family member is a source of balancing well-being in coping with the burden of training or medical services	Family member is a source of balancing well-being in coping with the burden of training or medical services
	7. Professional role models: peer and teacher	Professional role models: teacher is more influential than peer resident in knowledge acquisition	Peer classmate and selected senior residents are more respected as the source of real. knowledge and therefore more functional as role model than supervisor.

Agencies		The role of agency in context	
		Neurology	**Orthopaedics**
	8. Profession authority (local peer, national & international peer),	Profession authority (local peer, national & international peer) represent the hegemonic power in determining professional conduct	Profession authority (local peer, national & international peer) represent the hegemonic power in determining professional conduct
	9. Patient	Patient regarded as a powerful teacher and insight for developing reflective practice and therefore critical in the construction of professionalism conception and its application.	Patient's problem is the source of learning moment and developing surgical professional ability. Interacting and negotiating with patient is an opportunity for developing further professional ability and career security. Unsatisfactory patient might inflict legal / court problem.
Non-Human Agencies	10. Textbook, Guideline	Guideline-based practice is the prime feature of MP	Guideline-based practice is the prime feature of MP
	11. Cultural customs: Religious teaching, spiritual belief, cultural-philosophy belief	Religious teaching needs to be formally or informally exposed in the study programme as it is perceived to significantly influence the MP development of student	Religious teaching is critical in ethical virtue of professional practice but not necessarily needs to be taught formally
	12. Regulation from external authority (outside of profession)	External regulation represents one critical power in determining professional conduct	Despite external regulation, the profession is able to manage the impact of external power. External power can be ignored or diverted.
	13. Symbolic materiality: pin, name tag, name stamp, task classification, doctor white coat.	Symbolic materiality is inescapable. Pin, Name tag and name stamp are perceived as a part of critical identity and representation of professional conduct.	Symbolic materiality is inescapable. Task classification symbolized in pin and calling the group of residents (class of resident, e.g., OTL, TL1, yellow, Blue, etc) is preserved and symbolizing the vertical development of knowledge and professionalism

7.5 Defining and projecting situated ideological context for teaching-learning MP in Indonesian postgraduate medical education

In this third phase of CDA, it becomes more evident that medical professionalism is a fluid idea that emerges through various discourses in a dynamic and competing situated condition of medical specialist professional practice. As a discursive practice, either cognitively or operationally, MP definition is fluid because its conception is influenced by national cultural values, organisational policies, religious beliefs and multiple competing local agencies in medical specialist and education practice. In the third phase of 3D-CDA, analysing medical professionalism as a social practice has helped to identify wider ideological contexts and hegemonies (order of discourse) presented in everyday Indonesian medical specialists' education and practice. A postcolonial mind, spiritual-religious worldview, communalism/collectivism and external professional regulation are four order of discourses that are likely influential in MP conceptualisation in Indonesian medical specialist context.

7.5.1 Postcolonialism mind

This ideological-laden theme emerged, driven by one participant stating that adopting "goodness" from the West is not a continuation of colonization" (MSTO5, SSI). The literal meaning of the statement might be contra-colonial, or decolonisation thinking (against colonialism). Instead, the statement features particular characteristics of postcolonial mind or post-subaltern thinking identified by postcolonial theory. Rhonda Hammer asserts that in postcolonial theory or study, researchers are typically interested in, the perspectives of dominated, marginalised, oppressed, and subordinated peoples (Hammer, 2005). This ideological perspective allows post-colonized people to provoke, authenticate, or celebrate the voice of the other (colonizer). Meanwhile, at the same time, they also deconstruct assumptions about the discourses or texts to critique the cultural imperialism and narratives of dominant white, Christian, Western, patriarchal, or heterosexual thought (Hammer, 2005; van der Westhuizen, 2013; Ashcroft et al., 2014). For example, in a post-freedom era, issues about the need to hold strategic positions in government administrative emerged, despite the lack of suitably educated and competent candidates. In

overcoming this, a discourse might emerge to accuse he colonizer of manipulating the system so that strategic positions could only be held by them and, therefore, total system reform was needed. There was a time in Indonesia, several years after independence, to abolish the use of Dutch terms in medical and health care and change them to *bahasa Melayu* (old Indonesian language) even if there was not a Melayu term for it , such as using *kamar operasi* to translate *Operatie Kamer* (operating theatre).

The term of postcolonial as used by contemporary postcolonial theorists is no longer limited to physical or post-physical colonialization but applies to the situation in which one agency supresses another. Foucault has also addressed this phenomenon by arguing “technology” and “techniques” are emergent bio powers of modern orders of colonization (Foucault, 1984, p.50; Fairclough, 1994). The competency-based education, evidence-based practice and interprofessional education discourses in conceptualizing profession, professionalism and professional practice are indications of this postcolonialism mind ideology.

This postcolonialism ideology presents Western medical and Western medical education practices as the benchmark and dominant reference for current specialist practice and education. This ideology has also involved a struggle to find the adaptive version of practice to the local situation, concerning the gap in the knowledge and resources of the local people and environment in order to be recognized as an equal to the ideal or benchmarking version of the practice. The need for adaptation, in some instances, helps the community to realise and validate indigenous practices. This happened to the intellectual leaders who had opportunity to access Western discourses on professional education practice and worldview, and is mirrored in examples brought by some participants, such as MSTN1 who had access to international events, and MSTO5 who gained their degree abroad. MSTN1 stressed the importance of bringing the local wisdom of the past Indonesian freedom-fighter scholar and first Minister of National Education, Soewardi Suryaningrat, who had developed three education principles, “Patrap Triloka” (the Three Principles) as the inspiration for growing and maintaining moral reasoning in a new generation of physicians. Patrap Triloka was developed by Soewardi after coming back from his isolation punishment in the Netherlands to the East Indies (Indonesia’s

name prior to freedom) in guiding the teachers and pupils in his established public school in order to nurture the leadership mind and the anti-imperialism spirit among a new intellectual Indonesian generation. Patrap Triloka consists of three adagium, written originally in the Sanskrit-javanese language: *“ing ngarsa sung tulada (ꦲꦶꦁꦔꦂꦱꦱꦸꦁꦠꦸꦭꦢ*, "(those) in the lead / front giving example"); 2) “*ing madya mangun karsa (ꦲꦶꦁꦩꦢꦾꦔꦩꦁꦒꦸꦤ꧀ꦏꦂꦱ*, "(those) in the middle develop initiatives and spirit”); and 3) *“tut wuri handayani (ꦠꦸꦠ꧀ꦮꦸꦫꦶꦲꦤ꧀ꦢꦪꦤꦶ*, "from the back giving support"). This Patrap Triloka has been adopted as the national philosophy in educational practice, and the third adagium, *“tut wuri handayani*” has been amalgamated as the national motto to inspire all the nation that national education has a function to facilitate nation learning. Claramita argues that this Patrap Triloka is a core value and local wisdom in developing indigenous moral reasoning among Indonesian medical students to develop their professionalism as well as a guiding principle for teachers in advancing student-centred learning approaches in medical education (Claramita, 2016).

Additionally, MSTO5 brought an example of how first-generation orthopaedic surgeons in the country developed the very first local production of orthopaedic tools (e.g., screw, nut, bolt etc) and indigenous surgical procedures in order to treat the enormous bone tumours of mostly neglected patients which are not usually present in western-originated textbooks.

The involvement of most participants in the accrediting organisations is a feature of how a specialist community struggles with the discourse of adoption and adaptation of western professional practice in their everyday professional life. These struggles occur both in education and hospital accreditations. Almost all existing accreditation standards of the accreditation agency are adopted versions of western origin standards (e.g., WFME Standard adopted in LAMPT Kes accreditation, and Joint Commission International[12] standards adopted in Hospital accreditation). Therefore, this western-postcolonial mind potentially becomes a generic ideological feature that affects the wider medical specialist

[12] Joint Commission International (JCI) is a United States-based agency responsible for accrediting more than 22,000 US health care organisations and programmes. See further: https://www.jointcommissioninternational.org

practice in the country and influences their worldview and professional mindset and conduct, hence informing everyday features of medical professionalism.

7.5.2 Transcendental / Spiritual-religious professional practice

The critical ideology that emerged in the conceptualisation of medical professionalism is spirituality and religiosity (S/R). This ideology applies at the level of both individual and community in expressing professional identity and occasionally serves as an influential power beyond medical ethics and moral reasoning (see section 7.3 above). Despite the fact that Indonesian medical practice was developed and guided secularly (i.e., through the code of ethics), the current conception and practice revealed in the SSI and ITTD showed a tendency for more spiritual/ religious influence, dominated by a Javanese Islam worldview which Geertz asserted as the religion of Java (1960), a feature of blended fundamentalism (*santri*) and syncretism (*abangan*) ideological religious practice (p.6) What was found through analysis of discourses in the study shed light on the practice of institutionalising S/R into medical education and service practice and which therefore influenced the conception of medical professionals and acting in a professional manner, which is the main argument discussed in this section.

A recognition of the influence of spiritual and religious belief in professional decision making and identity development is not a new thing in the literature. However, most of the literature depicting S/R has centred on the social determinants of health, which focusses on understanding the patient's background to develop a socio-cultural approach to medical intervention. Only a few studies of S/R discuss its role in developing professionalism (Puchalski, Vitillo, et al., 2014; Puchalski, Blatt, et al., 2014; Klitzman, 2020). In this study, despite its presence in the participant's discourse, S/R appeared as a taken for granted philosophical practice that affects Indonesian medical specialists in conceiving their professional identity development and ethical reasoning. In the previous sections, the S/R practice appeared through *Ikhlas, tawakkal, ihsan* and *barokah* transcendental practice.

A similar Islamic worldview which affects professionalism conception has been proposed by Eraky *et a*l (2014) as part of the Four Gates system. However, although it has the same majority Muslim population, the S/R

conception that affects medical professionalism in Indonesia is different to the Four Gates system, which has been explored through a Delphi study among Muslim Arab professionals. *Takwa* and *ehtesab* in the Four Gates system are comparable to Ikhlas and tawakkal in this study, but the conception of *ihsan* and *barakah* surfaced in this study are argued to be unique to the Indonesia context. This is possibly because of the different Islamic jurisprudence and theological belief among Indonesian Muslims compared to Arab Muslims. The Four Gates Model was distilled from a Delphi study involving professional participants from four Islamic-Arab states (i.e., Egypt, Saudi, Oman and Sudan). By contrast, despite most of the Indonesian population being Muslims – 90% -, Indonesia is not an Islamic state. However, until recently, by law, Indonesia did not approve atheism for their citizens. Every citizen has to declare one of six official religions or one belief system to God and this citizenship-abiding law is also incorporated in the Indonesia National Qualification Framework (*Kerangka Kualifikasi Nasional Indonesia/KKNI*) as a national generic reference for developing learning outcome descriptors in all nation education levels.

A seminal anthropological study on the culture of Indonesian people performed by renowned anthropologist Clifford Geertz has revealed that the people of Java, the dominant race in Indonesia, is known for its S/R characteristics. In this study, Geertz argued that the transformation of Javanese people from pagan to Hinduism to Islam created the religious worldview of the Javanese people which became part of the development of the nation's culture and worldview (Geertz, 1960). This dominant spiritual Javanese culture and worldview is traceable and still influential in the current Indonesia socio-political situation (Ponka et al., 2019). One participant's statement "…but the Javanese proverb that-, I think even though I am not a Javanese yes, which say "*ing madyo mangun karso", "tut wuri handayani"*, I think that is right and influential (MSTN3, SSI), shed a light on this ideological and spiritual Javanese worldview influence.

The described exclusive Islamic – Javanese spirituality transcends speciality and participants, as seen in the profiles of participants in Table 6.1, although it is important to highlight that the participants in this study were all based in Java Island. Although confirming evidence that S/R ideology has been shown in many national, public regulation documents, a further study that

involved two specialist programmes that reside in exclusive Hindu (Bali) and Christian populations (Manado) might need to be considered in the future since these sites could not be included in this study due to distance, resources and time constraints.

7.5.3 Collectivism & Communalism

The family institute and brotherhood referred to in section 7.4 affects how medical specialists define and apply professionalism in education practice. Campaigning on fighting corruption in the country – by using corruption, collusion and nepotism ('*Korupsi, Kolusi, Nepotisme'*) as the tag line for common enemy - might somewhat limit the role of family in any social practice. The Anti-Corruption Law (Law Decree No. 28, Year 1999) forbids the involvement of family members in business that relate to the position of a government official. For instance, my wife will not be allowed to own or get involved directly (by name) in any health care related business (e.g., pharmacy store, medical tools supplier etc.) as long as I am a government official in health care service. My family member cannot also hold any similar or relevant position in a related service, even if they have suitable competency for the position. For example, if I were a public hospital director, my wife or sons or relatives could never be employed in the same hospital. These are examples of forbidden nepotism[13].

However, in specialist education practice, revealed both in the SSI and ITTD, many instances of "collective wisdom" happened in both positive and negative ways. Hofstede et al., (2010) assert collectivism or collectivist as the opposite of individualism. Hofstede (1986, 2010) assert that society with collectivist cultures shared a thought that any person through birth and possible later events belongs to one or more tight "in-groups" from which he/she cannot detach him/herself (Hosftede, 1986, p.307. The "in-group", whether extended family, clan, or institution/organisation, protects the interest of its members and therefore expects their permanent loyalty. Since the first study performed by International Business Machines (IBM) in 1970s, and its global replication

[13] Nepotism is defined as any act of government officials that against the law by providing benefits to family member, relatives or related underlings above the interest of public, nation, and country (Indonesian Law on Government Officials that Clean from Corruption, Collusion and Nepotism, 1999)

studies, Hofstede et al have identified collectivism as the cultural character of people in many Asian countries (Hofstede et al., 2010) including Indonesia (Hofstede et al., 2010; Hofstede Insight, 2021).

The intention to create a “brotherhood” climate expressed by some participants, who had roles as programme directors at different schools, showed how this collectivism ideology affects the specialist education practice in positive ways as it was meant to establish the teamwork climate. This practice of collectivism has also appeared in the professional practice in a form of “specialist firm”, or in participant’s word: “peer group”. This group is established to address the sustainability of income generation and patient safety issues. By this group (firm), the surgeons can continuously run surgical operation under his/her name with the help (replacement) of the peer group. This is how senior and well-known surgeons maintain their practice despite the increasing burden of consultation, academic and research schedule.

> “… Yes, so we are establishing a group so that we continue to share income. Actually, the main goal is not that, the main goal is first, I tell you, comfortable working. The second one is safety. Why is it safer? If I have a trouble, for instance when doing hip and knee because it is not my expertise, I just call Dr. D, because of what? He's my member and not my friend, this is not my friend, best friend! brother! If only friend, friends don't necessarily help.” (MSTO5, SSI)

Additionally, the collectivism discourse also appeared negatively when there is a need not to disclose professional lapses for learning purposes. This means that the identified lapses would not be disclosed in a public hearing or brought to the Disciplinary Council in the Indonesian Medical Association to protect the member of the peer/society from possible disciplinary action. Considering the essence of nepotism, the practice of covering might be included in this definition, especially when the act is done in the public hospital. This discourse appeared in discussion of how lapses are treated in residency programme, such as:

> “For us, it depends on the mistakes, Doc. If the fault, we think, does not have to be disclosed then others do not need to know, say it is not ethical to disclose it to other because it is a personal fault, then I will keep it personally. But if the fault/lapses should be known by the floor ((residents’ community)), so that it does not happen again, we will disclose it to the floor, usually at the time of pre-weekly meeting” (RESO3, ITTD)

Thus, collectivism or communalism discourse affects professionals' conception of their task and professional conduct, both positively and negatively, and this links with the wider national political discourse about collusion and nepotism practice.

7.5.4 Competing and symbolized external regulatory practice

The global – western - medical professionalism teaching movement has been presented as two intertwining endeavours. First, it represents a way to enforce the internal moral decision making or character building (e.g., through professional identity formation) among the current and new generation of physician (Evetts, 2003; Cooke et al., 2010; Cruess and Cruess, 2012; Fenwick, 2016; Sawatsky et al., 2017). Second, professionalism teaching is also characterized by recognising the interconnectedness of protecting the interests of medical professionals and the public to avoid cases of negligence or error by developing safeguarding and improved patient safety (Royal College of Physicians and Physicians, 2005). This involves methods of public surveillance and control. (Evetts, 2003; Susskind and Susskind, 2015; Fenwick, 2016). Analysing the discourses on conceptualizing medical professionalism in this study has shown a tendency towards compliance of medical specialist profession to legal (external) regulation rather than reliance on their internally-driven, moral-based professional regulation represented in the code of ethics or physician oath. It does not mean that teaching the code of ethics and invoking physician oath are not important and not done. But, concerning the experience from participants expressed in ITTD, this value-laden teaching needs to be enforced and elaborated more frequently in more systematic and longitudinal way throughout the residency curriculum (van Mook et al., 2009; Hodges, 2017). This will enable resident and practicing specialists to internalize into their system thinking and activities in order to produce the required social impact (Engeström, 1999; Engeström, 2018)

The strong influence of work arrangement and multiple organisational conflicts in practice and the definition of a good professional discussed in chapter 6, possibly becomes a critical feature of how teaching professionalism through medical ethics lectures, role modelling and attending spiritual events is perceived as no longer sufficient for future generations. This is because the intended professionalism traits go beyond being ethical and upholding moral

integrity. Participants demanded proficiency in legal literacy (MSTN1, SSI; MSTN2, SSI; MSTO2, SSI), conflict-ready ability (RESN, RESN, RESO) and cross-organisational leadership (MSTN4, SSI). Legal literacy is needed to uphold the overwhelming provision of conflicting rules and regulation in practice. Conflict-ready ability is a negotiation skill that helps professionals to adapt evidence-based practice over the commercial tendency of healthcare organisation. And cross-organisational leadership is a skill and character that is needed to manage multiple organisational roles undertaken by physicians in healthcare and teaching organisations.

Eraut *et al*'s (2000) research on managers and professionals in engineering, business and healthcare indicated that most professional learning happens in an informal way. Despite the fact that informal learning still dominantly occurs and was unconsciously expressed by some participants as a preferred way to learn professionalism and professional responsibility, the current trend in competency education and the accreditation demand from organisations swiftly change this into more visible, and therefore accountable, educational practice and clinical performance.

Results in this study show that while participants cognitively/theoretically believed that MP is developmental (a life-long professional development), in everyday practice, participants also believed MP should be taught and assessed as tangible traits. This is meant to fulfil the provision of medical credentials required by competing regulatory agencies. This credentialing process appeared as a provision of the certificate of competence required by Ministry of Education and Hospitals (MSTN1, SSI; MSTN2, SSI), fulfilling OPPE documents required by Hospital Accrediting body (MSTO1, SSI), and learning and teaching portfolio required by study programme accrediting body (MSTN3, SSI).

Thus, the pressure on the profession to produce a more tangible and measurable performance again reveals a greater influence of external agencies and again demonstrates a tendency of the profession to rely on external rather than internal regulation.

7.6 Discussion: Nurturing MP through the order of governing discourses, a further research agenda?

To this end, reflecting so far on the four orders of discourse I have presented, medical professionalism appears either as a concept or guiding principle for professional practice. Medical professionalism is shown here to be a fluid construct, influenced by profession-individual worldview, competing organisational interests and societal-ideological order of discourse. In the next section I discuss how the findings have relevance for, and could be brought into, teaching-learning practice in medical specialist education

Medical professionalism, when conceived as a learning outcome, or a form of professional knowledge, in the two studied specialities, has been learned and applied under the influence of at least four situated orders of discourse (i.e., postcolonialism mind, spirituality and religiosity, collectivism and symbolic external regulation). Recalling Fairclough's notion of the order of discourse, the identified four ideologies are serving as the orders of discourse in which medical professionalism is developed and at the same time influences professional practice. Consequently, teaching medical professionalism can be understood as a process of facilitating knowledge emergence, in which learners adapt and develop their new meanings and learning (i.e., on medical professionalism) through knowledge represented as semiotics (languages and discourses) across different levels of competing organisations and agencies. It is why Lewis and Ketter (2011) indicate that learning through knowledge or semiotic emergence depends on the relative *dialogicality* of text and talk - the dialogue between the voice of the author of a text and other voices. CHAT scholars, such as Ritva Engestrom (1995), have developed a theoretical bridging that brings Bakhtin's (1981) dialogicality concept into, and expands, early versions of activity theory.

Elaborating on the importance of knowledge emergence in incorporating CDA in professional learning context, Fairclough later theorizes that there are five orientations to difference which are critical to the knowledge emergence (the development of new knowledge) in social practice. The five orientations are summarized in the following Table 7-5. Fairclough's conceptualisation of orientation toward difference in knowledge emergence, and dialogicality share

Engestrom's theorization of multivoicedness and contradictions in the progression of expansive learning (Engeström, 2001).

Table 7-5 Five orientation to difference based on Fairclough (2011 p.125)

Orientation	Description
Openness to, acceptance of, and recognition of difference	An exploration of difference, as in dialogue in the richest sense of the term
Accentuation of difference, conflict, and polemic	A struggle over meaning, norms, and power
Difference resolution	An attempt to resolve or overcome difference
Bracketing difference	A focus on commonality, solidarity
Consensus	A normalization and acceptance of differences of power, which brackets or suppresses differences of meaning and over norms

Informed by this knowledge emergence and *dialogicality* sense, the four ideologies are potentially responsible for inducing conflict which trigger human actors to seek alternative solutions in their everyday activity. Some of the possible solutions are inevitably offered by the ideologies for a possible resolution to the tensions. In this situation, when the resolution is achieved, a new understanding in a form of conceptualising MP emerges. For instance, when MSTN2 saw some residents having difficulties coping with the burden of task, as a senior teacher, MSTN2 suggested residents should attend the religious sermon. When this suggestion helped solve the problem, she then incorporated the religious sermon as a "semi-mandatory" event for residents in that particular study programme. During the interview, MSTN2 boldly claimed that religious teaching has a significant contribution in building resident professionalism (MSTN2, SSI).

In CHAT perspective, the four identified ideological Discourses can be framed as the source of contradictions. It is because these ideologies might

function as the source of structural tensions that enables the boundary crossing of object of learning (i.e., medical professionalism concept and its application ideas) across activity systems (i.e., AS1 – AS3). In CHAT, the MP conception therefore results from an expansive learning cycle of the activity systems. However, because of the dynamic character of activity systems, the conception of MP would be constantly developing. This is why in one identified discourse, despite MP having a cognitive conception, it is also conceived as being operationalised and dilemmatic, and considering that new meaning and conceptualisation of MP will be evolving along the dynamic interaction and development of activity systems. With this perspective, teaching MP should be framed not just as nurturing residents to grasp and apply the MP conception into professional practice, but also as nurturing the activity systems to provide a context for learning MP. In a simple phrase, if learning medical professionalism means learning to be a good professional, then in the CHAT vision, the activity systems in which the professional is learning, should also be good/professional activity systems.

I have provided an account of the convergence of 3D-CDA and CHAT, especially between knowledge emergence (3D-CDA) and expansive learning (CHAT). In this study, the tendency of never-ending multi-voice discourse conflict in CDA has been resolved in CHAT by providing activity systems as object boundaries, despite the possible escalation through polycontextuality of activity systems. The five principles of CHAT in determining activity systems help to situate and problematise the context of learning, which has been identified as a problem in 3D-CDA (Collins, 2009). However, this study has also provided an insight that the second phase of 3D-CDA helped to identify the existence of a third activity system, i.e., professional association and college of speciality. This was later supported by the third phase analysis in 3D-CDA, through identifying ideologies and agencies that help to reveal the four ideological powers that influence the emergence of MP. In doing so, this study contributes to answering critiques focussing on the incompatibility of 3D-CDA and CHAT, both as research methodology and conceptual framework (Collins, 2008).

At the end of third phase of 3D-CDA, it seems the questions posted at the beginning of this study can be answered. I have shown that MP in

Indonesian medical specialist education is understood both as professional traits or competence and ongoing knowledge emergence. As professional traits, MP can be regarded as a set of individual, specialist and medical profession community-driven characteristics, abilities, and behaviours. As knowledge emergence, MP is an articulation of situated professional expertise development, which involve the transformation of cognitive, operationalised and dilemmatic professional practice of medical specialist in multiple activity institutions. This finding reframed some of the research questions regarding the conflicting agency of residents and MSTs (questions 1 and 2 as a continuum of community of practice and co-producers of collaborative conceptions of the medical specialism's unique MP conception.

In this chapter, I have also shown that two identified conceptions of MP (traits and knowledge emergence discourse) are influenced by four socio-political order of discourse/ideologies (i.e., postcolonial mind, S/R, collectivism, symbolic external regulation). The question is, how MP could be taught if the trainees' conception of profession and practice is likely to be influenced by the ideologies that are prevalent in multiple organisational settings?

In the socio-cultural perspective, it is believed that learning is developmental, situated and achieved through engaging in multiple activities and discourses. In this sense, it is important to consider that learning is not just about dealing with the learner, but also engagement of multiple elements across messy social actors / activity systems. This makes critical the exposure and designated engagement of residents into different competing interests in different health organisations and agencies during their training times in a supportive manner. . By doing this, it is expected that residents will allow themselves to be exposed to different situated activities and become reflectively aware of the different sources of power that might influence their decision making and professional judgment while at the same time learning how to adapt to these possible competing interests through designated task reflection. The experience of being present in a different organisational culture, role and profession might stimulate the cross communication and discourses that trigger semiosis emergence (i.e., new knowledge, reflection and professional learning). However, considering the greater potential of lapses and demotivation due to the burnout with conflict and contradictions, as well as the medical profession's

tendency to be more prudent with external enforcement and regulation, the role of longitudinal supervisory processes and institutionalization of feedback is also critical in nurturing medical professionalism development.

Therefore, another critical feature of learning professionalism that needs to be addressed is how to respond to lapses of self and peer/others, because conflicts and contradiction tend to cause lapses. If MST or residents had an opportunity to reflect on their fault or lapses, or if they were exposed to poor professionalism in others, especially when resident witness the lapses in their seniors or teachers, how will they recognise this behaviour as undesirable and then take action to make changes? Based on insights from this study, there are two possible responses to this challenge. First through strengthening internalization; and second, through externalisation strategies. The internalization can be achieved by giving more space to learning the cognitive aspect of professionalism. The habit in orthopaedic surgery of “enforcing” members of the orthopaedic surgeon community to sit and hear their colleague’s critical incident case and discussing how prevent it in their current and future practice is good practice for internalization.

The second, parallel with nurturing internalization, is externalization which basically allows careful longitudinal exposure to operationalised and dilemmatic MP discourse (designated externalization). However, it is also important to consider whether internalisation and externalisation, as key processes of expanding professionalism learning, need to be nurtured by surveillance (monitoring & evaluation). This surveillance can be sought through implementing peer and supervisory mentoring processes, and also cross health-professional engagement. This surveillance is expected to institutionalize reflective practice as a powerful method of the internalisation process and also designates conflicts and contradictions as a means to nurture resilience and shape collaborative norms and morality system.

The insightful lesson from the participant’s experience on the importance of externalization is of experience being entrusted to a “young expert” at a networking hospital where the number of specialists is much more limited. These networking teaching hospitals used to be regarded as secondary teaching workplaces for residents. This view is hindering the potential of these hospitals as the most authentic place for learning for the future specialist. Both

residents in orthopaedic surgery or neurology specialists conveyed a similar reflection of how their experience at these hospitals had provided rich learning moments but were often neglected due to a lack of coordination with, and isolation from, the main more “updated” teaching hospital. The residents had strong senses that the practice of a local supervisor in the networking hospital was outdated. Meanwhile, it would have been improved by being connected with resident training or the main teaching hospital. This resident’s sense is shared with CHAT’s expansive learning model which envisions the conceptual framework of enmeshing the individual professional learning toward organisation learning and institutional development (Engeström, 2004; Morris, 2010).

The example of externalization can also be found in an orthopaedic surgery case. Residents are randomly requested to deputise for their supervisors to attend some organisational meetings during their chief resident time. This, I believe, is a good learning activity that can show the resident organisational competing interests. However, this experience needs to be planned and designed more appropriately by using known instructional design and learning tools. This might include a systematic design of broadening experience through step ladder entrustment activities across the residency continuum /milestone (i.e., junior resident to senior resident and to chief resident) and for each milestone to write reflections and ask for developmental feedback to be collated in a learning-portfolio. This will allow each resident to gather minimum and equal experience rather than being randomly appointed, as described by the orthopaedic resident. The big challenge is, however, how to secure sufficient time for feedback. A possible answer is to engage technologies in the feedback process, especially utilising audio-visual technologies to provide feedback, as the Dictaphone is used in surgical operations. The main reason why feedback does not occur is because it is usually sought in a written form or a direct face to face event.

Another concern is about expanding interprofessional collaboration (IPC). While the same profession peer and supervisor mentoring has been practiced by the residency organisation in both neurology and orthopaedics, it is likely cross health professional mentoring needs to be further developed. This mentoring model is inspired by the formalities of residents asking for the head

nurse to mark their professional behaviour during ward work. Some Indonesian researchers see possibilities in nurturing inter-professional education and collaboration, so there are likely possibilities to nurture and expand the undeveloped collaboration by using same emergence learning and expansive learning conceptual framework identified in this study.

Nevertheless, despite the promising possibilities of these ideas and speculations because medical specialist education is a social practice they need to be evaluated and further studied since a designated social intervention might result in different outcomes and trajectories.

7.7 Chapter Summary

In this chapter I presented how the discourses on MP conceptualisation were used to identify ideologies and agencies that influence Indonesian medical specialist education practice. These agencies and politico-ideological circumstance (e.g., postcolonialism, spiritual-religiosity, collectivism and external-regulatory) represent the competing powers that influence how medical specialist trainees and medical specialist teachers develop and make sense of the application of professionalism in everyday duties, and at the same time influence their identity development as a professional. The identification of agencies and ideologies shed light on the wider situation of Indonesian medical specialist practice and therefore opens some possible speculations on how medical professionalism could be deployed in a more inspirational and transformative teaching-learning practice. These included possibilities for specialist residents to develop professionalism through intentional engagement or role exchange in different levels of health organisation during their training period. This will allow the development of cross-profession communication skills (e.g., communication with legal professions or political leader) that is necessary for adapting to competing interests that might influence their decision making and professional conducts.

This chapter has also concluded the complete first case study using Fairclough's Three-dimensional critical discourse analysis (3D-CDA) in analysing medical professionalism discourses in data gathered by semi-

structured interviews and interview to the double sessions with specialist and resident participants in two Indonesian medical specialist communities, i.e., neurology and orthopaedic surgery. In the next chapter (Chapter 8), I will discuss some lessons learned and critical reflections on the methodological approach applied in this study and how this contributes to the research of professionalism in medical education field, especially in Indonesia context as an emergent economic nation in South-East Asian region. This discussion precedes the final chapter, (Chapter 9) in which I summarize the key findings of this study, some recommendations from this study and final thoughts.

Chapter 8 Notes on Methodological Approaches in this Study

8.1 Introduction

To answer the research question and aims in this study, I came up with a concerted approach to data gathering and analysis methods originating from different research traditions and disciplines. The Interview to the double (ITTD) was initially introduced and used in the occupational-psychology and organisation-behaviour field. Meanwhile, I learned about three-dimensional critical discourse analysis (3D-CDA) from linguistics. Both methods are not commonly applied in the medical and health professional education (MHPE) field.

This chapter has two purposes. Firstly, it provides an argument by using evidence from the findings to just justify the combined approach, both ontologically and epistemologically, following the change of focus in the project. Secondly, this chapter will argue how the method combination potentially contributes to professionalism and professional learning in MHPE as both a research field and emerging discipline.

In the literature review and analysis, I used the 3D-CDA framework to guide my writing in analysing and discussing the data. Consistent with this, in this chapter I adopt a critical reflexive approach in which I describe and critically observe my experience in implementing the methods. This is combined with insights and reflections from my research diary and reflective fieldwork notes. These are discussed in relation to relevant studies and theories.

8.2 Combining SSI and ITTD

8.2.1 Background

In the literature review chapter, I argued that the definition of professionalism is fluid, and, as professional knowledge, it is represented as discourses conveyed through language. Following this idea, I reflexively chose a qualitative approach as the inquiry methodology to answer the research questions. Among many data gathering methods in qualitative methodology, I chose to use the semi-structured interview. First, because using interviews is more manageable compared to other naturalistic data gathering methods. For instance, it is

difficult to schedule different people with such intense academic schedules, like specialist teachers and residents. In this sense, group interviews, such as a Focus Group Discussion, is unlikely to be performed. Second, one to one interview enables the researcher to explore the feeling and experiences of participants in depth, and even to discuss sensitive issues, which is likely to form part of the discussion of professionalism.

8.2.2 Notes from the experience of utilising ITTD

It is difficult to say distinctively which contribution each data gathering method made to this research because I believe all meanings gathered resulted from combining SSI and the ITTD. However, as the ITTD became the distinctive method in this study, it is necessary to reflect on how ITTD is contributing to this study. I am doing this by pulling together my reflexive notes and thematic codes I made on the ITTD transcripts. I will discuss this through themes that I present them in the following sections.

The ideal and normative dimension of professional practice

Initially, when asked plainly to give the instruction of what to do in a professional day, most of the participants ended up with chunks of activities from morning till evening in a short and a normative way as the following excerpt shows:

> “Morning departs at, depending on the schedule of morning report. Usually, it is at 8 o'clock in the morning. If this the case, I directly depart from home at 7 AM, but my children first at the nursery, then arrive at the hospital at approximately 7:30 AM. Then I do patient visit, the morning visit, in about two wards. So, it takes usually about 30 to 45 minutes total for three patients. It includes writing the medical record, giving CIE ((communication, information, and education)), giving Assessment-Planning instruction for that morning … After the seminar, the seminar results were less than 1 hour, until 2 PM, has been completed. After that we are preparing in case. preparation night duty…” (RSN4, ITTD)

In the above example, I was not interrupting at all the participant as this was suggested in the literature. However, in this way I felt that the participant was only telling the normative and idealistic version of her professional life, and this was potentially duplicating information I got from SSI, which was not what I expected from the ITTD. When I tried to feel empathetically the position of a real person that would replace the participant in their professional life, I felt the descriptions did not provide enough details. In this situation, I recalled my

experience from a short training hosted by three lecturers from the School of Performance and Cultural Industry at the University of Leeds provided by the LIME on how to use performance art approaches to develop rapport and communication in health care. This course helped me with this actor-like feeling. On the training, I was trained to try to imagine if I were somebody else other than myself (like a figure in a movie). That's why when the short descriptions were given by the participant, I felt it was not helping me to imagine taking over her professional role. Following this reflection, I made an initiative by inserting some pace questions to follow the ITTD session, such as this:

> "Let's give the double more time with your activities, start with the first activity. You said I have to attend a resident group meeting. Where is this meeting usually held? Can you give me more description on how to do this?".

I found this kind of pacing question helped in understanding the very local situation and knowledge that occurred in the activities. The following chunk of ITTD is another example of how I (RSB) paced the participant (RSP) in recounting the detail of their activity:

> RSB: "If you come in the polyclinic, where do you usually go? Is there any favourite place?"
>
> RSP: "At the pantry, he he ((laughter))"
>
> RSB: "So there's no need to go first to the pantry this day"?
>
> RSP: "No..no. ((not this day)) I usually come to my desk first ((at polyclinic)). It is a desk with check-in paper, then usually I peek to the examination room, counting how many patients that day, right. Because right there, there should be two residents, and the ((examination)) rooms there are limited, so sometimes there's no place for us to sit. So, if I sat in the examination room, it would cause fullness, make the room so narrow. So, therefore, sometimes I go to the pantry, open my handphone, reading WA ((WhatsApp)) or else because I don't like doing WA while walking. Not get used like that. So, there I opened it, while if there is anything I'd like to do..., I am doing it there. "
>
> RSB: "It means that you carry your laptop with you that time."
>
> RSP: "Yes, I do"
>
> RSB: "So if I open the laptop at the pantry, it is a feature of doctor D, yes?
>
> RSP: "Yes, I am well known for that. There is even a favourite spot for me for having a seat there."
>
> RSB: "Why, doc, at that place?"
>
> RSP: "Yes, I just find my convenience there, he he ((laughter))."
>
> RSB: "Is it because it is hidden from certain things?"

> RSP: "Yeah, you know what, a pantry usually has a door that is usually closed, right? And also, I don't have a dedicated room there, while the rooms are already full, and I don't have any idea where to sit because, in each room, each examination activity is being taken place. That is only when I have no bedside teaching, no exam ((for student or resident)) so that's why I sat there. But If I must perform a bed site teaching, assessing MiniCeX, I will not have time to go there, to Pantry, just directly go to the Polyclinic.
>
> RSB: "At the Polyclinic, isn't there any dedicated room for you, doctor? Or is there such a doctor's office? "
>
> RSP: "No, I just find any empty space. If necessary, a resident might move out for a while because I have to test undergraduate students. Well, if I'm busy, for example, in the hours, I do bedside teaching. Usually have to attend a meeting somewhere, usually, I like to entrust the COAS student ((undergraduate medical student)) to the resident. ((using direct voice)) "Later, please find out any patient", the next time I meet that COAS student again, I will discuss the patient to ask what patient he already got. And the COAS should make their own version of the medical record." (MSTN3, ITTD)

In the above quote, rather than using her office at the different location of her on-duty clinic workplace, the participant (RSP/ MSTN3) chose pantry as her favourite place to do part of her professional tasks, whether it is waiting for examining patient, doing preparation for teaching, and doing paperwork in her laptop. For me, who has been working in a non-metropolitan city, I never had such a situation and never imagined had a situation like MSTN3 had. It is amazing to know that the daily professional life of one of the most respected neurologists in the country has a very humble situation. At the same time, from the above chunk, I can get an important lesson to learn that rather than being fussy or shy with not having an official place, MSTN3 created her own space ("pantry") with joy in order to fulfil her professional duties (as teacher and practitioner) efficiently. I believe this is a naturalistic representation of how a neurologist participant upholds their idealism to be a compassionate and altruistic specialist (putting patient's interest above self-interest) in a very unpleasant everyday routine.

In the above narrative, the participant describes formal features of professional life and in the next part talks about being happy to use the pantry as her office while waiting to examine patients and prepare for teaching. This highlights how ITTD has the capacity to capture both the normative and the idealised feature of professional life, even in a very strange situation.

Triangulating (self-confirming or confronting) statement in SSI

I found in some instances that the ITTD confirmed what the participant and I had discussed previously in the SSI. For instance, in the SSI, a neurologist MST highlighted how religious teaching was important in MP development. I found this view appeared naturally in the day-to-day schedule of the MST, especially their concern about ensuring a space for doing salat (prayer) in her tight schedule as a clinical education coordinator in the neurology Department. During the ITTD session, frequently, the MST (MSTN5) highlighted salat, which gave an impression that the salat activity has become an accepted practice and integral part of her professional life and identity.

Table 8-1 Example of ITTD confirming SSI

Issue/Theme	SSI	ITTD
Religiosity (With MSTN5)	I think another important thing is religious education anyway. Whatever your religion, religious teaching is important, in my opinion. Because surely religious teaching would never teach you any bad things, yes, there must be teaching that-, must be teaching good stuff.	RSB: "Usually after the meeting or before the meeting, you come to office? Is there a certain pattern?" RSP:"I usually go after the meeting, because before 12 o'clock or sometimes at 12 o'clock just come down from the polyclinic, I directly come here. Then after the meeting, after I did salat ((prayer)), then I went to the administrative office." … RSB: "Could you give me a sense of how is the order or things if the education coordinator is giving a report? I mean, is there any particular sequence? RSP: "Just give away to anyone who wants to report first." RSB: " Is it up to you or following the HOD schedule or how? " RSP: "Following the HOD pattern ((schedule)). Suppose like this day, I came at 12 o'clock sharp, 12.30 **I wanted to do salat ((prayer))**, then I'd say, can I do it first please, **I want to pray so**."

Note: RSB: Interviewer (the double); RSP: participant (the instructor).

In contrast, ITTD sometimes also contradicted (self-confronted) statements or issues the participant had asserted during SSI. One example of this is the dilemma of maintaining high ethical standard of professional skill and conduct as a critical component of being a good doctor. In a SSI session, an

orthopaedic resident participant (RESO) asserted that being a professional doctor for him is a reliance on high standard and evidence-based medicine. However, during ITTD, when giving an instruction of how to behave in a general round with several supervisor figures, RESO1 asserted an attitude and learning moment which differed from the high ethical standard he had claimed (See Table 8.2).

Table 8-2 Example of ITTD contradicting SSI

Issue/Theme	SSI	ITTD
Professionalism is compliance with a high standard. With (RESO1)	"… because professionalism is **in accordance with the law, ethics, theory, cognitive**, everything should have…"	RSB: "…Is there any supervisor to be concerned?" RSP:" That is doctor R. RSB: "Doctor R? Why? RSP: "KPS ((head of study programme)) Doc, he is indeed rarely, rarely ---." RSB: "Rarely doing patient visit?" RSP: "**Rarely present, rarely gives a scientific lecture. But once doing a general round his marking is significant** for resident assessment Doc. We are avoiding being rated badly, as a chief, by him. He is KPS! ((rising tone)). So-called it we scared, yeah!. While with Prof. Ar. We all are scared of Prof. Ar because his knowledge is rather old theory Doc. We fear being slaughtered because yes, he is the only professor in here, the theory is ---." RSB: "Old?" RSP: "Old. **We afraid he does not accept ((**any dissenting opinion)). We fear in this sense. 'Should be like this, should be like that **"**. RSB: "Well, what if there is a conflict?" RSP: "Yes we do not ---." RSB: "Just being silent?" RSP: "Yes, silent Doc. We are saying "ready prof, we just confess being wrong". We do not, we're never taught, what you call it---. RSB: "Consultation.? RSP: "Consultation, especially to Prof. **If the Prof had already spoken, we nod, silent.** That was how we learned how we have to behave with him".

Note: RSB: Interviewer (the double); RSP: participant (the instructor).

There are many definitions of triangulation, but what I mean in this section is a version of methodological triangulation coined and advanced by Denzin (Flick, 2018). Flick ascribes that in one of the developmental thoughts on triangulation, Denzin defined methodological triangulation as a concept used by researchers to develop interactionally grounded interpretations from different empirical sources (Denzin, 1989, pp. 235–236 in Flick, 2018). In the above examples, whether as a confirmation or contradiction, the ITTD provides methodological triangulation for SSI. Depending on the order the two data gathering methods, SSI could function as triangulation for ITTD but in this study SSI followed ITTD in all cases.

Conceptualising professional day when different day means different role and different self

At the beginning of the SSI, some participants conveyed that, as a professional, they have to bear multiple tasks and roles. Therefore, at the ITTD session, I intentionally invited participants to explain their professional day prior to giving instruction to their double despite having already done so at the beginning of SSI. With this invitation, I found most participants agreed that there was such thing as a professional day, which is represented by one or two days in a week where they have to perform at the peak of their professional role. There is a strong sense that the idea of “a professional day” was quickly grasped, especially by most MSTs, who reported they had different professional roles which needed to be interchangeably managed. The sense of ease of understanding is represented in the way participants responded to the question, which typically featured a direct reply, like the following excerpt:

> RSB: "Maybe you could give me examples of the busiest days for doctors in the services and teaching of the week. What day is it?
>
> RSP: "In one week?
>
> RSB:"A week that is where you have teaching schedule, service and also DPJP?
>
> RSP: "For me possibly like this, so my busy day is the day in the polyclinic. I always ask to the academic administrator, for instance, bedside teaching for undergraduate, I ask him to put that schedule in my polyclinic today (MSTN5, ITTD)

When conceptualising a professional day, participants, especially MSTs, referred to the multiple roles which are frequently linked to responsibilities as a medical teacher in specialist study programme, teacher for clinical rotation of

undergraduate medical student, being principals in teaching organisation, as well as being principals in hospital organisation. Another interesting part of the professional day is about managing the schedule between providing mandatory sub-specialistic service at the teaching hospital and also running general specialist service at private hospital/clinic. These indicate some binary realities of professional self like; morning-formal and evening-casual, teaching hospital-obligation and private hospital-voluntary.

Other features that appear in the further description of a professional day is the different self which relates to the socio-cultural function of the participant, either as a family member or a society member of religious teaching. Being in a professional day for some participants means being detached from their social function as a member of the family (a dad, a wife, or a son/daughter), while at the same time at the end of the day, they conveyed that the family is how they gain balance in their professional life.

Conceptualising professional identity through the instruction category

As explained in the previous section, the ITTD was conducted by inviting participants to give instruction to their double-researcher on what to do when the researcher is replacing them on their professional day. In regard to this, there are specific ways of instructing among participants during the ITTD, which can be categorised as the following five themes:

1) instruction on how to do

I created this theme to categorise participant's instruction that related to time series activities, procedures, or skills. This is possibly the dominant feature of instruction conveyed by the participant in the ITTD, which is typically expressed as a bulk of activity in a certain period of time, usually sequential. One example of “instruction to do” is the instruction at the beginning of ITTD, especially when the participant starts their professional day: “First, I always start my day by going to secretariat office before going to the ward…” (MSTN2, ITTD).

There is a sense of normal and ideal activity of professional life in most of the “how to do” instruction narrative. When I let the participant finish their chain of “to do list” instruction, the professional activities in which they are portraying the medical professionalism in action has linear or singular (i.e., start with doing… at …, and end with … at …) activities. In this type of instruction, participants are depicting the most common feature of their professional activity,

which are mostly heard as an idealistic feature of everyday professional activity. This is a common feature of using ITTD as described in the studies using ITTD.

2) instruction on how to behave

This theme categorises participants' instruction related to how they need to respond or used to respond to any particular situation which typically happens in their schedule. To differentiate this theme from the "instruction to do", in this theme, the participant is not just doing something like "park your car, take the suit behind the car, bring a bag, pump ((breast pump)) bag and laptop bag, then I walk from the parking lot "(RSN6, ITTD). Instead, participants also provide information about how they do the activity. For instance:

> "In the last one or two years I have been parking my car at the parking building inside the hospital. Before, I did it outside ((outside the hospital)) which really took my time" (RSN6, ITTD).

The instruction to behave appeared especially when I paced participants to explain the reason or detail of the activity. This question to participants is a result of my reflection during pilot and experience doing ITTD throughout the study. I was able in the third ITTD session to imagine myself to be as close as possible to the real "double" of the participant. This is like a question to myself, "Am I clear enough with the given instruction to act as the participant in the real situation? or do I need more detail and reasoning?". Reflecting on the instruction to behave gives me an understanding that applying professionalism in daily activity is beyond doing things, the doing is a result of exposure to many experiences that established certain situated behaviours, like in above case, changing parking behaviour because as a chief resident RSN6 learnt that she could have a parking privilege - inside the hospital - through establishing special relation with certain actor (parking man).

3) instruction how to adapt

This theme categorises participant instructions related to how they need to respond or will likely react in a possible situation that might happen. Still with the previous example about parking a car in the crowded hospital space "… once until the upper level I did not get a space ((parking place)), then I make a call to this guy ((parking man). Mostly solved".

4) Instruction to react/respond to people or situation

This category relates to the instruction from the participant that they need to stand out or stand up to specific principles for any particular issue or situation. In the neurology participants, one example comes from a senior MSTN who needs to highlight the importance of being polite when communicating with other specialities, but how, at the same time, a scientific truth needs to be sought, especially when other specialists put them in a difficult circumstance because they are more senior. This is highlighted in the following excerpt:

> "…But yes, if I need to protest, then it should be a protest. So, If I think the data is not complete, "It should be like this! We must browse first. We are both looking, yes" Essentially because I think it is a scientific event" (MSTN5, ITTD)

5) instruction to utilise knowledge

This theme categorises participants' instructions related to medical knowledge. The medical knowledge here refers to both general and specialist terms used by participants. What I meant by general knowledge is knowledge that I didn't need to clarify because I had learned it when I was a medical student, or it is commonly used in my practice as a GP. Meanwhile, the specialist knowledge relates to very specific terms, either from the specific use of jargon or the specific situation representing the latest development of knowledge or procedure applied exclusively in the speciality. For instance, when one neurology MST explained about the EMG and its technical terms, I did not know what they were exactly because I had no experience working or learning about EMG in my medical training and practice. However, during the interview, I tried to catch up with the conversation by asking for clarification or making notes. This means as a potential double I have to learn more about the term to understand better the situation.

Another feature in this type of instruction is how participants explain more on a term / jargon that is possibly only locally known among peers. For instance, the use of term "*Om Loop*", which literally translated as "Uncle Loop", is a name given to call the operating technician. When I was at medical school the role of operation technician in operating room was usually to manage the logistic needs of surgical operation before, during and after the operation, such as preparing surgical tools, take additional suture, needles, adjust electricity power for electric blade etc. But from some ITTD sessions with a MSTO and

RSO in one orthopaedics programme, I learned that the technician is also the one responsible for reading the surgical safety checklist as required in the emerging patient safety guidelines promoted by WHO Patient Safety Guideline (2010) and Joint Commission International (JCI) standard for hospital accreditation (2015).

> RSP: “From the beginning is usually like this, say a cervical surgery, yes. Yes, initially it may be working as usual, like a typical surgeon listening to ‘a time-out’, then follow the preparations from the start.”
>
> RSB: “Who will read the time out, the resident?”
>
> RSP: “No, the om loop does ((technician))” (MSTO3, ITTD)

The “time out” in above excerpt is the surgical safety checklist. During the conversation, I was amazed that the technician is the one who had this responsibility rather than the surgeon or another physician in the operating room, like the Anaesthesiologist. However, from the explanation, the reason for appointing the Om Loop as the time out reader is simple. The technician is the person who will know exactly the number of surgical tools and singe use materials, and therefore the one who can prevent any tools being left in the patient’s body during the operation. The surgical technician is also perceived to be the person least overshadowed by uncertainty of decision making and can therefore function as an external evaluator of the operator and anaesthesiologist.

Reflecting on how “om loop” and “time out” became jargon that might only exist in this particular hospital and orthopaedic programme, I realised the way it appeared naturally in our conversation, is a feature of the discursivity nature of discourse (language use) in professional practice. This was represented by the participant’s assumption t that I already knew the term so not explaining it in advance.

6) instruction on how to feel

This kind of instruction rarely appeared. However, when it appears, it presents an essential perspective of how the feeling is part of professional life and identity. This theme categorises participant’s’ feelings in a certain situation that frequently happens. One example is when I asked: “For your last everyday activities, what is the best part of having interaction with the patient?”. Responding to this question, RSN4, a neurologist resident, conveyed that the best part of having interaction with patients during residency are happiness and

the reward of being able to empathetically feel the patient's relief from their suffering. This is represented in her response: "…For example, the blood pressure he ((patient)) feels from our care, that he had been improving. Then he said, 'I want to go home', like that was actually making me happy." (RSN4, ITTD). This type of instruction reflects that in their everyday life, a learning professional such as resident, not only takes benefit of direct interactions with patient to improve their learning, but also to unleash a feeling that make them confident and happy carrying the burden of professional tasks.

Feelings of happiness and satisfaction emerging from interaction with patient are related to the individual satisfaction of doing professional everyday tasks, especially in neurology specialist case as featured in RSN4 instruction. However, this feeling seems to be escalating from resident to specialist practitioner. While RSN4 is made happy and rewarded by the patient's feeling of getting better from the care provided, MSTN6, a senior neurologist at a different specialist programme to RSN4, was able to convey the satisfaction of having a comprehensive medical consultation with each of her patients. MSTN6 even considers having protected conversation time with each of her patients has become part of her identity: "I think that who I am. I'd be better not earning a lot of money, but I am comfortable with my life…For me, once I examine patients, it can only be 8, or maximum 10, once I do practice. Why, because examination for each patient takes a long time ((thoroughly)) …" (MSTN6, ITTD). The feeling conveyed by MSTN6 is more advanced than RSN4. RSN4 requires a positive response from the patient to feel happy, while MSTN6 is able to activate the feeling from an idealistic process of professional practice, i.e., conducting a comprehensive consultation and physical examination.

The instruction to feel is also surfacing both explicitly and implicitly when participants elicit any activity about relationship with peer, engagement with family member (parent, children, couple, etc.) and the presence of cultural value such as life philosophy, spirituality, or religious value in their professional life. An example from an utterance from RSO3 when giving reasons why it is necessary to give a space to junior resident to perform operation with distance supervision: "…It is due our experience that if we do operation and then our senior is watching, I felt such an unpleasant feeling, uncomfortable. Although our chief is just watching, there is a glimpse of insecure feeling in doing the

operation". It is perceived to be important for RSO3 that interaction with their junior resident is also a process of "building their ((junior resident)) confidence…""(RSO3) and managing security feeling during operation which is necessary in skills acquisition and better operation result: " …because sometimes if we always being watched, first, there may cause a uncomfortable sense, for example. Then the second is a sense of at ease because 'ah I had my elder brother behind watching what I did' "(RSO3, ITTD). If the space is not given properly, it may cause inability to self-improve which is important for professional development: "So if we always stay there, it is likely the junior resident keep asking help. So ((in turn)) they may not be able to improve" (RSO3, ITTD).

The most profound insight in the use of instructions variety in ITTD is the feature of how the instruction help to understand that professional identity is developed through knowing, doing, feeling, behaving/being, adapting and reacting to the dynamic situation of activities around the specialist's professional practice. This is made possible by a frequent anchoring during ITTD that the participant is required to teach to the double the detail of activity so that the double would not be identified as a stand-in for the participant. This made the participants choose the most distinctive behaviour, feeling, thinking, acts that representing the unique identity of them as a practicing professional.

The six themes I created are also tangibly related to the professional activities in which MP, as a form of professional learning, is constructed and applied, and at the same influencing the professionals in doing the activity. For instance, my example in instruction to react where MSTN5 is standing up for the principle of evidence-based knowledge, occurred in an activity called the clinicopathology (CPC) meeting, involving neurologist, neurosurgeon and radiologist. This CPC has been a routine multi-professional decision-making process in discussing the best possible intervention option for any difficult case, especially in neuro-oncology (tumour disease in nerve system). In this particular aspect, a quote by MSTN5 in above "to react" theme, gives a sense that this CPC meeting has become a space or a social event where she and her neurology colleagues are able to establish distinctive neurologist characteristics. In turn, CPC has become a teaching point for her neurology resident to learn the importance of standing on science and evidence-based

principle: “…That's what I like to teach the residents, meaning we will only be seen by people if we could stand on our sound base of knowledge.” (MSTN5, ITTD).

Suppose we regard these instructions (knowing, doing, feeling, behaving/being, adapting and reacting) as the pedagogical instruction of learning medical professionalism and professional identity, I believe they would be a focus that should be explored further to establish the practical deployment of educating MP and nurturing professional identity development.

Singularity and multiplicity of medical professionalism and its development

Medical specialist practice is both a preservation of routine and an unpredictable course of action. Through the ITTD, medical professionalism is surfaced as ambivalent discourses. First, MP has been uttered as simply embedded traits while doing concrete professional tasks. This means in a normal routine; most professional tasks are performed in a certain professional way. For example, an epilepsy patient is treated by applying certain epilepsy guidelines with certain ways of performing communication, giving information and providing education to the patient. In treating the disease in a normal way, not many modifications or improvisation can be or should be made to the guideline. The focus is how to make the task done satisfactorily. The following is an example from ITTD from a MSTN in uttering a must -linear- type of professional action when facing an epilepsy patient.

> "… I think epileptic patient, there is a typical behaviour from me…So if the epilepsy patient just relieved from convulsing, for example, the seizure was in the morning, my nurse has already known if the patient had just had a seizure, I always ask to perform EEG immediately. Do not wait for the day after, cannot, so. I must chase. So, if for example the patient was consulted from Emergency, saying that "Doc, your patient come to ER with seizure". Then they must call EEG, call the nurse in EEG to ask for an EEG exam immediately now" (MSTN5, SSI)

However, secondly, during the ITTD, participants could conceive the idea that MP could also be an ability to perform various possibilities of conduct in a different possible situation. In this second type of uttering, participants’ discourses are indicating the relativity of actions that might be taken in a different situation. This is presented in the following excerpts:

RSB: "Is there any reference when I perform diagnostic procedure?

RSP: "If it is specific, for example like that MRI, they are already present in my private hospital ((the hospital where he practices)). But, for example like EMG or MRA need to perform here ((at the teaching hospital))".

RSB: "That is including the X-ray?

RSP: "For the X-ray, My nurse usually provided it already

RSB: "That is in the same day?"

RSP: "Well it depends, currently my patients are ((covered by)) BPJS 70%, 65%. BPJS is now not allowing us to directly perform it ((the X Ray)) despite it is actually breaking the rules, in violation of the ethical code of conduct. Suppose you comes with BPJS, from the BPJS you got the package 250 thousand rupiah, including the drugs, the consultation fee and all supporting exams. You know that 250 thousand is not enough, right. So usually, I manage it by asking patient to come again on a different day, "tomorrow yes come again" then usually when they came back to me it is ((The X ray result)) already available ".

RSB: "BPJS it is. But that still manageable?

RSP: "Well, for patients who are not .., usually for fracture patients, yes pity it is yes. I usually make it ((the X-Ray is performed)) direct ((with the same budget)). But, let say for the degenerative patient, OA ((osteoarthritis)) for example, the exam will be performed the next day. “Yes ma'am. I give medicine, or physiotherapy regiment first, Okay?”. The next day, when they came again at my practice they are already photographed. So, it won't be neglected for waiting time to have an X-Ray, so I provided drug and physiotherapy at the front.

RSB: "You always sure they will come back?"

RSP: "Definitely, that indeed how BPJS arranged the system. They ((patients)) don't have a choice not to return back". (MSTO2, ITTD)

In above example, as an outsider and the one who will replace the participant, I was able to see that the practice is an array of possibilities of decision making in different situation. Sitting in the same situation, as an observer of his own practice, the participant was also able to identify that there are possibilities of how the scenario could happen in practice, including to manage situation that require a tricky strategy, e.g., the underbudgeting of the BPJS scheme. This is what social practice scholars called as the duality nature of professional knowledge (Nicolini, 2011; Nicolini and Roe, 2014)

The duality (singularity and multiplicity) nature of professional knowledge is not a new concept. For example, Heidegger (1929) as cited by Nicolini and Roe (2014) already used terms ‘ready-to-hand’ (*zuhanden*) and ‘present-to-

hand' (*vorhanden*) to characterize the two modes of reality of professional knowledge. Ready-to-hand represents the condition of practitioners immersed in a world of immediate and present practical concerns, i.e., things that they care about, and they want to take care of. In contrast, present-to-hand articulates the detached observer's 'view of the acts being taken (Nicolini and Roe, 2014). In Bourdieu's words (1980 p.82), the practitioner's view is fundamentally different from that of the observer in conditions that frequently exclude distance, perspective, detachment and reflexion. Meanwhile, an observer can survey things in their totality, (p.82). Nicolini and Roe (2014) argue that representing a characteristic of post-modern professional, professional knowledge has a special type of work that produces a coherent and accountable course of action and at the same time requires a coherent and accountable professional self (Nicolini, 2009b; Nicolini and Roe, 2014). This is a perspective that might be worth to consider in understanding how MP is learned and applied in the current post-modern professional world.

8.3 The Use of Critical Discourse Analysis in this study

8.3.1 Background

In this study, I combined the Corpus Linguistic method to extend the text analysis phase in Fairclough's Three-Dimensional Critical Discourse Analysis (3D CDA). This combination has been inspired by Fairclough's recurrent statements in some of his writings that the 3D-CDA (or Text Oriented Discourse Analysis/TODA in his word) is not meant to strictly bind researcher to any particular techniques or methodological prescription, but rather, the framework is proposed to provide a new researcher, like me, with a useful tool to employ principles and essential aspects of the critical tradition in performing analysis of discourses in social practice (Fairclough 1992, 1995b, 1999). Another critical inspiration in combining CL with CDA has come from the work of Paul Baker, Tony Emery and Ruth Wodak, some of Fairclough's colleagues and fellows in the Department of Linguistics at Lancaster University, asserting that putting CL in CDA is an inevitable consequence to the fast improvement of digitalisation technology (Baker et al., 2008). Theoretically, the combination of CL and CDA in analysing text or discourse is not a new idea. However, its use in practice has progressed in the last decade, especially in media and political studies (McEnery and Hardie, 2012; Baker et al., 2013). Reflecting on the fast

development of digital technology in medical practice (e.g., a massive application of electronic medical record and medical decision making), I personally reflected that the use of corpus linguistic method in the medical and health professional (MHPE) field should have been done earlier, yet to the best of my knowledge, it has never previously been found before this study. Cultivating experience from an-eight weeks online facilitated course from the Department of Linguistic, The University of Lancaster during the lockdown, I made up my mind to employ this method in my analysis.

Corpus linguistic (CL) or corpus-based analysis is a set of methods that employ computer-based processing to look up the collocation or occurrence of words or *lemmas* (the core structure of word), which is unlikely to be done manually with the amount of text involved (McEnery and Hardie, 2012; McEnery and Brezina, 2020). The CL has been utilised in helping researchers in the linguistic tradition and wider social research fields to find the relation between text, language and discourses in any particular phenomena or research objects and interests (Baker and McEnery, 2015). I find there is a strong methodological connection between CL and the first step of Fairclough CDA (3D-CDA), either because both of them are developed under the same theoretical underpinning of linguistic studies which are nurtured in the Department of Linguistics at the University of Lancaster, or because CL has now been able to do the practice of analysis that during the conception of 3D-CDA could not be done (e.g., performing intertextuality analysis by finding the lexical relations among keyword use). I strongly believe that the CL and 3D-CDA can complementarily strengthen each other in interpreting the discourses and intertextuality. Therefore, I found it encouraging to combine these two methods in order to gain a greater academic benefit as they had already been together for a long time in the academic toolbox.

8.3.2 How the version of 3D-CDA is applied in this study and the role of the researcher in 3D-CDA.

In this section I want to argue that although 3D-CDA has been adopted from one version of Fairclough CDA, the end version of 3D-CDA in this study might not be 100% Fairclough CDA and to explore the role of the researcher in the 3D-CDA. This is because the decision of applying and choosing the version of CDA in this study has been evolving through my gradual understanding of CDA,

the experience of applying it, and my understanding of reflexivity as the critical component in an interpretivist study.

The 3D-CDA itself, like those found in different Fairclough's books and writings, is an evolving concept and practice. It is evolving from just an idea of analytic method to become theory, methodology and movement (Wodak, 2001; van Dijk, 2009). To be applied in research, I should choose which version I should be applying, and I decided to apply one version of CDA proposed by Fairclough in *Discourse and Social Change* which he calls text-oriented discourse analysis (TODA) as he argues this would differ from Foucault's CDA (Fairclough, 1992, p.60; Chouliaraki and Fairclough, 2011, p.152). But researchers used to call this TODA as the three-dimensional CDA, which I prefer to use. I sought a proper opportunity to join a training in CDA through course provided by Fairclough's colleagues and disciples at the Department of Linguistics, University of Lancaster, about Corpus Linguistics. Despite disappointment in the first week, in the second weeks of the online facilitated course I was exposed to literature and skills that I believe far more beneficial in the application of CDA. At the end of eight weeks, I became convinced that the versatility of Corpus Linguistic in identifying the relation between words and phrases through an application of computer-assisted programme would ease the process of intertextuality identification which is vital in the first stage of Fairclough 3D-CDA (Fairclough, 1992).

In the 3D-CDA, the discourse is intentionally framed under a particular conception influenced strongly by critical theory and theory of practice (Chouliaraki and Fairclough, 2002; Gee, 2014). This included the use of three frames in conceptualizing discourse as a text, as a product and source of discursive events, and as the representation of social practice which I believe, as a beginner in discourse study, provides a handier way of understanding discourse and social practice. In this context, the interpretation of data from SSI and ITTD has to fulfil certain criteria and shifting boundaries from analysing texts, discursive events and identification of agencies and social practice around medical specialist practice. However, as a method under the interpretivist paradigm, I realised that the researcher has also become an integral part of the data and analysis in 3D-CDA. This means, my reflexivity in

3D-CDA has also played a critical role in the development of knowledge in this study.

The reflexivity in 3D-CDA is represented in the meaning making and also in the modifications I decided to make. In the meaning making, 3D-CDA requires me not only to focus on the text resulting from the transcript but also text that I already had “in mind” as a reflection and understanding during the interview, which I anchored as researcher notes. In this notion, CDA shares a common feature of reflexivity like other qualitative analysis approaches, such as thematic analysis (Braun and Clarke, 2006), grounded theory (Corbin and Strauss, 2008) or modified grounded theory (Charmaz, 2008). However, in the “three-dimensional” of Fairclough, CDA provides the account of how reflexivity in CDA differs with other qualitative analysis methods as briefly explained in the following section

The first and second aspect of 3D-CDA are intentionally examining the various possible meanings of the text (textual aspect) and how the different ways of uttering construct the context and influence the production of the text (discursivity of the text aspect). This includes the variation in use of language as a mean of exchanging meaning through the interview. The textual analysis, including the corpus analysis with LancsBox software in this study, was performed in the original language used in the interview, which is in Bahasa Indonesia. However, the result of analysis and the meanings were coded and tabulated in English by myself. I believe this is the unique situation in which the study is influenced by the researcher’s I bilingual situation. This is I believe the first feature of unique reflexivity of my version of 3D-CDA.

In the third phase, 3D-CDA intentionally encouraged me to speculate or conceive the possible macro social circumstance, called social practice, of the discourse production. This is done by identifying the ideology and hegemony in the identified discourses and the possible source of power. Once, Fairclough uses the term “agency” to refer the idea of power source in the first edition of *Language and Power* (Fairclough, 1992). In another, *Discourse and Social Change*, he uses the term “social institution” (Fairclough, 1994, p.92-94) where he argues that family, schools, trade union, court of law, etc. are examples of institutions that possibly become the source of hegemony. While sources of power were mostly conceived as human, interestingly, in the latest development

of CDA, Fairclough has also indicated that the current conception of practice might include a possibility how a naïve object or artefacts can influence the production of discourse in a taken for granted (hegemonic) routine of human life (Chouliaraki and Fairclough, 2002).

> "All practices of production combine physical and symbolic resources, in varying degrees and discourse in always a significant moment because all practices are, as we have said, reflexive – construction of a practice constitute part of practice." (Chouliaraki and Fairclough, 2002.p.23).

I believe my ability to extract the agency component and power is closely influenced by the interaction with the participant during interview and also with the degree of familiarity of medical practice and health system in Indonesia. I have been involved in the development of national medical education standards in the country and how it was implemented and monitored for several years. I believe this experience gives a different sensitivity in recognizing the social agency and social practice compared to a researcher without this experience. This is the second distinctive feature of the role of researcher reflexivity in this 3D-CDA study.

The third feature is my intellectual journey in understanding and applying the research paradigm in this study. At the outset I called this study an interpretivist study. This is still valid, however when my reading evolved, especially getting more familiar with literature used in ITTD and 3D-CDA, I realised that it is more accurate to say that the study is using a criticalist/criticalism paradigm. Because interpretivist has evolved to become the umbrella term in qualitative study in opposition to the objectivist paradigm. The explicit influence of critical theory in Fairclough's CDA has helped me to see the capacity of the 3D-CDA as a dynamic lens to examine the relativity of reality in the production of MP. Through the influence of critical theory in seeing social practice, 3D-CDA is intentionally designed to zoom-in (looking into the micro level of discourse as a text), and to zoom-out (looking at the bird and macro level of discourse) through seeing the discursivity of MP discourse in medical specialist professional and social practice. This evolving methodological ground I think becomes the third unique feature of the CDA in this study, which is that, based on my journey towards seeking a research paradigm, I found more appropriate ground for this study to stand.

8.3.3 The contribution of 3D-CDA in the study

Influenced by the theoretical underpinning behind each stage in 3D-CDA, in the chapters 5-7, I have proposed some perspectives of MP applicable to Indonesian medical specialists. CDA helps in seeing MP as more than a list of traits and characteristics of a good specialist that achieved consensus in a Delphi study and used to construct a set of intended learning outcomes in a competency-based medical education approach (see MP as a text in Chapter 5). CDA also allowed me to see MP as a contested process of institutionalizing conceptions of professional specialists in a complex medical education-service organisation where specialists are working and exercising their multiple roles. With this contestation, the profession is always struggling between operationalised (hegemonic) and dilemmatic discourses in conceptualizing and applying MP (Chapter 6). From this understanding, seeking answers to a challenging question: “how is MP best taught or learned?” is difficult because MP as a concept became so fluid and relative.

However, a provision to identify the discursivity of MP as well as identifying power and agencies in CDA allowed me to examine the pattern and tendency of how MP as a discourse is developed in the two medical specialists studied. The identification of agencies which are dispersed in the SSI and ITTD texts allowed to see the pattern of how cognitive, operationalised and dilemmatic discourses are produced. Driven by a passion as an educationalist, this is how I formulated possibilities of how MP could be nurtured in a teaching-learning process. Table 8-3 summarizes the agencies which are discussed extensively in the chapter 5 and 6. The category of instruction in the ITTD (doing, knowing, reacting, adapting, behaving, and feeling), the agencies identification and the pattern of discourse production in neurology and orthopaedics open possibilities of pedagogical approaches that might nurture the development of MP in Indonesia medical specialist education.

In chapter 6, I reported some different conceptualisations of lapses between neurologist and orthopaedic surgery participants. In the same and the following chapter (Chapter 7), I also provided a visualization (Table 7-4) of how the agencies influence MP conceptualisations with different pathway and emphasis. This visualization provides a different view of how role models

contribute to the development of MP in neurology, where the vertical role model is much more dominant compared to the orthopaedic.

These findings suggest some possible practical ways to support teaching and learning MP – in Indonesian specialist education and more widely. However, systematic changes to the teaching, learning and assessment of MP would require further studies building on this work. This study only picked two out of 32 registered specialist field in Indonesia. Furthermore, the chosen specialists in this study might represent two extreme categorizations of specialist (surgical and non-surgical) and therefore transferability is quite limited to other specialities. Medical professionalism for other situated specialist, such as those working in the laboratory with biologic specimens or specialists without patient contact (e.g., clinical pathologist, clinical microbiologist, parasitologist), or those touching patient only after referral by other specialist (e.g., anatomical pathologist, diagnostic radiologist, radiotherapist, forensic pathologist and legal physician), or new specialities, such as emergency specialist, is likely to be experienced and developed differently.

8.3.4 A methodological convergence of 3D-CDA and CHAT

During the fieldwork, when jotting down waiting for the next interview appointment schedule, I was projecting how this study would end, especially how the result would provide a practical benefit in improving the study programmes where I have been working. Following this moment, I had been searching literature for a way to make this deployment possible. I found that the sociomaterial perspective, especially CHAT, offered a way to realise this vision. CHAT provides a conceptual framework that enables the result of analysis in 3D-CDA to be deployed in practice. Additionally, CHAT provides a methodological vision that makes the knowledge gained from this study i.e., professionalism conception more than a reference for developing a set of learning outcome for specialist trainees. It also functions as a framework to develop the organisations or context where learning activities occur through the expansive-collaborative learning concept.

There are more significant methodological compatibilities than differences between 3D-CDA and CHAT. Some concordances of these two approaches are presented in Table 8-3

Table 8-3 Methodology convergence of 3D-CDA and CHAT

Comparability Aspect	3D-CDA	CHAT
Origin & influence	Marxist – Frankfurt school of thought: • Foucault discourse theory • Bakhtin dialogicality (Fairclough, 2004)	Marxist – Russian organisation psychology school of thought: • Bakhtin dialogicality (Engestrom, 1995)
Basic assumption about learning	Knowledge is semiotic (discourse) emergence in social change	Learning is expertise development through collaboration and transformation of activity systems as object-oriented social practice
Conception of learning context	The emergence of knowledge occurs through the exercise of ideology and power in order of discourse Context is fluid - different discourses caused by ideology and power gap which forms the order of discourse	Learning occurs in the interaction of multiple elements in activity networks through continuous internal and external contradiction Context is a moving target and represented by poly-contextual activity systems
Conception of social practice	Social practice consists of relatively stable social activities which are discursively affected by power conflict (Fairclough, 2001)	Social practice is represented as object-mediated and goal oriented activities which have a beginning and end despite its long cycle of change (Engeström et al., 1995)
Conception of social activity	Elements of social activity are not limited but might include social relations, instruments, objects, time and place, forms of consciousness, values, and discourse or semiotics. (Fairclough, 2001, 2004)	Elements of social activity are localised in Rules, artefacts, community, division of labour, subject and object of learning. (Engeström, 1999; Russell, 2009)
How the approach is utilised in this study	Analysing text data to identify how MP is carried through discourses	Discussing how the result of analysis could be deployed in practice, conceptualising context of learning and projection of expansiveness of MP to nurture learning and improve learning context.

When it comes to the deployment in professional learning practice, CHAT is much more reliable since it is relatively open as some CHAT scholars have attempted to stimulate a possible elaboration with other social practice-based theoretical framework. This includes a discussion with Latour's Actor-Network Theory (Miettinen, 1999), and also a dialogue with the "sibling" of the CDA approach, Conversation Analysis (Engeström, 2018). This study could be considered as addressing both the critique that 3D-CDA has a chronic "context" problem (Collins, 2008) and, as Davydov (1999) argues, the critique that CHAT has interdisciplinary problems:

> "Very few experimental investigations are conducted in which representatives of different disciplines - logicians, sociologists, educators, psychologists, physiologists - participate. In our own experience, the organisation of such studies requires considerable expenses and special conditions. But precisely this sort of research is of great importance today (p.49)

8.4 Discussion

8.4.1.1 ITTD and 3D-CDA: an ontological and epistemological match?

A number of social scientists and philosophers assert that a combination of research method is inevitable in the current post-structural world. It is not just representing the logical consequence of the different ways in which the world is understood and interpreted, but also represents the expression of freedom, creativity and democratisation given by science in knowledge production (Bleakley et al., 2011; Plowright, 2011; Creswell, 2014; Waring, 2017). This is also representing the view that epistemic practice (knowledge production through research) does not exclusively belong to a certain school of thought or scholars. The epistemic practice itself is always metamorphosing, a very convenient form, as some philosophers believe that knowledge has dialectic characteristic where it influences and is influenced by other forms of knowledge and society (Foucault, 1972; Fairclough, 1992; Fairclough, 2001).

However, through my learning journey during this study, shifting from a positivistic point of view into an interpretivist one, I have learned that whatever research paradigm we embrace, the knowledge production through research should be justifiable through its methodological choices. This means despite a creative combination of methods being legitimate and encouraged in the

interpretivist sphere, in order to produce justifiable knowledge, the combination should share an ontological and epistemological root. Lingard says that: “these dimensions matter much more than the methodological tools, because they shape the way the research question is asked”(Lingard, 2007, p.s129). Even the extreme proponents of the mixed method (bricolage approach) and pragmatic research approach still provide criteria on how a creative combination of methods should be applied (Plowright, 2011; Waring, 2017). In other word, methods combination that do not share ontological and epistemological roots are unlikely to produce justifiable and useful knowledge. This is the main issue this chapter is trying to discuss. In the following sub-section, I provide an argument that the combination of ITTD and 3D-CDA share ontological and epistemological roots within the interpretivist paradigm, specifically the criticalist/criticalism research paradigm (Bunniss and Kelly, 2010; McMillan, 2015), from social practice theory.

ITTD root

In the previous section, I have shown that either as a data-gathering method or as a reflection elicitation in a participatory or intervention research, ITTD has been explicitly utilised under the big category of qualitative-interpretivist research paradigm. In my review, no study using ITTD either as a stand-alone or complementary method was quantitative or mixed method. In the last three decades, the term “interpretivist” has evolved from a sole representation of qualitative research into an umbrella term for area of debate concerning emerging research paradigms, such as cognitive-constructivist, social-constructivist and criticalist/criticalism, participatory research (Lincoln et al., 2018). Noting the importance of method categorisation to help new researchers, some scholars have attempted to identify the research paradigm to which ITTD belongs. Gherardi (1995) argues there is a strong linkage with the socio-cultural research paradigm or social-constructivist as it was originally developed by Marxists research tradition. On the other hand, Nicolini (2009) offers a different perspective; that ITTD might represent critical advocacy research in professional practice. A similar view is held by Fenwick, who asserts that ITTD is a feature of a method that can be used to advocate the voice of under-represented element of society in which discourse is created and exchanged (Fenwick et al., 2012; Fenwick and Nimmo, 2015). This view is supported by

Nimmo's (2014) and Scoles's (2017) studies, which have succeeded in critically surface the unheard voice and role of the non-human component of professional practice that influence the development of professional learning and identity (Nimmo, 2014; Scoles, 2017). Hill's study shows that ITTD has been able to help the researcher team to critically explore and advocate the developmental dimension of professional identity and at the same time capture the multiplicities of professional practice. She argues that this is how ITTD offers a critical perspective methodology to the understanding of the nature of professional identity development and professional practice (Hill, 2017).

CDA root

As an analytical method, CDA has been termed the development of discourse analysis (DA) promoted by Foucault's works, despite Foucault himself never naming the methodology. However, we know from the literature that the account of DA, as an epistemic practice, is ascribed to Foucault (Fairclough, 1992; Phillips and Jorgensen, 2002; Rogers, 2011; Fairclough, 2015). Foucault has been identified as the proponent of the critical theory research paradigm, which changes the landscape of research knowledge and practices under a new paradigm called criticism. In the medical education and health profession research field, this has been recognised as an emergent research paradigm (Bunniss and Kelly, 2010; Humphrey, 2013; McMillan, 2015). The term "critical" in CDA is easily recognised as a representation of the account of the rise of critical theory in social research. Moreover, the label "critical" has also represented a movement to advocate decolonisation of knowledge, which means to advocate the knowledge and voice of minority or colonised society. Wodak and Gee argue that one essential element of CDA, amidst the variation in technicalities, is the intentional identification of power and agency behind the revealed discourses and also an attention to the minority discourse either by advocating it directly or by asserting it as a critique of the existing hegemonic discourse (Wodak, 2001; Gee, 2014). In the MHPE field, this criticalist view of knowledge advocacy also represents a movement to democratise MHPE as an emergent research field and expertise against the current domination of positivist Western medical research paradigm on medical education and health professional knowledge and practices (Bleakley et al., 2008; Bleakley et al., 2011; Hodges, 2016). Thus, by design, CDA is a feature of an analysis method

within the criticalism research paradigm and therefore influences how the researcher perceives reality (ontology) and the production of knowledge (epistemology).

In this way, ITTD and CDA are both originally influenced by and representing the criticalist research paradigm which helps the researcher to frame the ontological and epistemological aspect of the research. This research paradigm allows me to frame MP as not just the participants discourses, but also a dynamic influence of competing hegemony and ideology of agencies in the multi-dimensional face of Indonesian medical specialist practice.

8.4.2 How the combination of ITTD and 3D-CDA contribute to medical professionalism conceptualisation and professional learning in the MHPE practice and research field

I have been reflecting a tacit expectation that this study will bring insight and projection of how MP could be learned and taught more tangibly in a speciality programme, especially in Indonesia and any other countries with a similar cultural context. Through a combination of SSI-ITTD and 3D-CDA, this study has let me to examine the complexity of professional knowledge production (i.e., MP conception), in the social practice of Indonesian medical specialist service and education. Applying these methods required me, as researcher, to accept the dispositions of reality and truth within these methods. The theoretical underpinning of these methods frames an perspective in my mind that reality, represented as discourse (semiotic), has always had two faces: objective or subjective (Chouliaraki and Fairclough, 2002; Kontos and Poland, 2009; Nunez, 2013; Curtis, 2014). Objective means it has descriptive feature of phenomena or events which is usually captured through genre and style. Subjective means that discourse is always interpretative, discursive and occurs in certain situated contexts. In Fairclough's term, a discourse is always produced in an order of discourse (a situation where diverse genres and discourses and styles are networked together) (Fairclough, 2001; Fairclough, 2011).

Consequently, it follows that knowledge is understood as arbitrary and dialectic, and therefore the formulation of truth and knowledge about reality is contested among the agencies, including myself, involved in the competing discourses. Therefore, the way I interpret truth and knowledge is influenced by the dynamic interpretation of statements made by participants in interview

transcripts (objective), but also possible subjective (reflexive) experiences, learning moments, and the application of theory during the process of analyses. This allows me to see that the conception of MP is also bounded in the very situated condition of materiality of professional practice elements and their interaction. This involved human to human interaction as well as human to material (artefacts/ non-human component) in which the latter frequently exists as a taken for granted (inescapable) hegemony in professional practice. In other word, applying ITTD and CDA pushed me to situate the study within the criticalism paradigm. Consequently, the study can be aligned with the third discourse of MP conceptions recommended by the Ottawa Conference (Hodges *et al,* 2011). This means that the MP, as a knowledge, is framed as a construct created by agencies and the elements of social practice (see cell no.9 in Table 2-2, p. 30).

The research findings argue that there are situated conditions that affect the conception of MP and its development in each speciality. Whether it is perceived as cognitive-idealised, pragmatic-operationalised competence or tasks, or as an evolving development of identity in complex dilemmatic circumstance, each medical speciality has unique elements. This challenges one-fit-for all approach in teaching-learning, or assessment of MP. For instance, a difference in understanding professional lapses between neurology and orthopaedic surgery community (see Table 6-4 in chapter 6, p.171) will likely influence the focus of supervision and focus of assessment practice in each specialist programme. In Table 5-5 (p.127), neurology participants tend to see lapses as a breaching interpersonal relation with patient, while orthopaedic specialist participant perceive the lapses as related to surgical techniques or over-confidence.

Some participants reported that the public still see the physician as a single community, regardless of their speciality. For example, while neurologists still hold the old view on the mutual social contract of the doctor-patient relationship, orthopaedics specialists, in contrast, see the relationship as a simple legal relationship. However, in many excerpts, the discourses uttered by participants perceive the physician community as the powerless agency in this legal relationship. This appears in the interview, both in the SSI and the ITTD, and is linked to the issue of how powerless medical specialists are in relation to

the lobby and implementation of the insurance scheme (BPJS Law) and education regulation. This is similar to what Neelakantan and Pols indicate in their study that there is a gradual shift in the power hegemony of medical professional association in the history of Indonesia (Pols, 2006; Neelakantan, 2014). Pols even argues in his compilation of ethnographic studies in Indonesia that the current generation of medical profession is less powerful, pragmatic and apathetic with political issues compared to its past during the warfare years, independence years or during old order administration (Pols, 2013; Pols et al., 2017; Pols, 2018).

8.4.3 Converging 3D-CDA with CHAT in reinforcing professionalism learning and expanding

The in-situ observation of CHAT in theorizing activity systems and the expansive learning development of activity systems provides a more readily available deployment of theory into practice which used to be neglected in 3D-CDA. In 3D-CDA the concern with ideology and power is sought in an emancipative and timeless way which sometime made it appear borderless and contextless. The CHAT, alternatively, frames an assumption that an activity system should have a certain beginning and end of development:

> "An activity system is a complex and relatively enduring "community of practice" that often takes the shape of an institution. Activity systems are enacted in the form of individual goal-directed actions. But an activity system is not reducible to the sum total of those actions. An action is discrete, it has a beginning and an end. Activity systems have cyclic rhythms and long historical half-lives" (Engestrom, 1995. P.320)

In this sense, projecting MP conceptions, either as traits and knowledge emergence discourse, in the development of teaching-learning strategies in three interwoven medical specialist institutions becomes more sensible and deployable. It seems Indonesian medical specialist communities of practice may find it easier to grasp "institutional improvement" concept rather than "ideological discourse dialogicality". Thus, despite the versatility of 3D-CDA in this study, the packaging of MP conception in a CHAT sensibility is much more likely to appeal.

8.5 Summary of the chapter

I have established a series of arguments in this chapter to defend the use of SSI-ITTD in the data gathering method and 3D-CDA as a combined analysis

method on the grounds that they share the same ontological and epistemological root. I have provided both theoretical and empirical evidence from previous studies as well as reflexive experience from this study to establish this claim. The ITTD specifically provided an exemplary exposure to a landscape of how MP as discourse is produced, applied, or influenced, and therefore contributes richly to the second and third phase of 3D-CDA (i.e., informing the discursivity and social practice of medical professionalism in medical specialist everyday life). ITTD has also sensitively captured the very local (emic) dimensions of medical specialists' knowledge in Indonesia in upholding their multiple professional tasks, roles and identities, which consisted of both human and non-human components. Meanwhile, 3D-CDA offered a set of lenses that can be used to zoom-in on the situated context of practice and at the same time zoom-out to see the practice as a part of wider social practice context through identification of connection between discourses and agencies such as the educational practice (e.g., learning neurology or orthopaedics), service organisation and wider health policy (e.g., health financial) and social culture (e.g., a change of social role and legitimation power of professional community in the country).

Another point of departure in the methodology discussion in this study is the methodological convergence between 3D-CDA and CHAT. The utilisation of two conceptual frameworks has made it possible to locate the fluidity of MP because of its situatedness and developmental (expanding) nature in Indonesian medical specialist contexts. This opens an insight that teaching-learning MP could be utilised not just to prepare good future professionals, but at the same time could be a way to improve the multi-layered activity institutions in which MP is sought to be developed and applied.

Chapter 9 Key Findings, Implication and Recommendation

Applying a socio-cultural perspective, this study attempted to understand how medical specialist teachers and residents conceptualised medical professionalism in their everyday teaching-learning-service practice in two chosen Indonesian medical specialist educations settings. This was triggered by the emerging adoption of competency-based medical education (CBME) as a national educational approach in Indonesia's postgraduate medical education programmes, which demanded a more open, accountable, authentic, and stable definition of the graduated learning outcomes commonly declared as a competency framework. In the national medical profession competency framework, medical professionalism (MP) has been declared as one essential domain of intended learning outcomes in a nationally defined competency framework. However, there were limited written reports and literature on how MP is conceptualised in the local Indonesian context, both in undergraduate and postgraduate medical education. These limited evidence-based resources meant there was a lack of a conceptual framework on how Indonesian medical specialists conceive MP and translate it into teaching-learning practice. At the same time, postgraduate medical education has become the main workplace for learning clinical skills for undergraduate medical students and the source of the future clinical teacher's pool.

Consequently, the identification of MP conceptions in medical specialist context is critical to the further development of teaching-learning, not just for medical specialists but also for undergraduate medical education. This study served as the first attempt to explore the medical professionalism conception in the medical specialist context in Indonesia.

In this final chapter, I summarise the study's main results and findings in regard to the research questions (9.1), and the overview of all detailed accounts presented in the previous chapters. Most importantly, in the next sections, I discuss the contribution of this study to the literature and understanding of MP and its implications for further research and teaching-learning on MP (9.2). This

is followed by reflective notes on the limitations of the study (9.3) and ends with some final thoughts (9.4).

9.1 Summary of Key Findings

This study asked how medical professionalism (MP) is conceptualised by specialist teachers and postgraduate residents in Indonesian neurology and orthopaedic surgery training, and to what extent these conceptions differ from current MP concepts and discourses within the medical education research literature.

1. The role of context in understanding MP conceptualisation and its teaching-learning

The literature review on MP, as an integral part of this study, informed a historical development of scholar's understanding on MP from "just" a set of characteristics of the physician defined by sociological studies into MP as a global movement to promote more compassionate patient care and safety that govern medical education societies (Chapter 2). As a global reform discourse supported by academic tradition in developed (western) countries, the MP movement has influenced health care policy in developing countries in which health inequalities are wide, and patient safety issues are neglected. In some countries, the campaign for professionalism shaped the policies by implementing new regulatory mechanisms for medical professionals. Possibly because of different academic traditions, some of the campaigns took and used the MP concepts in studies uncritically, so these triggered a dispute on the universality and contextuality of MP. A growing number of studies from non-western contexts surfaced to argue that MP is greatly influenced by context. However, despite sharing the reform spirit, I argue that there are tendencies that some of the context-based professionalism studies were used to maintain the status quo of medical and health care practice or halted the radical reform in medical profession regulation.

Another finding from the literature review showed that most studies in non-western contexts have also embedded a typical argument translating context as nuance and container (Chapter 4). This understanding of context is diminishing because it focuses on just one aspect of learning context concept that has been

debated by western socio-cultural scholars who identified the importance of socio-cultural perspectives in reshaping professional learning or education at the workplace. This is shown by bringing socio-culture aspects of learning context as a major determinant that influences different conceptions of professionalism. The view on context as container undermines the potential of the socio-cultural or socio-material approach, which also conceives context as "activity", "network" and expanding community of practice in which the framework is used as a means to bring improvement and change to social practice (e.g., education, workplace, health care services). This reform spirit has been brought by western socio-cultural research and scholars who studied professional learning and professionalism. The contribution of this study is that it goes beyond the current bounded idea of context dominant in non-western countries to bring a more complex understanding to the exploration of professionalism conception in a complex situation of medical specialist practice in Indonesia.

2. Socio-material theory and method to explore MP in the situated and conflicting workplace

If the context is critical in the development of learning outcomes such as MP, then there should be an appropriate methodology (paradigm, theoretical underpinning and methods) to understand how MP is conceived and applied. The decision to choose ITTD to complement SSI as the data gathering method was initially inspired by the work of British socio-culturalist education scholars who promote the socio-material perspective in medical education research (Bleakley, 2010; Fenwick et al., 2012; Fenwick and Nimmo, 2015). This decision (discussed in Chapter 3) was then fortified by a critical scoping review of the potential of ITTD as a powerful tool to explore such a complex construct as medical professionalism in everyday professional life (Chapter 8). The use of ITTD as a research tool required the researcher to adopt a set of theoretical frames that involved Cultural-Historical activity theory (CHAT) and actor-network-theory (ANTI) in making sense of the relation of professionalism as a discourse and learning outcome with the complex situation of professional learning context as an integral part of social practice. This theoretical underpinning also helped to suggest the researcher used Critical Discourse Analysis (CDA) as a data analytic tool. The CDA mediates to make sense of the

text data as a representation of discourses, intertextual and interdiscursive practice, and macro-level ideologies, to make sense of the text as a social practice in which the results are used to build an understanding of how MP is developed in medical specialist practice in Indonesia.

3. The current situation of Indonesian medical specialist practice: MP as a nested activity system

Guided by suggestions from participants to read further the documents produced by the specialist community, enabled me to understand that the current situation of specialist practice (i.e., service and education) for both neurology and orthopaedics surgery specialities in Indonesia are influenced by the cultural-historical development of the speciality and the societies they served (Chapter 4). This finding suggests and warrants the framing of context as activity systems that conceives learning as a part of social practice and thus mediated by social components (cultural artefacts/tools, object of learning, rules, communities, and division of labour) (Engeström, 1999, 2001). Using the guiding principle in the third generation of activity theory (Engeström, 2001; Russell, 2009; Morris, 2012) and interdiscursivity analysis of neurology and orthopaedic surgery speciality historicity enabled me to construct the characteristic of both medical specialist contexts as a nested activity system or as Engeström et al. call it, *polycontextuality* of the activity system (Engeström et al., 1995; Russell, 2009). Through the application of historicity and other four principles in CHAT, the context of learning MP in this study can be identified as three nested activity systems, i.e., university-based educational programme, hospital-based medical service, and professional organisation.

4. The MP definition can be cognitive, operationalised, and dilemmatic

The first phase of 3D-CDA (Chapter 5) helped to identify different accounts of conceiving MP among Medical Specialist Teacher (MST) and Resident (RES) participants. The analysis observed two discourses on MP conceptualisation which presents as professional traits and knowledge emergence. As professional traits, MP can be regarded as a set of characters, abilities, and behaviour either in individual, specialist community or medical profession as a whole. As a knowledge emergence discourse, the conception of MP can be

grouped as cognitive (idealist/theoretical) conception, operationalised/normalised behaviour that occurred and applied in the workplace, and dilemmatic conception that become an ongoing and competing discourse between the first and the second.

While both discourses might work as a set of learning outcomes in a competency-based sense, through critical analysis informed by CHAT, it is likely that MP as knowledge emergence has more potential to be deployed as a learning outcome. It is because conceiving MP as cognitive, operational and dilemmatic could inspire a new way of deploying MP other than just a learning outcome, but also as a professional responsibility to improve the institution where the practice is undertaken. In this notion, teaching-learning MP is not limited to facilitating individual cognitive, moral reasoning, behaviour development or professional identity formation, but also a means to transform practice and nurture adaptive ability toward the latent competing interests and powers in health care and professional organisations which have been envisioned by scholars and medical education reform agencies (Royal College of Physicians and Physicians, 2005; Frenk et al., 2010; Cooke et al., 2010). The transformative and adaptive ability should include not just the provision to work with different professionals, work arrangements and workplaces, but also the possibility of developing a new collective way of conduct, rules, new branches of professionals/workforces in health care.

5. MP, as learning outcome and professional responsibility, is contextually co-produced, involving many social actors

In the second phase (chapter 6), the analysis focused on the exploration of how the discourses on conceiving MP have a relationship which one another through intertextuality and interdiscursivity both in each speciality and across speciality cases. This resulted in the second phase of CDA which triangulates with the results of agencies and power identified in the third phase of CDA.

This analysis allowed the identification of a number of significant others/agencies that influenced the development of MP conception. The agencies could involve the patients, peer residents (junior, senior and same peerage), supervisors, other health professionals, organisational authorities,

and professional organisation chairs (See Table 7.4 in Chapter 7). While it is common to notice a top-down nature of teaching (teacher to student, or senior to junior), this study has also shown a feature of how senior residents learn through "informally" supervising activity with their junior peers as well as how some MST openly learn from their resident, especially on the use of new technique and medical technologies. For example, the ability to be a reflective practitioner is critical in nurturing the constructive longitudinal development of MP among residents. Concerning the perception of the majority of resident participants that they have less contact with supervisors and are keen to learn more with their peers, I argue there is a need to develop knowledge on teaching in the clinical context, especially in providing feedback during residency for both teacher and resident as a part of professionalism teaching. This is not just to empower the teacher as a role model (walk the talk) but also to empower the benefit of peer learning. In order to develop this, a form of faculty development or innovative teaching programme, such as resident as a teacher is likely needed.

The study has also shed light on a neglected potential of networking teaching hospitals. These used to be regarded as secondary teaching workplaces for the resident, but participants identified them as the most authentic place for the future specialist. Some residents, especially those in orthopaedic surgery, shared reflections of how an experience at this hospital provided a rich learning experience but was often uncoordinated and isolated from the main more "updated" teaching hospital.

Another interesting finding is a dominant perspective of medical specialists as to the importance of interprofessional collaboration and education. However, the perception of importance is almost limited to the provision of providing tasks and collaboration with the same profession (i.e., same medical profession but different specialisation). The discussion becomes salient and not engaged if it is related to other health professions (e.g., nurse, dietitian, pharmacy). Excerpts from ITTD showed a common disengagement feature in the current residency education on interprofessional education issues, which are frequently limited to the provision of completing tasks which inevitably "designed" to work with other health professions (e.g., a surgical theatre, at the ward, examination device). However, the topic of perceiving interprofessional collaboration as a means to

improve quality of care, patient safety and knowledge is likely undeveloped. This is in contrast with the growing campaign on IPE and patient safety in the country, which has been brought by the health professional education community and hospital accreditation.

The findings clustered in this section (i.e., teaching resident to become a teacher/providing constructive feedback, co-production in developing new technology-based technique, and interprofessional collaboration) are some paths this study has opened and warrant further academic work, either designing faculty development programmes or innovative teaching programmes which align with an educational improvement agenda (i.e., participatory research projects).

6. Four situated socio-cultural Ideologies (order of discourses) that frame MP conceptualisation of Indonesian medical specialist

In the third phase of CDA (chapter 7), framing discourses as social practice, I attempted to explore the social agencies and source of powers and ideologies that interplay in the emergence of discourses. In this phase, I have discovered four discourses that make up the distinctive feature of how MP is conceived across two specialist medical contexts. I argue that these discourses are the representation of ideologies that are rooted in the socio-cultural and historical development of the Indonesian medical profession. These four ideologies are 1) postcolonial mind; 2) spiritual-religious practice; 3) communalism/collectivism, and 4) competing-symbolised externally regulated practice. Understanding these ideologies suggests that learning MP as a learning outcome domain (education domain) and professional responsibility (practice domain) is mediated through conflicting and governing discourses. Therefore, an intriguing question follows, "How MP could be best taught and learnt in these situated conflicting and governing discourses." Chapter 7 offers some possible answers based on the theoretical underpinning in Fairclough's CDA, which resonates with the socio-material perspective. However, these speculations warrant further research and investigations.

9.2 Implication and recommendation of the study

As an explorative study, I argue the result of this research is more than just a way forward to open a discussion in developing conversations in medical specialist education practice, especially conversations about developing the teaching and learning of MP. There are several justifications for this

Firstly, I believe the methodological approach utilised in the study (combining CDA and CHAT) brings inspiration to explore further the potential application of a sociocultural perspective on professional learning in understanding how medical and health professionals in Indonesia develop their professionalism. This has special relevance because the current Indonesian medical education research community has been dominated by positivist and individualistic theoretical perspectives of learning, reflecting my own early position as a researcher. Learning at the workplace is frequently seen as an individual process of interaction of the learner with learning resources. Utilizing sociocultural perspectives on professional learning, such as CHAT, reinforces the critical role of the involvement of learners with community. This draws attention to how division within health workforces, as well as the role of learning environment, shapes professional learning, including learning medical professionalism which has been agreed as a core competency for the medical profession. The utilization of CHAT allows professional learning to be seen as participatory learning involving both human (peer, teacher, health professions, patients) and non-human components (rules, guidelines, ward setup, medical tools etc) in the workplace, while the utilization of CDA can help medical educators become aware of the competing powers and ideologies that might shape the quality of learning. Therefore, adopting an individual theory of learning (Mann, et al., 2011) or focusing solely on individual behaviour development (Martimianakis et al., 2009) as a means to facilitate instructional design for medical professional learning at the Indonesian workplace seems to be insufficient to foster the situated and collective context required for medical professionalism development. Rather, based on findings of this study, MP development in specialist education is transformed through active involvement with various activity systems represented as education, service and professional organizations. In Hafferty's (2017) words, in developing their MP, residents are involved in socialization with various community of practice at their multiple workplace which are mostly undisclosed in residency curriculum and become a hidden curriculum.

Secondly, although the methodological approach developed in this study was applied only to understand medical professionalism in two Indonesian medical specialist contexts, I believe it is an approach that is potentially transferrable to any similar complex situation of other medical specialist contexts because it is able to capture where the learner and activity systems might, and might not, share similar characteristics. The use of CHAT as an underpinning theory and approach in MP teaching-learning at workplace seems appropriate to Asian, especially, Indonesian learners, whose social values are characterised as both more collective and hierarchical when compared to western society, such as North American or European (Suhoyo et al., 2014; Claramita et al., 2019; Hofstede Insight, 2021), and likely the current specialist education worldwide (Bleakley, 2010; Engeström, 2014). However, studies need to be conducted to test this hypothesis and assumption.

Thirdly, reflecting on some of the findings, i.e., the lack of feedback, developing teachers to learn new methods with residents (learning co-production), and lack of interprofessional collaboration, gave me strong encouragement to think about the relevance and potential of the socio-material perspective as a framework to develop a systematic participatory project such as the Change Laboratory (Engeström, 2018). Such a project could facilitate the improvement of teaching-learning in specialist study programs, along with the provision of the hospital and the management of study program, to develop the quality of care and research. This would be specifically applicable to my own school

Fourthly, the different accounts of conceiving MP in this study also suggest strongly that MP is a socio-culturally construct, which is affected by the different agencies and ideologies (power) impacting on the two specialities. The similarities and differences of the MP conception that arise may open new conversations for performing a research-based formulation of MP as a set of new learning outcomes. It might also inspire further inquiries to develop more congruence but innovative ways of teaching-learning and assessing MP in the complex situation of professional workplaces. For instance, deliberate involvement of health professionals (e.g., nursing, dietician) in specialist teaching learning, which were not sought in most of the speciality study programs in this research. Another possibility is formal recognition by the

accreditation team of the roles undertaken by the residents as a way for the resident to learn collaborative leadership and system improvement as many residents (RESO4, RESO5) regarded the administrative work in organization management as a demanding task given to them by their supervisors but one which was not relevant to them

Finally, although the study took place in the biggest ASEAN country (population and geographically), it is unlikely that the results of the study are generalisable to the medical specialist context in any other ASEAN country, nor was it intended to do so. Instead, this study intended to open a conversation, or perhaps a debate, on how context influences practice and the conception of professionalism and, following from this, how “context” could be used to make sense of the development of complex knowledge/competence, such as professionalism. Furthermore, I am enthusiastic that the study brings a different insight to wider discussions of MP by demonstrating how MP is differently conceived and nurtured among medical specialists in Indonesia (a non-western, ASEAN country)

9.3 Limitation of the study

Despite the fact that the study has been conducted by following the methodological rigour of the qualitative approach in sampling and analysis, this study has several limitations. Firstly, the study purposively took sampling from four leading faculties of medicine where the principals of specialist associations and college of specialist originated from, and these faculty of medicine are all located in Java, the most populated island in the country. Consequently, as indicated by some participants (e.g., MSTN1, MSTN4, RESN2, RESO1) and supported by anthropologist writings (Geertz, 1960; Thornton, 1972; Santoso, 2015; Ponka et al., 2019), the view captured in the interview might strongly be influenced by and representing the dominant Javanese socio-cultural perspective. Although this feature provides strong evidence of the current influence of a long-standing hegemonical socio-cultural ethnic group in the nation, in critical discourse analysis perspective, this might have limited the opportunity to explore the less dominant influence of race in medical specialist education practice. The surfacing of the dominant Javanese view might have masked the other races’ view (if there is any) because the concern was to

understand how the dominant hegemony influenced the MP conception. This might inform future research to deliberately sample the different races as a possible influential context (activity systems) in the development of MP.

Secondly, the study also took purposively two out of 32 existing medical specialities (specialist branches), which covers the limited scope of specialist education context. Although the chosen specialities (i.e., neurology and orthopaedic surgery) might have a similar context to other speciality programme profiles, there are some contexts in another speciality that clearly will not be able to be captured, mainly because of the nature of service and work of the specialist. For instance, by the nature of services, both neurology and orthopaedic surgery are specialists that meet their patients directly. Furthermore, they both are typically sending patients to another specialist to collect data for fulfilling their duty (e.g., radiologist, clinical pathologist, anatomical pathologist, and medical rehabilitation). Consequently, there are specialists that typically work based on the referral of these two specialists, which are beyond this study's reach. In this sense, however, these unique situations might be the next research avenue to be explored, considering the uniqueness of their activity systems/contexts. An insight from this study provides a theoretical warrant that different contexts of specialities might serve as a possible different trajectory of conceptualising medical professionalism and its application.

Thirdly, the result of the study is influenced by its design and methodological approach. This study adopted a critical interpretivist paradigm and methodologies which are different to the more common and dominant positivist approach understood and adopted by the majority of medical profession in Indonesia. Therefore, the extent of the acceptability of the study result depends on the ability of researcher to collect and interpret the data critically with three aspects of discourse as advocated by Fairclough. In this sense, considering that discourse research is not popular amongst Indonesian medical education practitioners, it might provide a challenge to translate and suggest the result of the study to inform medical education practice because it might not be easy to persuade people of the value of something which originates in a different research tradition and interpretation

Finally, whilst this research consistently covers the view of purposively selected medical specialist professions in relation to their own conception of professionalism, and how this related to patients as their main customer, both MST and resident are still representing their own community. Their views on the patient could well be limited as a one-sided perspective or the outsider view of patients. Consequently, any conclusions about how patients understand or experience a doctor's professionalism are unlikely to capture an accurate view of the patient perspective. This reflection opens many possibilities and suggestions concerning the design of further studies regarding professionalism in medical and health profession education (MHPE) that could involve patients exploring current or possible different conception of professionalism followed by an in-depth critical discourse analysis. Another option a researcher could take is utilizing the combination of SSI and ITTD as a modification to the Change Laboratory introduced by Engestrom (2018) to gather both patients' and professionals' perspectives to improve the educational practice (activity systems) that support the development of professionalism at the workplace.

9.4 Final thoughts

As an explorative study, this work attempted to understand how medical professionalism is conceived and applied in the everyday practice of medical specialist residents and teachers in a developing country in the Southeast Asia region. The study was inspired by the lack of information on how professionalism is developed in a local situated context of Indonesia due to a minimal number of published papers. Moreover, the minimal research experience in interpretivist stance and totally new socio-cultural research traditions have complicated the situation, making these like double horse whips to learn more. However, at last, this study has ended with two significant contributions to the development of knowledge about understanding professionalism conceptualisation in a situated context and an appropriate methodological approach to studying it.

Although the knowledge on situated MP conception might provide insights to support the medical specialist educator in designing MP teaching-learning in the country, the results of the study also generated a lot of questions and challenges other than the answers to the research question being asked.

However, I believe the typical contribution of an explorative study becomes a basis for further study, which means this study is just a small beginning for another tougher journey on researching and reshaping how MP is taught and learned in the medical education continuum in the country.

Reflecting back to this study as a whole, from the beginning up to this stage, makes me realise that it is indeed a work in progress as I was intrigued by the spirit of never-ending system learning in CHAT's expansive learning. Projecting myself as a subject in my own activity systems, I feel there are still more boundary crossings that can be done in analysing existing data and reflecting on identified results. Time, boundaries, and my limited research experience seem to have interfered with this progress. However, I still expect that what this study offers can shed light on what I regard as an essential concept in approaching the nature of situated and indigenous medical professionalism through discourses and socio-materiality perspectives. I consider that the corpus-based critical discourse analysis characterising MP from the socio-material perspective and sensibility (i.e., CHAT and Actor-network-theory) can inspire medical educators in the country to make sense of the context of learning and its relationship with the teaching-learning practice of MP.

I am motivated to advance my work in this study by using the methodological approaches developed, the findings, and the proposed speculative ideas to develop them further. To this end, I remain unsure how MP could be taught and learned better, even in my medical school, where almost all specialist medical education programmes are present. However, I do believe that through this study, I could oversee the next pathway on my identity development as a medical educationist teacher and an agent of change to my medical school and country's medical education society.

Appendices

Appendix A. National Curriculum for Indonesian Medical Education

Table A.1 Content Heading Comparison of Indonesia's national curriculum for medical education from KIPDI I, II and SKDI

Milestone	Content Headings / Intended Learning Objectives	Length of Study & Measures
KIPDI I (1981)	Basic Science Department:	Bachelor: 4 years of fully classical & laboratory-based courses Each course was delivered by distinct experts in established department Clinical Rotation: 2.5 year
	- Medical Chemistry knowledges	
	- Medical Biology knowledges	
	- Medical Physic knowledges	
	Pre-Clinic Department:	
	- Anatomy& Histology	
	- Physiology	
	- Biochemistry	
	Para Clinical Department:	
	- Microbiology	
	- Parasitology	
	- Clinical Pathology	
	- Anatomical Pathology	
	- Anatomy	
	- Pharmacology	
	Clinical Department:	
	- Internal medicine knowledges	
	- Surgical knowledges	
	- OBG knowledges	
	- PeDNLc knowledges	
	- Public Health Knowledges	
	- ENT Disease Knowledges	
	- Neurology Disease Knowledges Eye Diseases knowledges	
	- Psychiatry Disease Knowledges	
	- Teeth & Mouth Diseases knowledges	
	- Forensic Medicine	
	- Anesthesiology	
	- Radiology	
KIPDI II (1994)	Ibid	Ibid
Competency Standard for Indonesian Medical Doctor SKDI (2006)	**Area of Competency:** 1. Effective Communication 2. Clinical Skills 3. Basic medical Sciences 4. Health Problem Management 5. Information Management 6. Self-Assessment & Self-Development 7. Ethics, Morality, Medicolegal and	Bachelor: 3,5 years with early clinical exposure in Year 3 Clinical Rotation: 1.5-2 years

Milestone	Content Headings / Intended Learning Objectives	Length of Study & Measures
	Professionalism and Patient Safety **Appendices**: a) List of health problem b) List of Diseases c) List of Clinical Skills	
Competency Standard for Indonesian Medical Doctor SKDI (2012)	**Area of Competency:** 1. Noble Professional 2. Self-awareness & self-development 3. Effective Communication 4. Information Management 5. Scientific Based of Medical Knowledges 6. Clinical Skills 7. Health Problem Management **Appendices**: a) List of Core Topics Content on each area b) List of Health Problems c) List of Diseases with level of competency / expected entrustability per Body System (12 Body System) d) List of Clinical Skills with level of competency / expected entrustability per Body System (12 Body System)	Bachelor: 3,5 years with early clinical exposure in Year 3 Clinical Rotation: 1.5-2 years

Notes:

KIPDI: Kurikulum Inti Pendidikan Dokter Indonesia (Core Curriculum for Indonesia Medical Education

SKDI: Standar Kompetensi Dokter Indonesia (Competency Standard of Indonesian Medical Doctor)

Appendix B. Demography of Medical Education in Indonesia in 2018

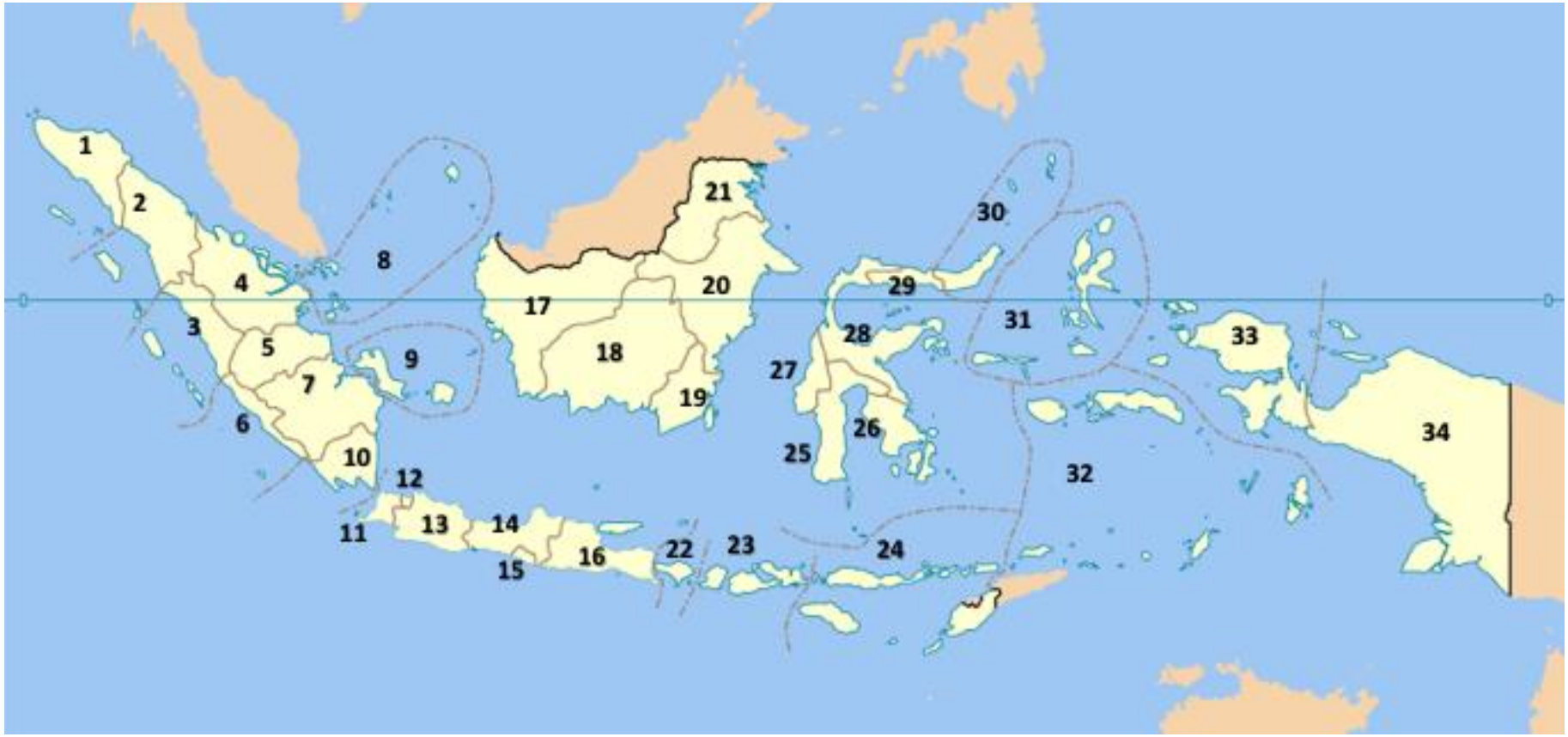


Figure B.1 Province where faculty of medicines are located in Indonesia

Table B.1 The number of faculty of medicine in Indonesia Its province location based on Figure B.1 in 2018

No.	Province	Number of Med School	No.	Province	Number of Med. School	No.	Province	Number of Med. School
1	D.I Aceh	3	13	Jawa Barat (West Java)	4	25	Sulawesi Selatan (South Sulawesi)	4
2	Sumatera Utara (North Sumatera)	6	14	Jawa Tengah (Mid Java)	8	26	Sulawesi Tenggara (South-East Sulawesi)	1
3	Sumatera Barat (West Sumatera)	3	15	D.I Yogyakarta	5	27	Sulawesi Barat (West Sulawesi)	-
4	Riau	2	16	Jawa Timur (East Java)	13	28	Sulawesi Tengah (Mid Sulawesi)	2
5	Jambi	1	17	Kalimantan Barat (West Kalimantan)	1	29	Gorontalo	1
6	Bengkulu	1	18	Kalimantan Tengah (Mid Kalimantan)	1	30	Sulawesi Utara (North Sulawesi)	1
7	Sumatera Selatan (South Sumatera)	2	19	Kalimantan Selatan (South Kalimantan)	1	31	Maluku Utara (North Maluku)	1
8	Kep.Riau (Riau Islands)	1	20	Kalimantan Timur (East Kalimantan)	1	32	Maluku	1
9	Kep.Bangka Belitung	-	21	Kalimantan Utara (Norh Kalimantan)	-	33	Papua Barat (West Papua)	1
10	Lampung	2	22	Bali	2	34	Papua	1
11	Banten	3	23	Nusa Tenggara Barat (West Nusa Tengara)	2	Total Number of Medical School		85
12	DKI Jakarta	13	24	Nusa Tenggara Timur (East Nusa Tenggara)	1			

*The cells with green background are the chosen faculty of medicine in this study.

Table B.2 List of Registered Postgraduate Medical Education/ Specialty Programs in Indonesia per October 2018

No	Specialty Training	Standard Length of Study (semester)	Medical Schools													
			1	2	3	4	5	6	7	8	9	10	11	12	13	14
			UNSYIAH	USU	UNAND	UNSRI	UI	UNPAD	UGM	UNS	UNDIP	UB	UA	UNUD	UNHAS	UNSRAT
1.	Internal Medicine	12	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
2.	General Surgery	11	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
3.	Orthopedic Surgery	10	-	Y	-	-	Y	Y	Y	Y	-	Y	Y	Y	Y	-
4.	Neurosurgery	11	-	Y	-	-		Y	Y	-	Y	-	Y	-	Y	-
5.	Plastic Surgery	10	-		-	-		Y	-	-	-	-	Y	Y	-	-
6.	PeDNLc Surgery	10	-	-	-	-	-	Y	Y	-	-	-	Y	-	-	-
7.	Urology	10	-	Y	-	-	Y	Y	Y	-	-	Y	Y	Y	-	-
8.	OBGyn	9	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
9.	Anesthesiology	8	Y	Y	-	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	-
10.	PeDNLc	8	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
11.	Neurology	8	-	Y	-	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
12.	ENT	8	Y	Y	-	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	-
13.	Ophthalmology	8	-	Y	-	Y	Y	Y	Y	-	Y	Y	Y	Y	Y	Y
14.	Dermato-Veneorology	7	-	Y	-	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
15.	Pulmonology	8	Y	Y	-	-	Y	-	-	Y	-	Y	Y	Y	Y	-
16.	Cardiology	9	Y	Y		-	Y	Y	Y	Y	Y	Y	Y	Y	Y	-
17.	Psychiatry	8	-	Y		-	Y	Y	Y	Y	Y	Y	Y	Y	Y	-
18.	Forensic	7	-	Y		-	Y	Y	Y	-	Y	-	Y	-	Y	-
19.	Anatomical Pathology	8	-	Y		Y	Y	Y	Y	-	Y	Y	Y	Y	Y	-
20.	Clinical Pathology	8	-	Y		-	Y	Y	Y	Y	Y	Y	Y	-	Y	-
21.	Radiology	8	Y	-	Y	-	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
22.	Clinical Microbiology	8	-	-		-	Y	-	Y	-	Y	Y	Y	Y	Y	-
23.	Clinical Parasitology	8	-	-		-	Y	-	-	-	-	-	-	-	-	-
24.	Radiotherapy	8	-	-		-	Y	-	-	-	-	-	-	-	-	-
25.	Medical Rehabilitation	8	-	-		-	Y	Y	-	-	Y	-	Y	-	-	Y
26.	Emergency Medicine	8	-	-	-	-	-	-	-	-	-	Y	-	-	-	-
27.	Sport Medicine	7	-	-	-	-	Y	-	-	-	-	-	-	-	-	-
28.	Nuclear Medicine	7	-	-	-	-	-	Y	Y	-	-	-	-	-	-	-

No	Specialty Training	Standard Length of Study (semester)	Medical Schools													
			1	2	3	4	5	6	7	8	9	10	11	12	13	14
			UNSYIAH	USU	UNAND	UNSRI	UI	UNPAD	UGM	UNS	UNDIP	UB	UA	UNUD	UNHAS	UNSRAT
29.	Clinical Nutrition	8	-	-		-	Y	-	-	-	Y	-		-	Y	-
30.	Clinical Pharmacology	7	-	-		-	Y	-	-	-	-	-		-	-	-
31.	Occupation Medicine	6	-			-	Y	-	-	-	-	-	-	-	-	-
32.	Andrology	8	-			-	-	-	-	-	-	-	Y	-	-	-

Note: Y: present; (-): the programme is not present; * School where the researcher is working. Yellow cells represents the involved specialty in the study

Figure B.2 Location of Faculty of Medicine offering Specialty Program

Table B.3 List of Medical School Offering Specialty Program and its Location

NO	Name of School	Abbreviation	Town	Province & Number in Figure B.2
1	Universitas Syiah Kuala	UNSYIAH	Aceh	NAD (1)
2	Universitas Sumatera Utara	USU	Medan	North Sumatera (2)
3	Universitas Andalas	UNAND	Padang	West Sumatera (3)
4	Universitas Sriwijaya	UNSRI	Palembang	South Sumatera (4)
5	Universitas Indonesia	UI	Jakarta	Jakarta (5)
6	Universitas Padjajaran	UNPAD	Bandung	West Java (6)
7	Universitas Gadjah Mada	UGM	Yogyakarta	Jogjakarta (7)
8	Universitas Negeri Sebelas Maret	UNS	Solo	Mid Java (8)
9	Universitas Diponegoro	UNDIP	Semarang	Mid Java (8)
10	Universitas Brawijaya	UB	Malang	East Java (9)
11	Universitas Airlangga	UA	Surabaya	East Java (9)
12	Universitas Udayana	UNUD	Denpasar	Bali (10)
13	Universitas Hasanuddin	UNHAS	Makassar	South Sulawesi (11)
14	Universitas Sam Ratulangi	UNSRAT	Manado	North Sulawesi (12)

Appendix C. Ethical Approval

C1. Ethical Approval from MREC University of Leeds

The Secretariat
University of Leeds
Leeds, LS2 9JT
Tel: 0113 3431642
Email: FMHUniEthics@leeds.ac.uk

UNIVERSITY OF LEEDS

31 May 2019

Rachmad Sarwo Bekti
PhD Student
LIME
Faculty of Medicine & Health
Worsley Building
University of Leeds
LEEDS LS2 9NL

Dear Rachmad

Ref no: **MREC 18-067**
Study Title: **Exploration of Medical Professionalism Across Postgraduate Medical Education in Indonesia**

Thank you for submitting your documentation for the above project. Following review by the School of Medicine Research Ethics Committee (SoMREC) I can confirm a conditional favourable ethical opinion based on the documentation listed below, received at date of this letter *and subject to the following conditions which must be fulfilled prior to the study commencing:*

1. **Evidence of in-country permission/approval and local managerial permission from the research sites should be submitted where required to be in place**
2. **Check all documents for typographical errors (particularly the PIS)**
3. **Add your University of Leeds email address to the flyer for residents**
4. **Add the University of Leeds logo to all documents**

The study documentation must be amended as required to meet the above conditions and submitted for file and possible future audit. Once you have addressed the conditions and submitted for file/future audit, you may commence the study and further confirmation of approval is not provided.

Please note, failure to comply with the above conditions will be considered a breach of ethics approval and may result in disciplinary action.

Document Received	*Version*	*Date Received*
RSB_Ethical_Review_Form_V 1.4	1.4	16/04/2019
RSB_Annex.1 _Information Sheet_v1.4	1.4	16/04/2019
RSB_Annex.2_Participants Consent_V1.4	1.4	16/04/2019
RSB_Annex.3_Interview Guide_v1.4	1.4	16/04/2019
RSB_Annex.4_Flyer to Resident Participant	1.0	16/04/2019
RSB_Annex.5_Data Management Plan_V 1.3	1.3	16/04/2019
RSB_Annex.6_Fieldwork Assessment Low Risk_v 1.1	1.1	16/04/2019
RSB_Annex.7_Letters to College and Dean FM v1.4	1.4	16/04/2019

Please notify the committee if you intend to make any amendments to the original research as submitted at date of this approval. This includes recruitment methodology and all changes must be ethically approved prior to implementation. Please contact the Faculty Research Ethics Administrator for further information FMHUniEthics@leeds.ac.uk

Ethical approval does not infer you have the right of access to any member of staff or student or documents and the premises of the University of Leeds. Nor does it imply any right of access to the premises of any other organisation, including clinical areas. The SoMREC takes no responsibility for you gaining access to staff, students and/or premises prior to, during or following your research activities.

You are expected to keep a record of all your approved documentation, as well as documents such as sample consent forms, risk assessments and other documents relating to the study. This should be kept in your study file, and may be subject to an audit inspection. If your project is to be audited, you will be given at least 2 weeks notice.

C2. Ethical Approval from MHREC Universitas Gadjah Mada

MEDICAL AND HEALTH RESEARCH ETHICS COMMITTEE (MHREC)
FACULTY OF MEDICINE, PUBLIC HEALTH AND NURSING
UNIVERSITAS GADJAH MADA – DR. SARDJITO GENERAL HOSPITAL

ETHICS COMMITTEE APPROVAL

Ref. No. : KE/FK/0458 /EC/2019

Title of the Research Protocol	:	Eksplorasi Konsepsi Profesionalisme Dokter pada Pendidikan Spesialis di Indonesia
Document(s) Approved and version	:	1. Study Protocol version 01 2019 2. Information for Subjects version 01 2019 3. Informed consent form version 01 2019
Principle Investigator	:	Rachmad Sarwo Bekti
Participating Investigator(s)	:	1. Prof Richard Fuller 2. Prof Trudie E Roberts 3. Dr. Rebecca O'Rourke
Date of Approval	:	30 APR 2019 (Valid for one year beginning from the date of approval)
Institution(s)/place(s) of research	:	Jakarta, Bandung, Yogyakarta, Malang, Surabaya

The Medical and Health Research Ethics Committee (MHREC) states that the document above meets the ethical principle outlined in the International and National Guidelines on ethical standards and procedures for researches with human beings.

The Medical and Health Research Ethics Committee (MHREC) has the right to monitor the research activities at any time.

The investigator(s) is/are obliged to submit:
□ Progress report as a continuing review (state its due time)
□ Report of any serious adverse events (SAE)
☑ Final report upon the completion of the study

Dr. dr. Eti Nurwening Sholikhah, M.Kes., M.Med.Ed.
Panel's vice chairperson

dr. Rizka Humardewayanti A., Sp.PD-KPTI.
Panel's secretary

Recognized by Forum for Ethical Review Committees in Asia and the Western Pacific (FERCAP)
26-Apr-19

C3. Ethical Approval from HREC Universitas Brawijya

KEMENTERIAN RISET, TEKNOLOGI, DAN PENDIDIKAN TINGGI
UNIVERSITAS BRAWIJAYA
FAKULTAS KEDOKTERAN
KOMISI ETIK PENELITIAN KESEHATAN
Jalan Veteran Malang - 65145, Jawa Timur - Indonesia
Telp. (62) (0341) 551611 Ext. 168; 569117; 567192 - Fax. (62) (0341) 564755
http://www.fk.ub.ac.id e-mail : kep.fk@ub.ac.id

ETHICAL APPROVAL

No. 153 / EC / KEPK – S3 / 05 / 2019

Health Research Ethics Committee (HREC) Faculty of Medicine Brawijaya University, after conducting ethical review of research protocol:

TITLE : **Exploration of Medical Professionalism Across Postgraduate Medical Education in Indonesia.**

Principal Investigator : **dr. Rachmad Sarwo Bekti, M.MedEd**

Institution : **Faculty of Medicine and Health, Leeds Institute of Medical Education**

Has confirmed this protocol is approved. This ethical approval is May 07, 2019 until May 07, 2020. Should there be any modification (amendment) and / or extension of the study, the Principal Investigator is required to resubmit the protocol for approval. A progress and final summary report should also be submitted to the HREC Faculty of Medicine Brawijaya University.

Malang, 14 MAY 2019

Chairman,
Health Research Ethics Committee

Prof. Dr. dr. Moch. Istiadjid ES, Sp.S, Sp.BS(K), SH, M.Hum, Dr(HK)
NIPK. 2018024605161100 1

Appendix D. Research Protocols

Form D1. Semi-Structured Interview (SSI) Guide for MST

Date / Time :

Place :

Introduction Script

Hello my name is Rachmad Sarwo Bekti. Thank you very much for your availability to be interviewed. This interview is a part of my PhD project entitled "Exploration of Medical Professionalism concept across Indonesia's Postgraduate Medical Education". This interview should take about 120-180 minutes to complete. Please remember that everything you share with me will be kept strictly confidential and anonymous. None of your information or information you convey will be shared outside this study. Please note that there is no right or wrong answers to these questions. I am only interested in your opinions. If you find any of these questions difficult, please let me know. If you wish to decline to answer, you may do so. And you don't have to give an explanation for this. I would like this interview to follow the sequence, but if you need to take a break, please let me know. If you have any questions, please let me know.

As a part of Ethical approval, you are requested to sign to say you give your informed consent. Do you mind doing that? Do you have any questions before we begin the interview?

To make sure I catch what you will say comprehensively and to make easy the analysis, I will be using an audio recorder and may make notes during this conversation, do you mind if I do that? You have the right to see the transcript of the recording to make sure that I catch your views correctly.

This is interview (Study ID#) on (date) and he/she understand that this interview is being recorded. Is this correct? [let the respondent answer].

This Interview will consist of two sessions. In the first session I am going to ask several questions regarding the topic of medical professionalism and in the second session we will do exercise which is called talking to the double. Let's start for the session.

Table D1. List of expected questions

No	Construct	Main & Probing Questions (Probing question only being asked if the main question is not addressed fully)
1.	Worldview / Cultural Values	1. How would you describe a good specialist? a. What makes for a good doctor? b. Do you think there is a specialist-specific professionalism? What does it include? c. How is that different from other specialties? d. Is it shared among all doctors in Indonesia? Or only your peers? 2. What do you know about medical professionalism (MP)? What is it about? a. Reflecting to this understanding (refer to what participants said, When and how do you achieve this understanding?) / How do you 3. How does MP apply in your professional life? a. How does it apply in your teaching life? 4. Is this knowledge related with what you believe in life? / Your values in life? What are they? a. Do you transfer this values/belief in your teaching session? How?
2.	Ethics, Moral Reasoning, Lapses and Dilemma	1. Have you ever had a critical moment in practice that challenged your belief understanding of MP a. Elaborate on the pharmacy role, and treatment technology b. What is it & How did you deal with that? 2. How do you thin other doctors will deal with that situation? 3. Is there such a thing as lapses in professionalism? What are they? can you describe and give example? a. Is there anything that can be done to fix or prevent this? 4. What is the function of the code of ethics & moral reasoning?
3.	Teaching Learning Paradigm & Theory	1. Should the specialty programme teach medical professionalism? Why and how? a. Is there such a thing that school value influencing the professionalism construction? b. Which is stronger - school value or peer (specialist) value? c. Why do you think so? 2. What factors in specialty teaching influence the development of MP?? Can you say more? a. What will positively contribute to development of this MP? b. What will negatively contribute to demise of this MP? c. What is the role of learning environment play any role in MP development in specialty? How? d. What is the role of technology
4.	Patient & external party Involvement	Do patients play any role in MP development in specialty? How? What do you think the role of the Medical Association and College of Specialty is in the development of MP
5.	Any (perceived) Distinct / Unique Conceptions? With existing components in SKDI	1. Have you read SKDI's description of medical professionalism? a. If YES, what do you think about it? How does it relate with your specialty? 2. If you had an authority to make changes, what would you do for this medical professionalism conception in your specialty?
6.	Miscellaneous	Any other things you would like to add? Any question you would like to ask?

If there is no other response could be added, I think this interview session can be finished. There is one more session about sharing experience in a monologue form. I would like to do it at a different time to respect your valuable time, but if you would like to conduct it now, I would also be please to do it.

Would you like to do it now or sometime in the future?

Researcher Note:

Form D1b. Semi-Structured Interview (SSI) Guide for Resident

Date / Time :

Place :

Introduction Script

Hello my name is Rachmad Sarwo Bekti. Thank you very much for your availability to be interviewed. This interview is a part of my PhD project entitled "Exploration of Medical Professionalism concept across Indonesian Postgraduate Medical Education". This interview should take about 120-180 minutes to complete. Please remember that everything you share with me will be kept strictly confidential and anonymous. None of your information or information you convey will be shared outside this study. Please note that there is no right or wrong answers to these questions. I am only interested in your opinions. If you find any of these questions difficult, please let me know. If you wish to decline to answer, you may do so. And you don't have to give an explanation for this. I would like this interview to follow the sequence, but if you need to take a break please let me know. If you have any questions, please let me know.

As a part of Ethical approval, you are requested to sign to say you give your informed consent. Do you mind do that? Do you have any questions before we begin the interview?

To make sure I catch what you will say comprehensively and to make easy the analysis, I will be using an audio recorder and may make notes during this conversation, do you mind if I do that? You have the right to see the transcript of the recording to make sure that I catch your views correctly.

This is interview (Study ID#) on (date) and he/she understand that this interview is being recorded. Is this correct? [let the respondent answer].

This Interview will consist of two sessions. In the first session I am going to ask several questions regarding the topic of medical professionalism and in the second session we will do exercise which is called talking to the double. Let's start for the session.

Table D-2. List of expected questions

No	Construct	Main & Probing Questions (Probing question only being asked if the main question is not addressed fully)
1.	Worldview / Cultural Values	1. How would you describe a good specialist? a. What makes for a good doctor? b. Do you think there is a specialist-specific professionalism? What does it include? c. How is that a different from other specialties? d. Is it shared among all doctors in Indonesia? Or only your peers? 2. What do you know about medical professionalism (MP)? What is it about? a. Reflecting to this understanding (refer to what participants said, When and how do you achieve this understanding?) / How do you 3. How does MP apply in your professional life? a. How does it apply in your teaching life? 4. Is this knowledge related with what you believe in life? / Your values in life? What are they? a. Do you transfer this values/belief in your teaching session? How?
2.	Ethics, Moral Reasoning, Lapses and Dilemma	1. Have you ever had a critical moment in practice that challenged your belief understanding of MP a. Elaborate on the pharmacy role, and treatment technology b. What is it & How did you deal with that? 2. How do you thin other doctors will deal with that situation? 3. Is there such a thing as lapses in professionalism? What are they? can you describe and give example? a. Is there anything that can be done to fix or prevent this? 4. What is the function of the code of ethics & moral reasoning?
3.	Teaching Learning Paradigm & Theory	1. Should the specialty programme teach medical professionalism? Why and how? a. Is there such a thing that school value influencing the professionalism construction? b. Which is stronger - school value or peer (specialist) value? c. Why do you think so? 2. What factors in specialty teaching influence the development of MP?? Can you say more? a. What will positively contribute to development of this MP? b. What will negatively contribute to demise of this MP? c. What is the role of learning environment play any role in MP development in specialty? How? d. What is the role of technology
4.	Patient & external party Involvement	Do patients play any role in MP development in specialty? How? What do you think the role of the Medical Association and College of Specialty is in the development of MP
5.	Any (perceived) Distinct / Unique Conceptions? With existing components in SKDI	3. Have you read SKDI's description of medical professionalism? a. If YES, what do you think about it? How does it relate with your specialty? 4. If you had an authority to make changes, what would you do for this medical professionalism conception in your specialty?
5.	Miscellaneous	Any other things you would like to add? Any question you would like to ask?

If there is no other response could be added, I think this interview session can be finished. There is one more session about sharing experience in a

monologue form. I would like to do it at a different time to respect your valuable time, but if you would like to conduct it now, I would also be please to do it.

Would you like to do it now or sometime in the future?

Researcher Note:

Form D2. Interview to the Double (ITTD) instruction

In this interview section I would like to know further about your personal experience during your life as professional. This interview is called interview to the double methods.

Plot Alternative 1 (Expected to be more fit with Resident)

Let's pretend that on a full day of appointments consisting of teaching and practice you have to replace yourself with a professional artist (your double) or an alien. Your double will perform exactly like you in this whole day activity. In order not to betray the switch and alert your family, colleagues, resident, and patient, your double must conduct him/herself exactly as you behave, down to the smallest detail of personal habits. Therefore, please give as detailed as possible instructions to me as if I were your double, on precisely what I must do from the moment I enter your workplace. Start with 'First you must ....'

Plot Alternative 2 (Expected to be more fit with medical specialist teacher)

Let's imagine that one day a film producer is interested to make a movie about you and your life as a professional medical specialist. The producer would like the actor to perform exactly like you in terms of physical form, gesture, attitude, behavior, style, choice of words and your thinking perspective. In order to portray as exactly like you so that the viewer of the movie, even your family, colleagues, resident, and patient really think it is you that is performing in the movie, the actor must conduct themselves as exactly as you, down to the smallest detail of personal habits.

Therefore, please give as detailed as possible instructions to me as if I were the actor, on precisely what I must do from the moment I start a single busy professional day of yours. Starting from waking up in the morning up to going to bed. Start with 'First you must ....'.

Appendix D.1. Example of SSI Transcript

Table D.1 English translation of SSI transcript with DNL (MSTN4)

ROW	Actors	Transcript
1.	RSB	"Doctors DNL might give an idea into my daily activities dr.DNL how?" ((This is typical of our communication addressing colleague with using "Doctor" rather than use direct you as a way to respect a colleague))
2.	DNL_SSI	"So it is my every day, yes (0.3) I am as a medical staff at the CM Hospital and as a lecturer at the FMXX ((pseudonym)) Department of Neurology. So for (0.3) actually, for a teaching staff for undergraduate medical education programme as well as for education programme of the neurology specialist. Well, for neurology specialist education, we bear a role as a DPJP ((a physician responsible for a patient for teaching purposes)). As a medical staff we have a role as DPJP, where we have to perform patient care follow-up every day. Well, while we are visiting the patient, at the same time we do the transfer of knowledge to the learners. So while we also supervise patients, I as a DPJP we also supervise resident which follow up the patient. Likewise, I had an assignment in the clinic as the medical staff yes, as DPJP in general polyclinic a month may be about 1 to 2 times. Yes, there is also transfer of knowledge as well as supervising resident DPJP inspecting ee patients in the clinic and also in poly and also diagnostic poly. I am also, now being in charged as the Head of Division of Neurobehavior in Department of Neurology. I am there twice a week, just like that. "
3.	RSB	"Neurobehavior was a major in what doc, If I may know it further?"
4.	DNL_SSI	" Neurobehavior is, .. well our brain has a function which is ... before, it is called a noble function of the brain, yes .. the highest function of the brain, which is for a cognitive function, a thinking function. So, in cases with brain injury, whether traumatic or not, such as stroke, infection, it may cause neurobehavior abnormalities. So is the case with vascular risk factors eg, stroke and others. "
5.	RSB	"There may be a case that for those in sub-section neurobehavior doc? Any Illnesses ..? "
6.	DNL_SSI	"Examples such as the Alzheimer's dementia, or in patients with symptoms of aphasia in the case of a stroke, for example, in other cases such as of infection, trauma, memory impairment in those cases."
7.	RSB	"Previously, when you said poly, does it mean general neurology clinic?"
8.	DNL_SSI	"So, in our clinic there is a general neurology, neurological patients treated as usual, and there was intervention poly which is usually for diagnostic examination. And among these polies, there is my division, neurobehavior, to diagnose symptoms in neurology patients. Then there was a division neurophysiology, such as ENG or EEG examination. There is another, neurovascular, TCD examination, or Doppler tests like that. "
9.	RSB	"That's the intervention poly is usually for referred patient from where, doc?"
10.	DNL_SSI	"Some patients come by themselves. But now with the BPJS system, mostly they were referral General Neurology poly, or from Geriatric clinic at the Internal Medicine, or from other departments. "
11.	RSB	"What departments are frequently referring to this neurobehavior division?"
12.	DNL_SSI	"Other departments, to neurobehavior, were usually from geriatrics."
13.	RSB	"That apart from geriatrics?"

ROW	Actors	Transcript
14.	DNL_SSI	"From Internal Medicine most frequently. We have a routine examination. On some heart diseases which require CABG, usually before being operated, they will be screened in advanced. But there are also cases, now there are many immunology and allergy cases, auto immune disease or something like that that being referred to us."
15.	RSB	"Oh, the autoimmune disease might cause disruption on the noble function?"
16.	DNL_SSI	"Yeah .. Because if, for example, if there is an acute vasculitis or vasculits syndrome for example."
17.	RSB	"How long have you been in this neurobehavior division?"
18.	DNL_SSI	"So, since graduation. I graduated at the end of 2001, so early 2002 I worked here directly in that division. "
19.	RSB	"2001 was already being the SPS yes doc?"
20.	DNL_SSI	"Yeah late 2001. December, more accurately, 2002 I started working, so I deal with some general neurological cases. But my main post is at the neurobehavior"
21.	RSB	"In RSCM only doc? outside RSCM as well?"
22.	DNL_SSI	"If for neurobehavior is at the RSCM. But outside there is one place in private practice where I also received patients. But the other one not, general neurology service, because the examination would take a long time. "
23.	RSB	"In Jakarta ((capitol city)), is it common that a private hospital opens any sub-specialty service?"
24.	DNL_SSI	"Yes. Generally, at a rather large private yes. But if in a private where I work on neurobehavior service, the divisions are not as much as that "
25.	RSB	"Because it is specific only for service, right? fully service? Based on your experience, if I counted 18 years in neurobehavior, 17 .. Maybe doctor has had sort of template, or a definition, of what is a good neurology physician, the professional one. What is it looked like? "
26.	DNL_SSI	"Neurology, neurology professionals as a whole, not just fragmented. In here, we work under sub-specialist section. But a good Neurologist is an overall neurology, yes holistic. Because in determining a diagnostic in neurobehavior we also consider other clinical symptoms also, not merely cognitive function, that is the main thing. The second one anyway, if you ask me, a good neurological .. now I'd agree on the current concept, tends to the prevention, preventive medicine. So that, there would not be severe neurology cases anymore, ... more on preventative, *lah*. ((slang for emphasize))"
27.	RSB	"So that according to doctors, good neurological neurology who was also able to prevent not until the patient has a neurological disease?"
28.	DNL_SSI	"For example, I give examples from some studies, for example in cases of hypertension that occurs in middle age, middle-aged or Diabetes. They had a faster risk of having cognitive impairment compared to those who did not have the vascular risk factors. So what do we do so that the damage would not be reaching the brain. Because it is already late if the actual damage already happens "
29.	RSB	"I still need to know more doc .. About the holistic thinking in Neurology, is that a wholeness about patient or about the discipline of neurology?"

ROW	Actors	Transcript
30.	DNL_SSI	"A Whole. Overall with other discipline That is because earlier, in hypertensive patients and DM it's not that, if it is a pure that disease, it's possible that they will not go the neurology, right? But surely it has an impact to neurology. Well, a neurologist should know how to rule out, so that the severe case might not be happened. So, need cooperation is also true with other areas so. So that they know that the impact of e.g., autoimmune diseases, vascular diseases such as hypertension, diabetes and others that have an impact in the future be neurobehavior diseases. "
31.	RSB	"Can you tell me what might be the case that dr.DNL arrive to this definition?"
32.	DNL_SSI	"Yes, maybe earlier as you mentioned...it is possible like that yes .. yes .. this is my perception. Sometimes a professional or specialist that is mostly not satisfying at all, regarding professionalism, is said to be the neurology. There was a term used "come in lame, come out still paralyzed". So .. and yet I know, what from I see yes .. in the neurology field, actually there were no drugs that could totally repair brain damage that occurred, right. Not exist, until now. Actually, from that bit we can start. Because if there is a damage, treating it becomes so hard. Whatever we do, it turns out difficult. Or for example in my field, a case of dysfunctional Alzheimer, the available treatment modalities are only meant to treat the symptoms, but for fixing the process, stopping the process from the ongoing reaction, there is still no available drugs. So, our effort so far is....and it was said as well that if we had an Alzheimer gene, actually we could not prevent. We can only be able to make the Alzheimer would only be appeared at the late ages. Prevent young age from being a subject of Alzheimer's disease. Well, this is the most important things, a prevention process. Because cases in the field of neurology like in my field, yes .. if there are functional abnormalities it means a person will loss of his/her value, right? The highest value of a person is on his cognitive functions, right. I'll give you an example. Take Steven Hawking, he had ALS which paralyzed all his motoric function, there was a swallowing disorder, but the thinking function is still good, and he is still being appreciated of that. Compared to people who are still able to walk, but cannot speak, cannot communicate, they are not invaluable. So, I think the good things is the prevention anyway, and therefore should involve other disciplines so. "
33.	RSB	"Well, if the vision of a doctor, to be able in that way, what should the neurology educational process look like to reach that comprehensiveness"?
34.	DNL_SSI	"well if .. what we already did, right?. Actually, in neurology education anywhere, they were already being there, working round at the internal medicine, internal medicine, and psychiatric as well . And we, inside, had a greater involvement with other disciplines. In my field, we have a long relation to do joint research exploring the relation of cognitive function relationships on SLE patients with the Internal medicine, or cognitive function in patients with Diabetes, with multiple sclerosis. Then on HIV. For HIV, here, we run an integrated care under POKDISUS, yes, it is Special Study Group, There it is [the collaboration] .. actually, it was a combination of several disciplines such as internal medicine, neuro was also there. We did a lot of joint research there. It made other fields aware that is related to neurology. Like yesterday, for instance, we conducted a joint study with the Pulmonary Department, how the effects of COPD on cognitive functioning in taxi driver for example. So we are doing more collaborations with other fields. "
35.	RSB	"Regarding the Wholeness serving to the patient's, is this collaboration related to the institution's vision, doc?" Either the FKXXI or RS Hospital
36.	DNL_SSI	"The vision, right. .. Our vision is we commit to give infinite experience .. yes .. if RSCM it should be to the learner.
37.	RSB	Can you tell me more about it?

ROW	Actors	Transcript
38.	DNL_SSI	It is an unlimited experience, right... That might be, one of them is we must collaborate. Then the second one maybe, we do more beyond competency standards that have been defined by the college, for example. It means we provide the experience at the University of Indonesia. Not limited to the competence description which has been determined by the college, so we add more on it"
39.	RSB	"Do you think there is such thing that call specific professionalism, professionalism that specific for specialist. So, It will distinguish the definition of a professional neurologist and other, in such a way the professional trait is not owned by other specialist, or GP? Is it such a things like that?
40.	DNL_SSI	"Well, I think there are .. Indeed, in the neurology service, actually since I was a student, possibly yes .. the merit of neurology is diagnosing clinical neurology and correlate with a topical lesion in the brain or other nervous system. That is, in my opinion, the basic is there. So, our ability really needs to be skilled in that. And the neurological examinations I think are complicated, yes, a lot ... from assessing consciousness, acid and base condition, assess the 12 cranial nerves condition, motoric, sensory, for motoric only there are several kinds, continue to uncontrolled movements. So, we have a clinical ability that, I think ... if I think, is much higher than the other discipline. And secondly, why we must be skilfully there. Because the supporting examinations in the field of neurology are very expensive. For example, need CT scans, MRI, then LP ((lumbar puncture)), LP analysis is now also various which cost millions of rupiah. So, the neurological examinations in neurology are so high costs. And sometimes, be the cause of the neurological clinical symptoms, with different causes sometimes give similar features on the machinery examination result. For Examples, the feature of Tumour MRI with infection, it we don't collect the clinical data from a thorough anamnesis we would have confused to determine whether it is tumour or infection. Though the cost is already high for that MRI examination. Or if we're wrong, for example .. we incorrectly do topical diagnosis. Actually, a topical lesion was on the cervical, but if we examined carelessly we could consider that the lesions is in the thoracic. Or on the examination it led to cervical, while it was actually cerebral like that. So, we did a thoracal MRI but we did not have anything, it turned out after a thorough clinical re-examination the lesion was on cervical. So twice MRI. That means if a MRI costs 3 millions rupiah, it was turned to 6 millions. So, it cannot be abolished. The professionalism in clinical capabilities must be maintained despite technological advances. Now that it is often overlooked, perhaps by our own, and perhaps also among other the teaching staffs .. well it needed time to get there yes. Perhaps by ourselves or sometimes by the resident so. And instead of laziness to think, yes, I wrote MRI only, CT scan only. One that stands out is that. And we often also being asked, for example, a patient comes to neurosurgery, neurosurgical inpatients for example with the case of tetra paresis. Well sometimes they confused to determine the topical lesion. Because later topical diagnosis will need supporting examination, must do an MRI, but in which area? At that situation, they [neurosurgeon] sometime asking us to determine the topical lesion. Yes. I had several occasion on cases like these. I got a consultation request to determine the topical lesion, clinical diagnosis. That is my opinion yes...maybe other have similar feature. So, sometimes we do reflex examination, well nowadays, many don't want to do it. For example, in daily practice (0.3) reflex examination is rarely being performed (0.6) Though it's important to determine topical diagnosis "

Table D.1b The first 20 rows of the original SSI transcript with MSTN4

ROW	Actors	Transcipt
1	RSB	“Dokter DNL mungkin bisa memberikan gambaran ke saya aktifitas dr.DNL sehari-hari bagaimana?”
2	DNL_SSI	“Jadi sehari-hari saya saat ini ya.. saya sebagai staf medik di rumah sakit CM dan sebagai staf pengajar di FKXX departemen neurologi. Jadi untuk.. sebenarnya staf pengajar untuk programme pendidikan dokter dan program pendidikan dokter spesialis neurologi. Nah kalau untuk pendidikan spesialis neurologi, kami punya peran sebagai DPJP. Sebagai staf medik kita punya peran sebagai DPJP, dimana kita harus melakukan follow up pasien setiap hari. Nah pada saaat kita melakukan *visite* kita melakukan *followup* pada pasien disitu pula kita melakukan *transfer of knowledge*. Jadi sambil kita juga melakukan supervisi terhadap pasien saya sebagai DPJP yang *difollowup* oleh residen. Begitu juga saya mendapat tugas di poliklinik sebagai staf medik ya, sebagai DPJP di poliklinik umum mungkin sebulan sekitar 1 sampai 2 kali. Ya disitu juga terjadi *transfer of knowledge* juga saya sebagai DPJP sekaligus melakukan supervisi residen yang melakukan pemeriksaan pasien di poliklinik ee dan juga di poli tindakan atau poli diagnostik saya kebetulan sebagai ketua divisi di divisi neurobehaviour, di departemen neurologi. Disitu saya seminggu 2 kali, sama halnya seperti itu.”
3	RSB	“Neurobehaiour itu majornya di apa ya dokter?”
4	DNL_SSI	“Neurobehaviour itu di.. kan otak kita itu punya satu fungsi yang... Kalau dulu istilahnya fungsi luhur ya.. suatu fungsi yang paling tinggi yaitu untuk fungsi kognitif, fungsi berpikir. Jadi pada kasus-kasus dengan brain injury, baik yang trauma maupun tidak, misalnya stroke, infeksi, itu dapat menimbulkan gangguan neurobehaviour. Begitu juga kasus-kasus dengan faktor resiko vaskuler misalnya stroke dan lain-lain.”
5	RSB	“Mungkin ada contoh kasus kalau untuk yang di sub-bagian neurobehaviour dok? Penyakit-penyakitnya..?”
6	DNL_SSI	“Contoh misalnya pada Demensia alzeimer, atau pada pasien-pasien dengan gejala afasia pada kasus stroke misalnya, pada kasus lainnya infeksi, trauma, gangguan memori pada kasus-kasus tersebut.”
7	RSB	“Tadi poli klinik umum maksusnya poli klinik neurologi umum gitu dok?”
8	DNL_SSI	“Jadi di poliklinik kami ada neurologi umum, jadi pasien neurologi berobat seperti biasa, dan ada poli tindakan, jadi tindakan itu biasanya untuk diagnostik. Jadi itu sala satunya di didivisi saya itu neurobehaviour untuk mendiagnosis gejala-gejala neurobehaviour pada pasien-pasien neurologi. Terus ada divisi neurofisiologi, misalnya pemeriksaan ENG atau EEG. Ada lagi neurovaskuler, pemeriksaan TCD kalau tes dopler khusus seperti itu.”
9	RSB	“Yang untuk poli tindakan itu biasanya rujukan ya dok pasien dari..e.”
10	DNL_SSI	“Ada yang pasien datang sendiri. Tapi kebanyakan sekarang dengan sistem BPJS kebanyakan rujukan dari poli neuro umum,

ROW	Actors	Transcipt
		atau dari poli geriatri di penyakit dalam misalnya, atau kadang dari departemen lain.”
11	RSB	“Kalau yang paling sering kalau departemen lain yang ngerujuk ke neurobehaviour itu departemen apa dok?”
12	DNL_SSI	“Departemen lain kalau neurobehaviour biasanya dari geriatri.”
13	RSB	“Yang selain dari geriatri?”
14	DNL_SSI	“Dari penyakit dalam sih yang paling sering. Kita ada pemeriksaan rutin. Pada kasus-kasus jantung yang menyebabkan CABG itu biasanya rutin sih sebelum operasi dia screening pemeriksaan..... terlebih dahulu. Tapi ada juga kasus-kasus... sekarang banyak kasus-kasus alergi imunologi, penyakit autoimun atau semacam itu banyak juga yang dirujuk ke tempat kami.”
15	RSB	“Kan ada dari penyakit autoimut itu yang menyebabkan gangguan fungsi luhurnya gitu dok?”
16	DNL_SSI	“Iya.. Karena kalau misalnya terjadi vaskulitis atau terjadi akut vasculits syndrom misalnya.”
17	RSB	“Berarti dokter di neurobehaviour itu sudah berapa lama?”
18	DNL_SSI	“Jadi saya semenjak lulus. Saya lulus akhir 2001, jadi awal 2002 saya bekerja din sini langsung di divisi tersebut.”
19	RSB	“2001 itu sudah SpS ya dok ya?”
20	DNL_SSI	“Iya 2001 akhir. Pas desember deh kalau gak salah. 2002 saya mulai bekerja, ya saya menangani beberapa kasus neurologi umum, ya main post saya di neurobehaviour.”

Appendix D.2. Example of ITTD Transcript

Table D.2a. English translation of ITTD transcript with MSTN4

Row	Actor	Transcript
1.	RSB	"Maybe you could give me an xamples of the busiest day for you doctor in the services, and teaching of the week?"
2.	DNL_ITTD	"In one week?
3.	RSB	"A week, that is where you have teaching schedule, service and also DPJP ((doctor responsible for patient care))
4.	DNL_ITTD	"Well, typically my busy day is the day I work at the polyclinic. I always ask to the academic administrator, for instance, bedside teaching for undergraduate, I asked him to put that schedule in my polyclinic today
5.	RSB	"What day is that doc?
6.	DNL_ITTD	"Tuesday and Friday
7.	RSB	"Then today it is?
8.	DNL_ITTD	"I'm busy actually, he he ((laughter)). But I had a schedule for S1 ((Undergraduate medical student)), so I had a journal reading at poly then briefly here for a moment because normally residents is examining the patients, I'll go there again. One make it busy is the S1. Usually bedside teaching. That's why I am asking ((to medical students)), the bedside should be in poly as well, so that I am able to focus at poly. So I could do teaching at General Neurology clinic, and then move to intervention clinic where my division is existed. And it also happened when I have to do MiniCex ((Mini Clinical Examination)), for instance every clerkship student has to perform MiniCex in each rotation, so that's why I am requesting that it can be done on Friday while I am working at the clinic, so I can focus there. Well, actually a sudden meeting agenda at RSXX or meeting at FMXX ((Pseudonym)) that cannot be anticipated."
9.	RSB	"Still often?
10.	DNL_ITTD	"Sometimes yes
11.	RSB	"Cito ((Very urgent)) isn't it? [I am using a term that is well known in any public officials about urgent meeting]
12.	DNL_ITTD	"Yes, there are difficult cases, for example, or a meeting let alone. But I've already managed the education schedule like that. Because I also have schedule for private services and also in Kencana ((VIP service in this hospital)). So if my schedule at Clinic are Tuesday and Friday then Schedule for other and Kencana will be other day, like that."
13.	RSB	"The day, where there are DM are Friday or Tuesday, right doc?
14.	DNL_ITTD	"What is DM, anyway?
15.	RSB	"Young doctor, Clerkship student"
16.	DNL_ITTD	"Oh young doctor, we called in COAS ((Clerkship / Junior Doctor)) here between those two days anyway, at least I've ordered the academic administrator if I had a schedule for bedside teaching or clinical work or MiniCeX exams, it should be in my polyclinic day, that's all".
17.	RSB	"Say it is Friday, for example."
18.	DNL_ITTD	"All right, Friday."
19.	RSB	"Now your double will replace your role as dr.DNL, could you give her a very understandable instruction so that she can replace the dr.DNL exactly like dr.DNL, So she would not be recognized by people around her that she is your double anyway. Started from the morning, how would you give her instruction.

Row	Actor	Transcript
20.	DNL_ITTD	"Now Friday yes?"
21.	RSB	"Yes Friday."
22.	DNL_ITTD	"On Friday, the doctor in the clinic should arrive before 9, absent in the Hospital is 8 am sharp at the latest, to do attendance check log e .. fingerprinting and then go to the clinic, absent in the clinic yes, then have a talk little bit with the resident there for a while, knowing how many patients there that day, we have to know this number so that later I could expect what time should go back here. Then from my clinic, I am going to the ward, at that building A to follow up patients, in that A building that I responsible for any trauma patient. We perform rounds trauma patients likely, if at 8 o'clock I was at poly, then 8.30 until 9.30, after that I proceed to the poly. At poly then I inform to the residents or nurses if I have to do bedside or Mini CeX ((Mini Clinical Examination)) with COAS ((Junior Doctor)) at next room, those room are side by side. Well, if we do bedside teaching, then we will examine the patient in front of COAS, anamnesis [history taking], physical examination and then later discussion. If MiniCeX e .. usually there are 2 students for MiniCex, so I gave instructions to COAS e .. "there will be poly patients, so you have to as effective as possible, possible doing anamnesis about 15 minutes after that in the examination, do not have to do all examination, but only do the most relevant neurological examination that related with anamnesis. After that while the COAS took anamnesis and physical examination, I write in status [medical record] later after finishing that, if it is possible the students will give information or educate the patients and then we give the treatment prescriptions. After that, after the patient came out we do discussions, or discussions may be done later on. Then we start again for the second student to MiniCex exam. When finished, if it is possible the discussion sometime is merged at the time the second one is finished, or if it cannot, then I usually promise to the student that the discussion will be done at 3 pm or next Monday. After completion MiniCex, back to the interventional poly to confirm patients' diagnosis".
23.	RSB	"How late dock?"
24.	DNL_ITTD	"Usually till .. depending on the number of patients yes, if there are a lot it can be up to at 3 or 3.30 pm, but the quickest one is perhaps at 2 pm it is already over."
25.	RSB	"If it is a lot, how much are they usually"
26.	DNL_ITTD	"The most that I ever had ee .. 6 patients, but that's a long time to perform neuro function examinations."
27.	RSB	"Doc, in that morning, do you have a favourite place to do it, the attendance check log?"
28.	DNL_ITTD	"Yes, there is. It is one near to my parking spot. The finger-print devices actually are dispersed at all RSXX ((the hospital name)), in building A, medical staff building, and near the parking lot. I drive myself, so I would not be stop by a driver in certain place like other would do. So I chose my parking spot near to medical staff building."
29.	RSB	"what if it is in Policlinic doc, where do you usually do for the attendance check log?"

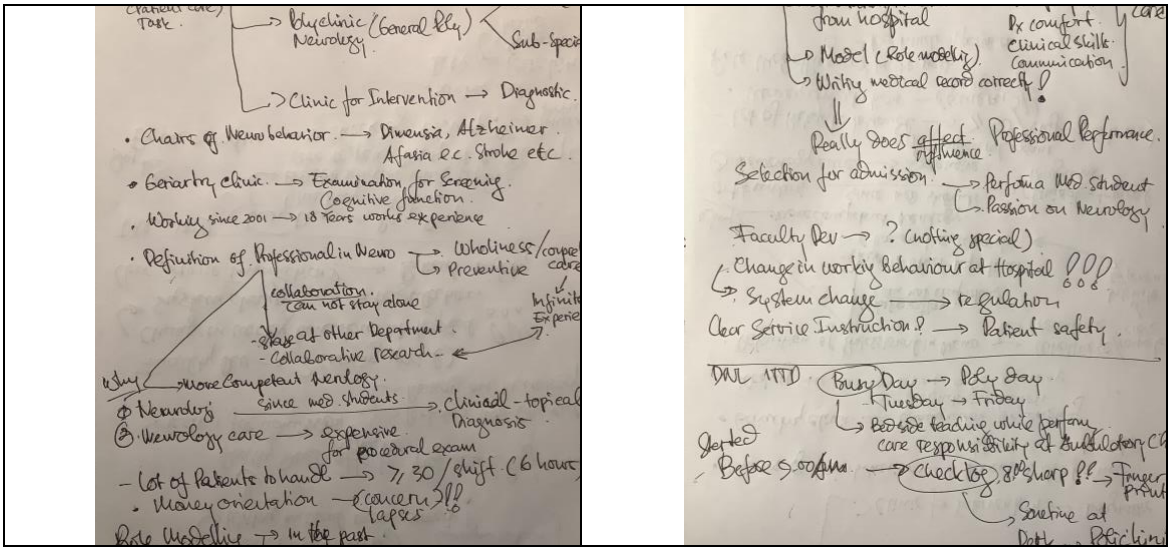
Row	Actor	Transcript
30.	DNL_ITTD	"The attendance check log it is .. by signature. Then there will be a handyman's taking care this document, also from RSXX, this handyman will come at the time as he wish, when he came he would see if doctor DNL present or not. There also a nurse, [the participant use direct voice] "oh she had already come but she just went for assessing student" for instance like that, than he [the handyman] would look up my signature on the check in document and sampling any medical record where I also put my signature in patient evaluation section. But usually when he already trust in me anyway he is not checking again the medical record [e.g. regular handyman] but if he was in doubt, he would ask where the medical record were and asked whether I already examined patient or not. And there he would check whether the signature has already been there or not "
31.	RSB	"If, for example, this handyman guy is not present, will dr.DNL still looking for him ?"
32.	DNL_ITTD	"Nope."
33.	RSB	"Just straight go to the check log place, right?"
34.	DNL_ITTD	"So for example at 1 pm he has not come yes, I am still examining patient, but at the same time I am being called for a meeting for example. On that case, when I finished examining the patient, I will give a word to leave the clinic, but I should have to put my signatures in the medical record. If people there [nurses] said " We see dr.DNL" and then he would ask "did she examine the patient or not?" "She Did", but if he could not find my signature in the medical record, then I will be regarded as not present.
35.	RSB	"If you come in polyclinic, where do you usually go? Is there any favorite place?"
36.	DNL_ITTD	"at pantry, he he ((laughter))"
37.	RSB	"So there's no need to go first to pantry this day"
38.	DNL_ITTD	"No...no...I usually come to a desk first, it is a desk with checkin paper, then usually I peek to the examination room, counting how many patient that day, right...because right there, there should be 2 residents and the room there, are limited, so sometimes there's no place for us to sit. So if I sat in the examination room, it will cause fullness, make the room so narrow. So therefore sometimes I go to the pantry, open my handphone, reading WA or else...because I don't like doing WA while walking... not get used like that. So there I open it, while if there is anything I'd like to do..., I am doing it there. "
39.	RSB	"It means that you carry your laptop with you that time"
40.	DNL_ITTD	"Yes I do"
41.	RSB	"So if I open the laptop at the Pantry, it remains doctor DNL, yes
42.	DNL_ITTD	"Yes, I am well known with that, there is even a favorite spot for me for having a seat there"
43.	RSB	"Why doc, at that place?"
44.	DNL_ITTD	"Yes, I just find my convenience there, he ((laugther))"
45.	RSB	"Is it because it is hidden from certain things?"
46.	DNL_ITTD	"Yeah, you know what, a pantry is usually having a door that is usually close right?. And also, I don't have a dedicated room there, while the rooms are already full, and I don't have any idea where to sit because on each room any examination activity is being taken place. That is only when I have no bedside teaching, no testing [for student or resident] so that I sit there. But If I had bedside teaching, assessing MiniCeX, I would not have time to go there....to Pantry, just directly go to the Polyclinic.

Table D.2b The first 30 rows of the original ITTD transcript with MSTN4

Row	Actor	Transcript
1.	RSB	“Mungkin bisa diberikan contoh hari yang paling sibuk bagi dokter dalam melakukan pelayanan dan teaching dalam seminggu itu hari apa yah dok?”
2.	DNL_ITTD	“Dalam satu minggu?
3.	RSB	“Seminggu, yang disitu hari itu ada ada teaching, ada service juga DPJP?
4.	DNL_ITTD	“Kalau saya gini, jadi hari sibuk saya itu di poliklinik karena saya selalu minta sama tenaga pendidik, misalnya ada bedsite teaching program pendidikan dokter nah saya mintanya tu di hari poliklinik saya
5.	RSB	“Itu hari apa dok?
6.	DNL_ITTD	“Hari selasa, jumat
7.	RSB	“Berarti hari ini?
8.	DNL_ITTD	“Saya lagi sibuk sebetulnya, hehehe. Tapi saya lagi ada S1, makanya saya ada jurnal reading di poli trus kesini sebentar karena biasanya residen lagi periksa pasien, nanti saya kesana lagi. Kan sibuknya tuh ada S1, S1, Bedsite teaching, nah saya minta bedsite teachingnya ada di poli juga jadi supaya saya fokus di poli, jadi saya sambil ngajarin di poli umum neuro setelah selesai baru saya ke poli umum tindakan. Nah begitu juga kalau ujian MiniCex misalnya setiap pendidikan dokter kan ada MiniCex dalam satu putaran itu, nah saya mintanya di hari jumat jadi pas hari saya poli gitu, jadi supaya saya fokus disitu. Nah kadang-kadang yang suka mendadak itu sebenarnya ini ya kalau ada rapat di RSCM atau rapat di FKUI yang mendadak gitu.
9.	RSB	“Masih sering?
10.	DNL_ITTD	“Kadang masih
11.	RSB	“Amat segera gitu yah
12.	DNL_ITTD	“Iya, ada kasus sulit misalnya, atau rapat apalagi lah. Tapi kalau jadwal pendidikan ya saya atur kayak gitu. Saya kan ada pelayanan di swasta juga di Kencana. Jadi kalau selasa jumat saya jadwal di poli ya saya nggak terima tugas di kencana, kencana tu di hari lain gitu.”
13.	RSB	“Hari yang ada DM nya tu seringnya hari jumat atau hari selasa dok?
14.	DNL_ITTD	“DM tu apa?
15.	RSB	“Dokter Muda.”
	DNL_ITTD	“Oh dokter muda, antara dua hari itu sih, paling saya udah pesan sama tendiknya sih saya kalau ada bedsite teaching atau kerja klinik atau ada ujian MiniCeX di hari saya di poliklinik gitu aja sih.”
16.	RSB	“Katakanlah hari jumat ya dok misalnya.”
17.	DNL_ITTD	“Iya hari jumat.”
18.	RSB	“Nah si penggantinya dokter ini misalnya hari jumat akan menggantikan dokter, kira-kira instruksi yang bisa dia pahami agar dia bisa menggantikan dokter DNL seperti dokter DNL, jadi tidak lebih pintar atau tidak pintar tapi dia berusaha untuk seperti dokter DNL sehingga dia tidak dikenali oleh orang-orang disekitarnya, oleh Tendik atau oleh pasien, lab kontrol kalau dia ini sebenarnya bukan dokter DNL, mulai pagi dok itu kira-kira bagaimana?”
19.	DNL_ITTD	“Sekarang hari jumat yah?”
20.	RSB	“Iya hari jumat.”

Row	Actor	Transcript
21.	DNL_ITTD	“Hari jumat itu dokter di poliklinik harus datang sebelum jam 9, absen di RSCM itu jam 8 paling telat, jadi jam 8 itu paling telat udah harus absen e.. finger print kemudian ke poliklinik, absen di poliklinik ya kemudian bicara sama residen sebentar, pasiennya ada berapa ya kita harus tahu kan supaya nanti saya bisa perkirakan harus baliknya berapa. Trus dari poliklinik saya ke bangsal, ke gedung A untuk follow up pasien, kalau di gedung A itu saya pegang pasien trauma. Kita ronde pasien trauma mungkin kalau jam 8 tadi ke poli jam 8, bisa setengah 9 yah sampai mungkin setengah 10, setelah itu saya balik lagi ke poliklinik, ke poliklinik kemudian kasihtahu ke residen atau ke perawat kalau saya mau ada bedsite teaching dulu atau MiniCex sama KOAS di poli sebelah kan bersebelahan tu. Yah udah kita e.. kalau bedsite teaching kita periksa pasien didepan KOAS, anamnesis, pemeriksaan fisik kemudian nanti diskusi. Kalau MiniCeX e.. biasanya MiniCex itu ada 2 mahasiswa, jadi saya kasih instruksi ke KOAS e.. nanti ada pasien poli jadi anda harus seefektif mungkin anamnesis paling lama sekitar 15 menit setelah itu dalam pemeriksaan, nggak usah semua pemeriksaan neurologi anda lakukan tapi pemeriksaan neurologi yang ada kaitannya sama anamnesis. Setalah itu sambil KOAS nya melakukan anamnesis dan pemeriksaan fisik saya menulis di status kemudian setelah selesai e.. kalau bisa si mahasiswanya mungkin bisa melakukan edukasi atau informasi kepada pasien trus kita memberikan terapi. Setelah itu, setelah pasiennya keluar ya kita diskusi, atau mungkin diskusinya nanti bisa belakangan. Kemudian kita mulai lagi untuk mahasiswa yang kedua untuk ujian MiniCex. Setelah selesai, misalkan diskusi sempat digabungkan pada saat itu ya selesai, kalau nggak nanti biasanya saya janji mahasiswa nanti kapan ada waktu mungkin jam 3 atau nanti hari senin ya mungkin ya kalau masih ujian MiniCeX minggu ke 3 kita diskusi lagi, tapi kalau bisa dilakukan di poli ya di poli. Setelah selesai MiniCex, kembali ke poli tindakan ke neurobehaviou untuk konfirmasi pasien.”
22.	RSB	“Sampai jam berapa dok?”
23.	DNL_ITTD	“Biasanya sampai jam.. tergantung jumlah pasiennya ya, kalau lagi banyak bisa sampai jam 3 atau setengah 4, tapi kalau cepat sih mungkin jam 2 sudah selesai.”
24.	RSB	“Banyak itu, kira-kira berapa jumlahnya?”
25.	DNL_ITTD	“Yang paling banyak itu e.. saya pernah dapat ada 6 pasien tapi kalau fungsi neuro kan lama pemeriksaanya.”
26.	RSB	“Dok, pagi itu finger print ada tempat favorit nggak?”
27.	DNL_ITTD	“Ada tempat parkir saya, kan finger printnya tersebar nih di RSCM, di gedung A, medical staf building trus didekat tempat parkir. Saya kan nyetir sendiri jadi nggak diturunin sama supir di pintu mana gitu, jadi tempat saya parkir disitu ya yang paling dekat di medical staf building.”
28.	RSB	“Untuk yang poliklinik dok? Absennya?
29.	DNL_ITTD	“Absennya absen ini e.. tanda tangan. Trus nanti ada tukang absennya juga dari RSCM, petugas absennya dia datang jam ya suka-suka dia lah, dia datang dia melihat ada dokter DNL nggak. Disana kan ada perawat oh tadi udah datang tapi dia mau lagi nguji mahasiswa misalnya gitu, nah biasanya dia membuktikannya dengan dia lihat tanda tangan saya di absen itu sama dia ambil satu status/satu medical record dimana saya disitu sudah tanda tangan di catatan evaluasi pasien. Tapi biasanya kalau dia udah percaya sama saya sih dia nggak ngecek lagi statsu itu, tapi kalau dia ragu-ragu dia tanya mana statusnya kalau memang dokter DNL udah datang udah periksa pasien belum? Nah dia cek disitu udah ada tanda tangan saya atau belum.”

Appendix D3. Example of Fieldnotes



Appendix E. Participant Information Sheet (This is part of Ethical Form submission and was given to participants)

Title of the Research:
Exploration or Medical Professionalism Across Postgraduate Medical Education in Indonesia

I would like to invite you to take part in the above-named study but before you decide, please read the following information. Please feel free to contact me if you would like further information

What is the purpose of this study?
The aim of this study is to explore the conception of medical professionalism across different postgraduate medical education context in Indonesia

Who is doing the study?
The study is being conducted by Rachmad Sarwo Bekti, a PhD student at Leeds Institute of Medical Education (LIME), University of Leeeds. The study is supervised by Prof Richard Fuller, Dr. Rebecca O'Rourke and Prof Trudie E Roberts from LIME.

Who is being asked to participate?
I am interested in talking to medical specialist teachers who are still active in their professional role either as medical practitioner and teacher, and are also actively engaged in any professional organisation, mainly the college of specialty. I am also interested in talking with specialist resident (trainee) who are already have responsibility to handle patient and responsibility in teaching other junior resident or medical students.

What will be involved if I take part in this study?

This is a piece of qualitative research which will be completed by July 2020. A small number of specialist teachers and residents will be recruited and they will be asked to participate in two interview sessions. The first session will be a one-to-one semi-structured interview which will last between 60 to 90 minutes and the second session will be a unique interview called Interview to the double that will last between another 60 to 90 minutes. And both of the interview will be audio recorded.
Semi-structured means that you will be asked open questions about your thoughts, feelings and experiences about medical professionalism in your professional life. The interview will take place in a suitable and mutually agreed place.
The interview to the double (ITTD) means that you will be asked to give instruction to an actor (which will be acted by researcher) who will be portraying you as the main figure in a movie about professional life of an Indonesian specialist. The actor should perform as exactly as you in term of physical form, gesture, attitude, behavior, style, choice of words and all your known of not known thinking perspective. In order to portray as exactly like you so that the viewer of the movie, even your family, colleagues, resident, and patient really think it is you that performing in the movie, the actor must conduct as exactly as you, down to the smallest detail of personal habits.
Any information about something breaking the law will not be taken into account in this study and therefore researcher will terminate the interview and follow the relevant guidelines for dealing with such incident.

What are the advantages and disadvantages of taking part?

This study offers you the opportunity to reflect on your experiences of being a professional specialist physician either on teaching and practice. You may find it meaningful to share your story, value, belief, and experience that you think essential to build better concept of medical professionalism in specialty training in Indonesia.
The interviews will impact on your time and, apart from reimbursement of any travel expenses incurred, no payment will be made for your involvement in the study.
It is possible that the interview may be taking more time than it is being planned and might cause any distress due to this matter. You are welcome to take any rest in between interview and /or we could manage to find another convenience time and place if it is more comfortable for you.
It is also possible that the instruction in interview to the double (ITTD) a bit difficult to understand, To help you with this technicality, I will be available during the interview to give you more explanation needed and give assistant to making it possible to be done.

Can I withdraw from the study at any time?

All participants have rights to withdraw from this study at any time up to three months after the interview was taken. Participants do not have to state their reasons if they wanted to do so. It will help the researcher to maintain the process of thesis writing and publication where anonymity of the participant will be strictly preserved and assured.

Will the information obtained in the study be confidential?

All information collected in the interview, either about you or possibly the name of people or third party that you might think will relevant with the response you are given will be kept strictly confidential, *unless* you give information that suggests you and/or others could be seriously harmed, which might require the researcher to speak to a third party, normally his academic supervisor in the first instance, for safeguarding purposes.

The information about your contacts required will be your name, telephone number and/or email address. All interview recordings will be destroyed once the examination process is complete and the transcripts will be destroyed 5 years after the data collection period or once all publications have been completed arising from this research.

Your name and contact details will not be recorded on interview transcripts or in the thesis; you will be asked to choose from a list of pseudonyms, which will be used in place of your name. Any details which could potentially identify you, will be removed or changed. Only the researcher and his academic supervisors will have access to the audio recording, transcript of your interview and your consent form. Data handling will be in accordance with the General Data Protection Regulation 2016/679.

What will happen to the results of the study?

The results, in which all responses from participants will be fully anonymised, will form the basis of the thesis to be submitted to the Leeds Institute of Medical Education, with copies sent to the University of Leeds library database. It is also possible that the study may be submitted for publication to peer reviewed journals or for conference presentations.

Who is funding this study?

The study is funded by Lembaga Pengelola Dana Pendidikan / LPDP (Indonesia Endowment Fund for Education) as part of PhD Scholarship scheme.

Who has reviewed this study?

Ethical approval has been granted by the School of Healthcare Research Ethics Committee at the University of Leeds [Date] with ethics reference [ref number] and Ethics Research Committee of Faculty of Medicine Universitas Brawijaya Malang, Indonesia [Date] with ethics reference [ref number]

If you agree to take part and would like more information or have any questions or concerns about the study please contact Rachmad Sarwo Bekti, researcher, by phone (+6281330705541) or email (umrsb@leeds.ac.uk**). The research will be supervised by Prof Richard Fuller, Dr. Rebecca O'Rourke and Prof Trudie Roberts**

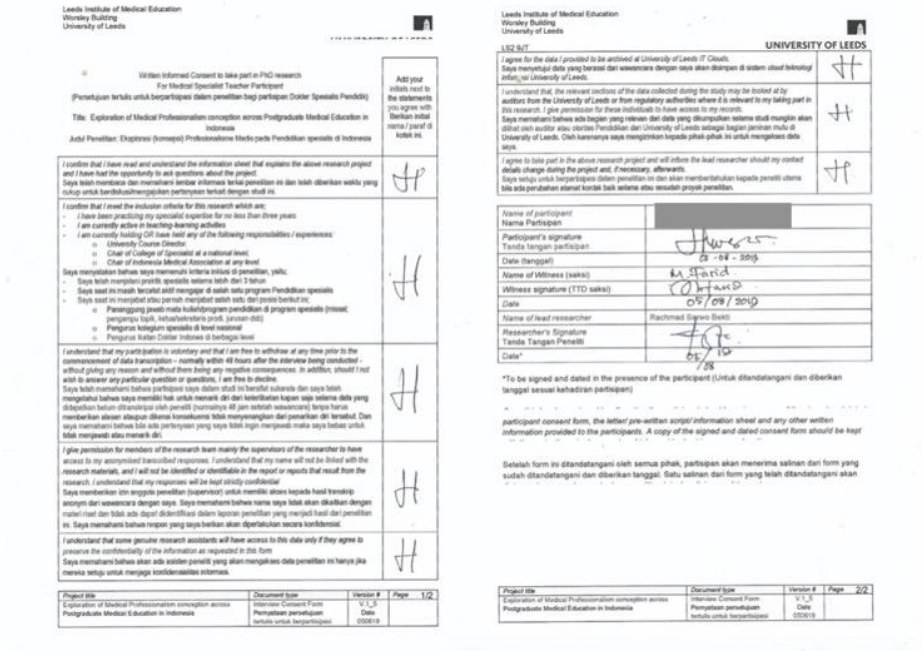
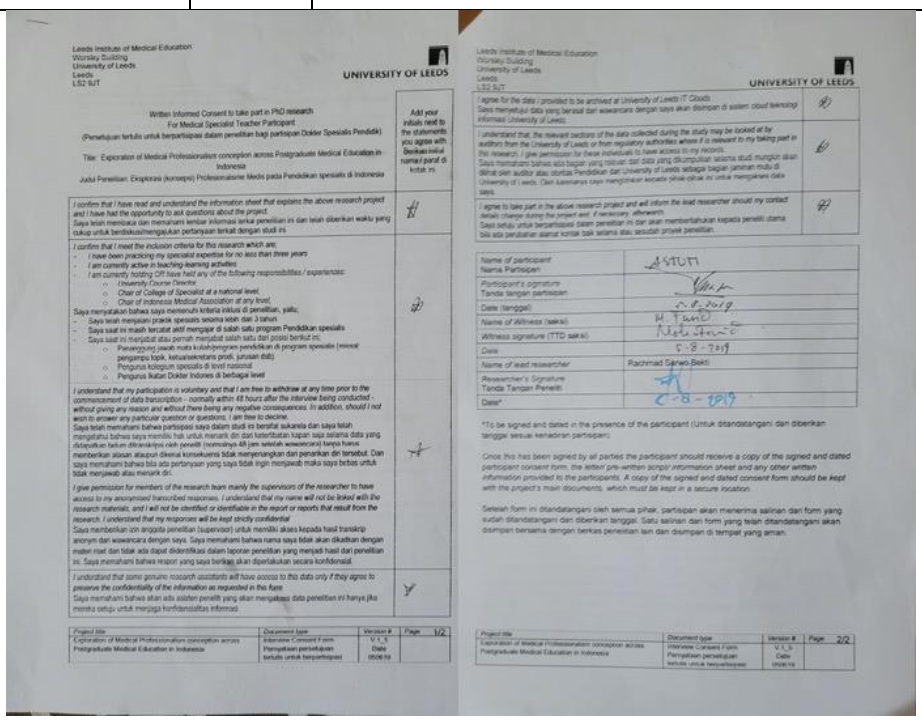
Appendix F. Written Informed Consent Form

Written Informed Consent to take part in PhD research **Title: Exploration of Medical Professionalism conception across Postgraduate Medical Education in Indonesia**	Add your initials next to the statements you agree with
I confirm that I have read and understand the information sheet that explaining the above research project and I have had the opportunity to ask questions about the project.	
I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without there being any negative consequences. In addition, should I not wish to answer any particular question or questions, I am free to decline.	
I give permission for members of the research team (the supervisors) to have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research. I understand that my responses will be kept strictly confidential	
I understand that other genuine researchers will have access to this data only if they agree to preserve the confidentiality of the information as requested in this form	
I agree for the data collected from me to be stored and used in relevant future research. **or** I agree for the data I provide to be archived at University of Leeds IT Clouds.	
I understand that relevant sections of the data collected during the study, may be looked at by auditors from the University of Leeds or from regulatory authorities where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.	
I agree to take part in the above research project and will inform the lead researcher should my contact details change during the project and, if necessary, afterwards.	

Name of participant	
Participant's signature*[1]	
Date*	
Name of lead researcher	Rachmad Sarwo Bekti
Signature*	
Date*	

[1] *To be signed and dated in the presence of the participant. Once this has been signed by all parties the participant should receive a copy of the signed and dated participant consent form, the letter/ pre-written script/ information sheet and any other written information provided to the participants. A copy of the signed and dated consent form should be kept with the project's main documents which must be kept in a secure location.

Appendix G. Example of Participant Informed Consent scan copy

No	Pseudonym	CODE	Scan
1	MSTN1	HAR	
			
2	MSTN2	AST	
			

Appendix H. Coding and Memo (Notes) In Phase I – Text Analysis of Three-Dimensional Critical Discourse Analysis

Table H-1 Example of Notes and Initial Coding From SSI

Row	Actor	Transcript	Notes	Theme + Track
10	MSTN2_SSI	"Kemudian sekarang melihat neurologi itu sudah lama mungkin 8 tahun lebih menjalankan skrinning fungsi kognitif ini, sekarang kita di neurologi ini sudah mulai menerima permintaan dari departemen penyakit dalam, kemudian dari bedah baru 2 semester ini. karena memang dalam perjalanannya juga ba. itu nyak problem dan sebagainya memang dievaluasi kalau memang tidak kompeten ya salah satu pertimbangan untuk meresignkan. Itu semoga makin kesini semoga menyadari bahwa lebih bagus awalnya recruetmentnya. Jadi kita betul-betul mendapat anak didik yang bisa dididik, bisa kompeten, ee.. mempunyai kapasitas untuk menjadi seorang spesialis. Jangan sampai di tengah perjalanan nanti gagal, terhenti dan sebagainya."	a discourse that there is a specific capacity for any medical graduate for being a resident…..a requisite to be able to survive?	Resilient as provision (R10-11_MSTN2_SSI)
11	RSB	"Kalau untuk neurologi itu sendiri dok, ada khusus gak dengan tes yang standardised, ini memang ada harapan khusus untuk seorang neurologis itu mestinya harus begini-begini?"	a discourse that there is a specific capacity for any medical graduate for being a resident…..a requisite to be able to survive?	

Row	Actor	Transcript	Notes	Theme + Track
14	MSTN2_SSI	“Oh ya..nggeh sebentar ini ada bukunya..[taking a moment to take a standard of competence for neurology Specialist] Ya jadi ini bisa dibaca. Ini yang sudah disahkan oleh konsil jadi, juga yang formatnya juga sudah direvisi. Jadi prinsipnya dia akan mencetak dokter yang profesional, yang kompeten, yang mampu bersaing di dunia internasional itu, terus kapasitas kemampuan personal itu dia sendiri. Ini semua kompetensinya sudah tercantum di sini. Kemudian nanti dokter itu selain seorang klinisi juga sebagai seorang yang mempunyai kemampuan manajerial, kolaborator dengan disiplin lain, entrepreneur, gitu.. Jadinya yang kompetensi bidang sesuai pendidikannya, ini ada kompetensi yang baku, ini sekarang malah 22, karena dibagi menjadi lebih kecil lagi. kalau kemarin masih 19 kompetensi. Ini sekarang nyeri sendiri, nyeri kepala sendiri. Kompetensi tambahan ini sudah ada materi fokus seperti EEG, neuro intervensi sekarang yang pasang stent, kemudian ee... apa namanya? Ya untuk intervensi apa sih yo? yang ke atas gitu. Neurologi teknologi yang genetik ya.. neurologi genetik kita sudah punya staf lulusan jepang PHD. Terus doktor R ((Pseudonym)) staf muda kita PHD dari jepang itu kolaborasi dengan dokter Yekti sudah stem sel, untuk cedera medula spinalis.”	The core of being a professional specialist is the competence . Aside as a physician it is prescribed that being physician should poses a managerial, collaboration and being able to internationally competitive. The latest mean to catch up with updated undertaking in science, research and care that have been developed in developing countries. This has a hidden discourse that we are not competitive yet.	Profeesionalism = Competence / ability of doing task (R14_MSTN2_SI)
16	MSTN2_SSI	“Ya, jadi ada beberapa kompetensi kita yang sifatnya abu-abu istliahnya. Contohnya neuro intervensi. Intervensi itu adalah ee.. itu nanti singgungannya dan itu sudah duduk bersama, kemudian ada SK dari.. SKnya dari KEmenkes atau KKI atau dari mana ya? Karena ada beberapa kali duduk bersama, neuro intervensi itu neuro neurologi, bedah saraf, ee.. kemudian radiologi, sama jantung. Dan diagnostik mestinya bukan terapi. Radiologi bukan klinisi, dia diagnostik. Tidak boleh untuk mengobati, gitu.. hehehe.. terus apa namanya?”	There are service areas that overlapping between different specialist, there have been mediation process to arbitrary how will these specialist will deal with the patient in the health care field Authoritative Field	No specific professionalism (R16_MSTN2_SSI) Authoritative Field (R16_MSTN2_SSI)
18	MSTN2_SSI	“Tindakannya sapa yang boleh melakukan itu hanya untuk DSA tapi tidak mudah diagnostik. Kalau intervensi ppasang misalnya embolisasi itu neuro bisa, bedah saraf bisa. Biasanya di bedah saraf ya minta tolong neuro. Jadi	The problem of authoritative field of care is a serious matter that need to be solved in the day to	Authoritative Field (R18_MSTN2_SSI)

Row	Actor	Transcript	Notes	Theme + Track
		pada saat operasi pasien perdarahan terus embolisasi dulu, sehingga perdarahannya berhenti pada saat operasi ya tertolong. Jadi selama ini radiologi juga bisa."	day practice.	
20	MSTN2_SSI	"Embolisasi.. iya neurolog kita punya satu staf sudah belajar dari luar. Sudah profesional ada satu staf itu.."	A shared competence Have a learning experience in abroad is a guarantee for a professional skill.	Abroad (West) is the Gold Standard of quality (R20_MSTN2_SSI)
22	MSTN2_SSI	"Ini udah vaskuler itu ini.. intervensi yang vaskuler itu ada bedah saraf, stroke. Nah itu juga abu-abu.. terus punya saya ini.. gangguan tidur terbentur dengan psikiatri. Tapi kalau di Sarjito itu pakenya tim kaptennya saya dari neuro. Karena kita punya sub klinik. Jadi sama diatur itu tim akhirnya. terus namanya konsulen ada neuro geriatri dalam kasus-kasus neurologi pada anak, endokrin, jantung, THT, psikiatri, terus ee bedah mulut pada ee.. gangguan pada anatomisnya sendiri. Terus namanya juga tim.."	Collaborative service that require multi specialist work Doing Collaborative care is inevitable because of service package policy (BPJS)	Collaboration = Component of MP (R22_MSTN2_SSI) Policy determine practice (R22_MSTN2_SSI)
24	MSTN2_SSI	"Ada SK.. Karena idenya dari kita. Tapi direktur ndak mau kalau hanya neurologi aja.. iya.. karena ini menjadi pelayanan unggulan to?"	The Hospital leader's approval is critical in defining the type of services provided by the doctors	Governmentality of MP
26	MSTN2_SSI	"Jadi ee.. profesinalisme setelah kita menyelesaikan pendidikan.. pendidikan ya.. pendidikan stase-stase. Terus ada ee.. profesionalisme yang diakui itu kita saat tingkat kompetensi itu. Nah ada kolegium, ada satu komisi yang ketuanya saya sudah 2 periode ini uji kompetensi nasional untuk melihat kompeten. Dia harus kompeten. Jadi misalnya dia tidak lulus satu kompetensi ini, untuk melihat profesionalisme dan sebagainya, ee.. dia tidak bisa jadi neurolog. Karena yang buat sertifikat atau ijasah kan univesity, tapi dia tidak bisa praktek. Profesi tidak boleh. Jadi masih ada 1 tahap lagi untuk bekerja sebagai seorang dokter profesional, berprofesi sebagai seorang ahli saraf dan sekarang beban jadi spesialis saraf neurologi Sp.N. Dokter spesialis itu cukup wajib ikut uji kompetensi sampe lulus."	professionalism can only be recognized through examination and competency certificate; Professionalism should be accountable?	Professionalism = measurable traits (R26_MSTN2_SSI)

Appendix L. LancsBox Feature

In this Appendix I briefly outline some features of LancsBox that I used. Some of the explanations are orginiated from manual that can be downloaded freely[1] and my own experience on using the application.

1. LancsBox is licensed under BY-NC-ND Creative commons license. This means LancsBox is free for non-commercial use. The full license is available from: http://creativecommons.org/licenses/by-nc-nd/4.0/legalcode

2. Main Feature of LancsBox

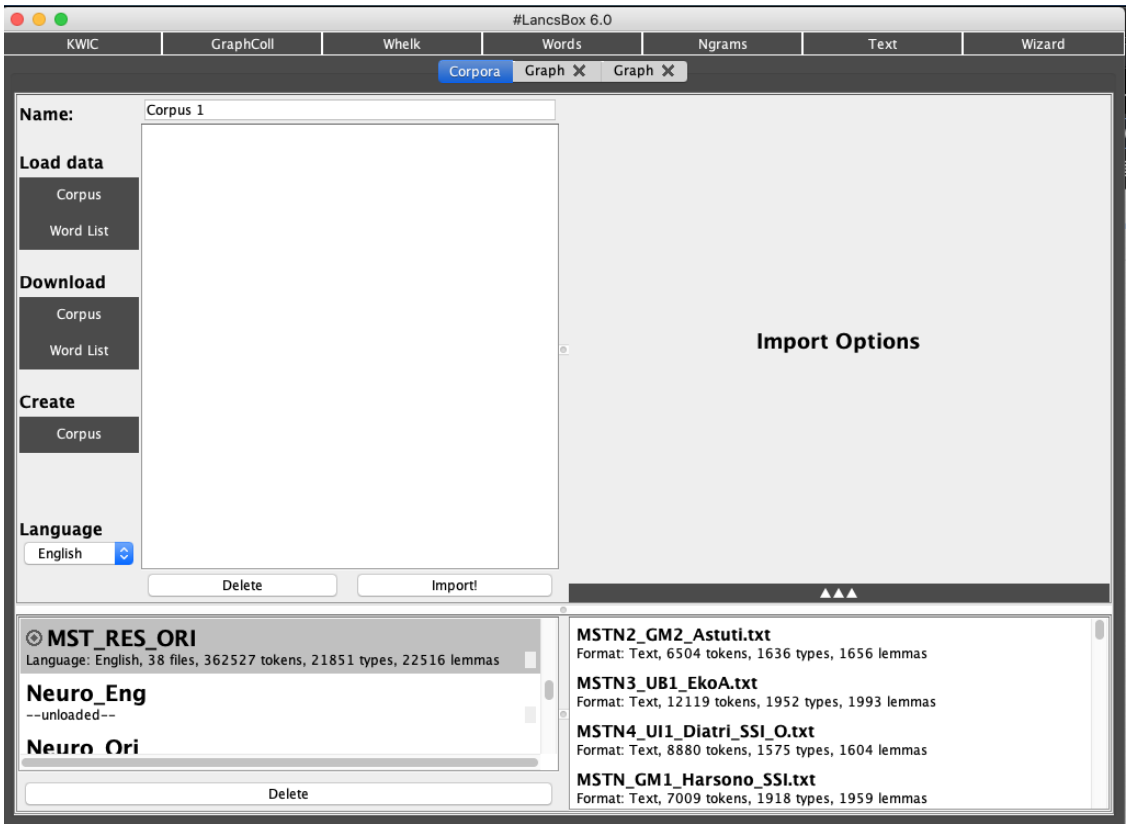


Figure L-1. The main feature of LancsBox version 6.0

Notes to Table L-1: In above caption, notes that the Corpus contains 362527 characters (tokens) and these characters consist of 22516 lemmas. For instance, the terms calling, calls and called are names as 3 tokens of one lemmas i.e., call.

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[1] The complete manual for using LancsBox can be downloaded at : http://corpora.lancs.ac.uk/lancsbox/docs/pdf/LancsBox_6.0_manual.pdf

3. Exploration of collocates by using GraphColl

The Graphcoll a LancsBox menu to find collocations / concordances and present them in a table and collocation graph or network. This feature can be used, for:

a) Finding the collocates of a word or phrase.
b) Finding colligations (co-occurrence of grammatical categories). Visualise collocations and colligations.
c) Identify shared collocates of words or phrases.
d) Summarise discourse in terms of its 'aboutness'.

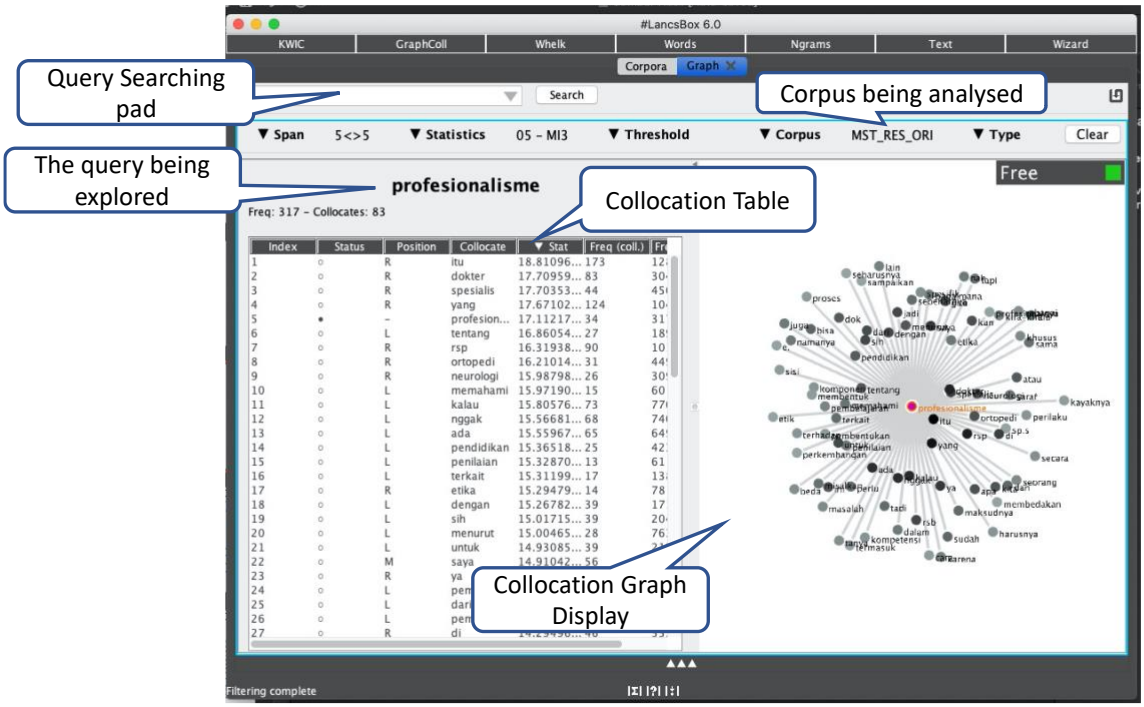

Figure L-2. Feature of GraphColl Analysis in LancsBox

Figure L-2 shows the result of collocation exploration by using GraphColl menu of word 'professionalism' in all transcript records (called the interview corpus). The result of exploration is presented in two modes; 1) collocation table and 2) collocation graph. A collocation table is basically a traditional way of displaying collocates (Brezina et al., 2020). The collocation table in GraphColl result shows the following pieces of information for each collocate: i) status, ii) position, iii) statistic measure, iv) collocation frequency and v) frequency of the collocate anywhere in the corpus. By default, the table is sorted according to the selected collocation statistic from largest-smallest. The default of statistic measure is frequency the list of statistic measure in GraphColl is presented in Table L-2 belows. The second presentation of collocation in GraphColl is the collocate graph. The collocate graph is a visualisation of collocation table into several

dimensions. In GraphColl display, a collocate graph shows three dimensions: i) strength of collocation, ii) collocation frequency and iii) position of collocates. In LancsBox, each collocate can be further checked in its natural position keyword in context (KWIC). See Figure L-3.

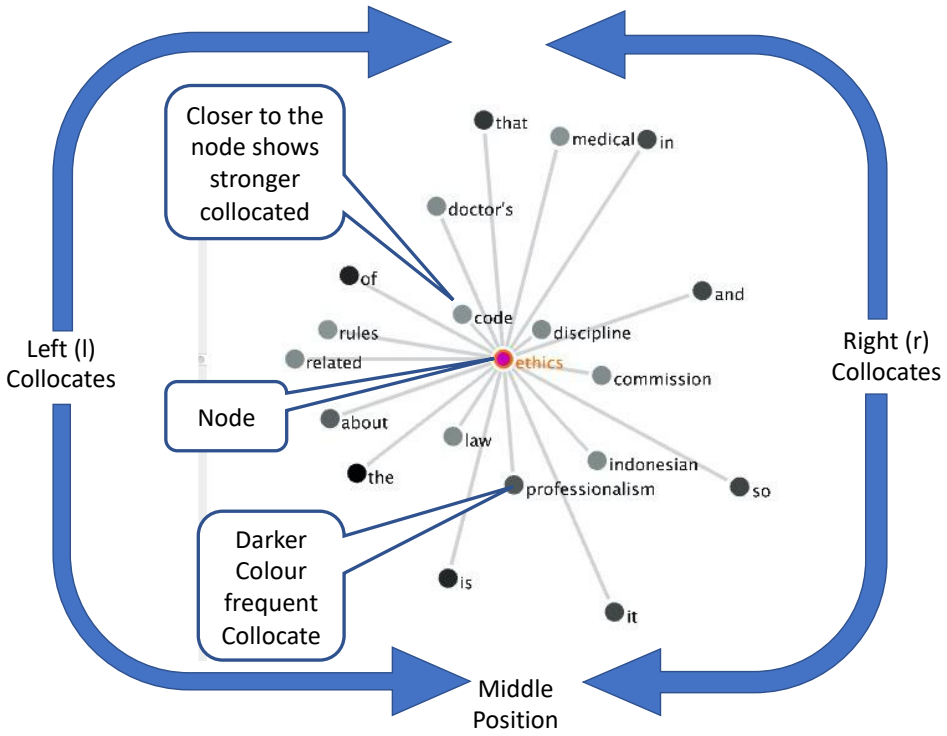

Figure L3 The Collocate Graph from GraphColl menu for word ethics

4. Reporting Collocation using Collocation Parameter Notation (CPN)
   Brezina(2015) introduces the use of collocation parameter notation (CPN) to ensure the replicability of results. In this view, all major parameters that can affect collocate identification should be reported, and CPN fulfill all important parameters for collocate identification. CPN consist of seven parameters as presented in Table L-3 below

Table L-3 Collocation Parameter Notation (CPN)

Statistic ID	Statistic name	Cut-off value	L and R span	Collocate freq (C)	Collocation freq. (NC)	Filter
4b	MI2	3	L5-R5	5	1	Function words removed/ unremoved

Example: 4b-MI2(3),L5-R5, C5-NC1; function words removed

5. Keyword in Context (KWIC)
   Another feature in LancsBox used in this study is keyword in Context (KWIC) menu. KWIC has a function to see where the collocations are happening in the participant's transcript record. I am using KWIC feature to see where the location of collocated words is. After seeing this, I move my work to excel as LancsBox does not have feature to make a note like a qualitative analysis software (e.g., NVIVO, ATLASti, CQDAetc)

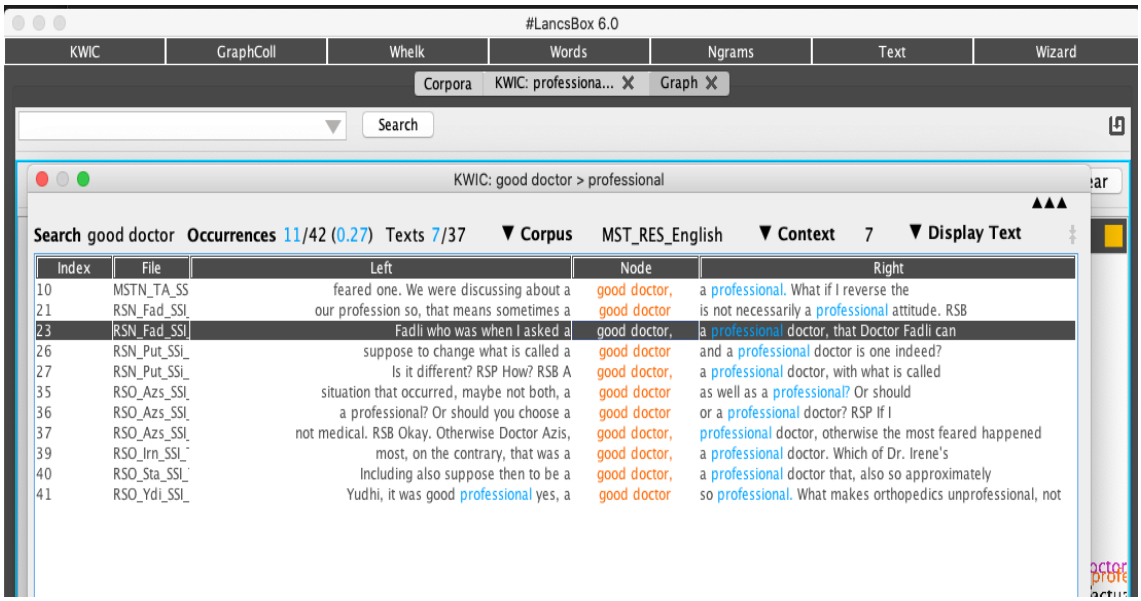

Figure L-4 KWIC feature in showing keyword "good doctor" in speech context (participant's speech)

Appendix I. Collocates Graph Result Supporting 3D-CDA

1. Checking the collocation nature of phrase “good doctor” and “professional” and professionalism

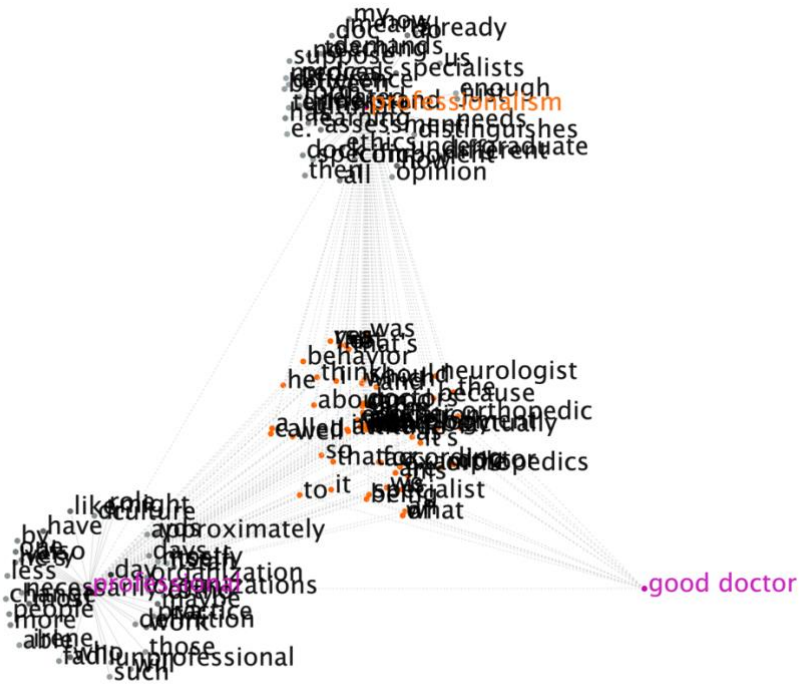

Figure I-1 The collocations between good doctor (right), professiona (left) and professionalism (top)

2. Exploring the relation of professionalism and high-stake examination practice

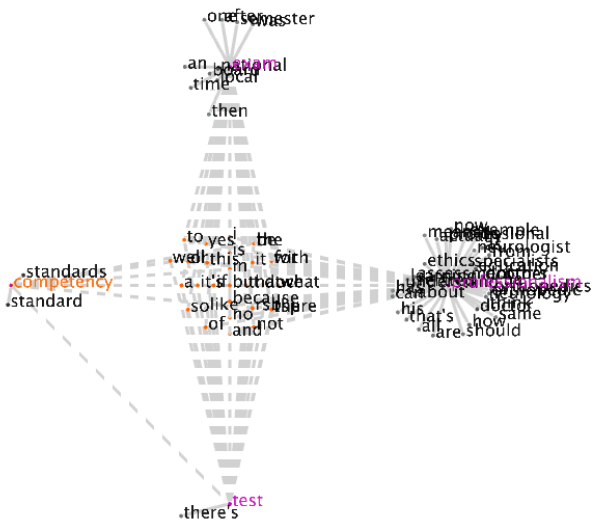

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Figure I-2 Collocations between professionalism (right), competency (left), test (below) and exam (top)

In figure I-2, I explored whether ‘professionalism”, collocate with “test”, “exam” and “competency”. The result showed that they are collocated

3. Professional and professionalism keywords exploration

Table I-1 Top 20 words (in bahasa) that most collocated with “profesional” (professional)

Position	Collocate		Stat	Freq (coll.)	Freq (corpus)
	Bahasa	English Translation			
R	organisasi	organisations	9.02947623	5	11
R	definisi	definition	8.21944559	7	27
R	perilaku	behaviour	8.14461063	16	65
R	pengembangan	development	7.84505095	9	45
R	neurologist	neurologist	7.52312241	28	175
R	tingkah laku	attitude	7.24414656	12	91
R	hari	day	7.05049288	55	477
R	seringnya	mostly	6.9039439	5	48
R	spesialis	specialist	6.88569249	18	175
R	budaya	culture	6.87419714	5	49
R	orthopaedic	orthopaedic	6.76098639	5	53
R	tidak-	unprofessional	6.46653872	5	65
R	dokter	doctors	6.15202826	12	194
R	praktik	practice	5.76704803	9	190
R	berdasarkan	according	5.71631729	15	328
R	peran	role	5.59408915	5	119
R	kerja	work	5.35028582	11	310
L	baik	good	6.58389589	64	767
L	profesionalisme	professionalism	5.15880465	11	354
L	perubahan	change	5.05150156	6	208

CPN For ‘professional’ query: Corpus: MST_RES_Ori| Search Term: professional| Statistic: 03 - MI| Span: 5-5| Collocation freq. threshold: 5.0| Statistic value threshold: 5.0| CPN: 03 - MI (5.0)/ L5-R5/ C: 5.0-NC: 5.0|;

Table I-2 Top collocation of “profesionalisme” (professionalism) with GraphColl

Position	Collocate		Stat (MI)	Freq (coll.)	Freq (corpus)
	Bahasa	English			
R	membedakan	distinguishes	8.80440701	7	18
R	sarjana	undergraduate	8.58201459	6	18
R	spesialis	specialists	7.44208605	18	119
R	dokter	doctors	6.6545286	17	194
R	perilaku	behavior	6.46653872	5	65
R	edukasi	education	6.04842204	27	469
R	pendapat	opinion	6.00854937	7	125
M	komponen	component	8.64341641	8	23
L	puncak	ultimate	9.31898344	5	9
L	kebutuhan	demands	7.90394513	5	24
L	etika	ethics	7.42155146	17	114
L	ujian	assessment	7.17905165	15	119
L	terkait	related	7.01497546	18	160
L	formulit	form	6.52312266	8	100
L	belajar	learning	6.44816033	12	158
L	spesifik	specific	6.37690193	6	83
L	pengajaran	teaching	6.04803749	8	139

CPN for ‘professionalism’ query: Corpus: MST_RES_Ori| Search Term: professionalism| Statistic: 03 - MI| Span: 5-5| Collocation freq. threshold: 5.0| Statistic value threshold: 6.0| CPN: 03 - MI (6.0)/ L5-R5/ C: 5.0-NC: 5.0|

4. Confirming the unique conception of professionalism in neurology and orthopaedic surgery group through frequent word comparison.

Table I-3 Words that unique in orthopaedic participants

	Ortho	Ortho		Neuro		Statistic
		Freq	Dispersion	Freq	Dispersion	(Cohens' D)
1	*operasi* (operation)	633	0.495	22	1.979	2.743
2	*Ortho* (orthopaedic)	445	0.966	4	3.351	1.451
3	*kelasnya* (classmate, peer)	30	0.950	3	2.503	1.371
4	*implan* (bone implant)	28	1.061	0	0.000	1.333
5	*operator* (surgical operator)	85	0.992	4	3.388	1.317
6	*OK* (surgical theatre)	256	1.160	2	3.031	1.212
7	*fraktur* (fracture)	50	1.172	0	0.000	1.206
8	*teknik* (technique)	55	0.843	11	2.707	1.188
9	*diserahkan* (delegated)	9	1.174	0	0.000	1.205
10	*plat* (bone plating)	42	1.221	0	0.000	1.158

	Ortho	Ortho		Neuro		Statistic
		Freq	Dispersion	Freq	Dispersion	(Cohens' D)
11	*bone*	18	1.251	0	0.000	1.131
12	*tindakannya* (intervention)	12	0.982	2	3.147	1.107
13	*asisten* (assisstant)	41	1.202	3	2.481	1.100
14	*chiefnya* (the chief)	119	1.082	32	1.851	1.097
15	*pasang* (install)	44	1.018	8	1.944	1.096

Log notes for Table I-2.: Corpus 1: Ortho_Orl| Language: Indonesian| 18 files| 160312 tokens| 12073 types| 12445 lemmas

Table I-2 Words that unique in neurology participants

No	Neuro	Neuro		Ortho		Statistic
		Freq	Dispersion	Freq	Dispersion	(Cohens' D)
1	*stroke*	137	0.961	0	0.000	1.472
2	*neurologi* (neurology)	304	0.938	5	2.028	1.472
3	*keliru* (faulty)	12	1.050	0	0.000	1.347
4	*obat* (drug, medicine)	98	0.673	17	1.806	1.289
5	*diagnostik* (diagnostic)	31	1.028	1	4.123	1.293
6	*epilepsi* (epilepsy)	63	1.213	0	0.000	1.166
7	*saraf* (neuron)	206	1.122	14	2.236	1.156
8	*pasien* (patient)	1447	0.333	764	0.495	1.151
9	*lainnya* (others)	65	1.011	10	1.289	1.125
10	*penyakit* (disease)	88	0.821	20	1.335	1.122
11	*dirawat* (being cared)	18	1.268	0	0.000	1.115
12	*pemeriksaan* (examination procedure)	173	0.821	43	1.362	1.040
13	*sikap* (attitude)	20	1.241	1	4.123	1.037
14	*kejang* (seizure)	43	1.385	0	0.000	1.021
15	*akademik* (academic)	32	1.307	2	2.921	0.993

Log notes. CPN for Table I-3. Corpus: Neuro_Ori| Language: Indonesian| 23 files| 202215 tokens| 14937 types| 15396 lemmas|

5. Ethics and professionalism in orthopaedic and neurology

Table I-3 Ethics frequency and dispersion in neurology and orthopaedic participants

	Orthopaedic		Neurology		Statistic
	Freq	Dispersion	Freq	Dispersion	(Cohens' D)
Etika (ethics)	64	1.59313	14	1.728978	0.72003809

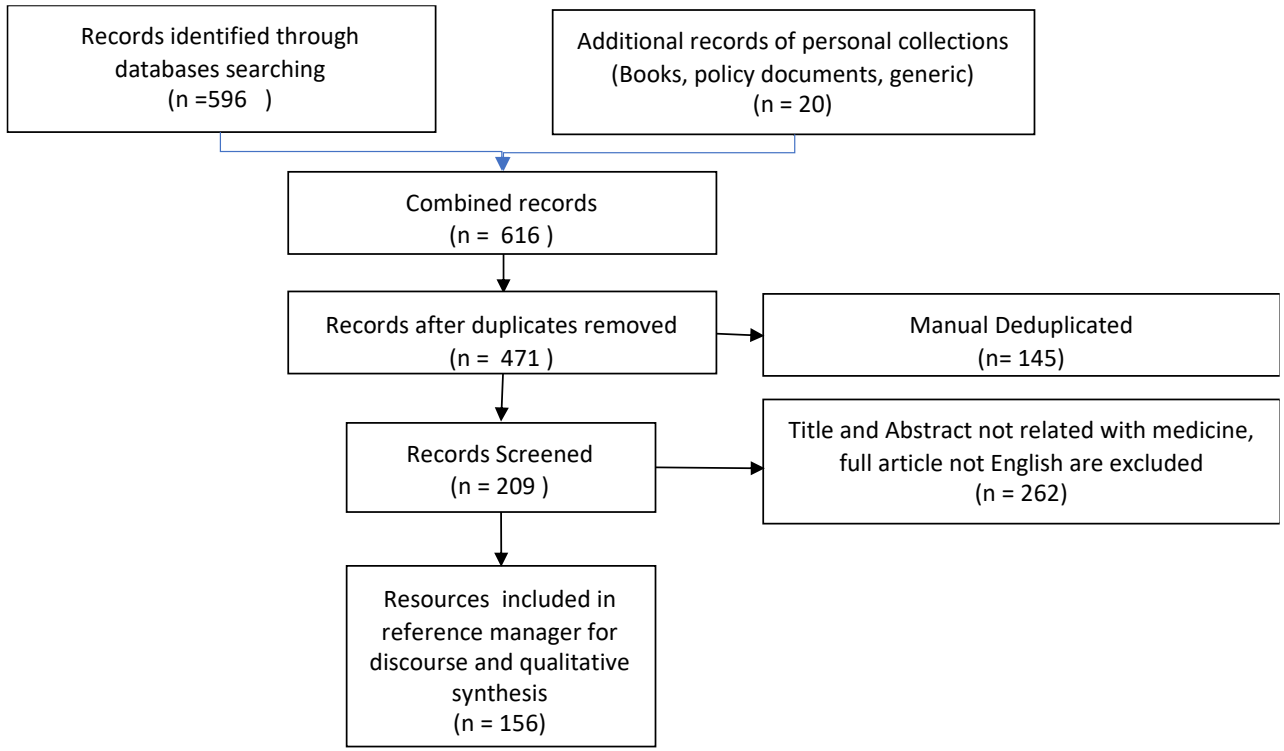
Figure I-3 Ethics (left) and professionalism (right) in neurology participants

Figure I-4 Ethics (left) and professionalism (right) in orthopaedic surgery participants

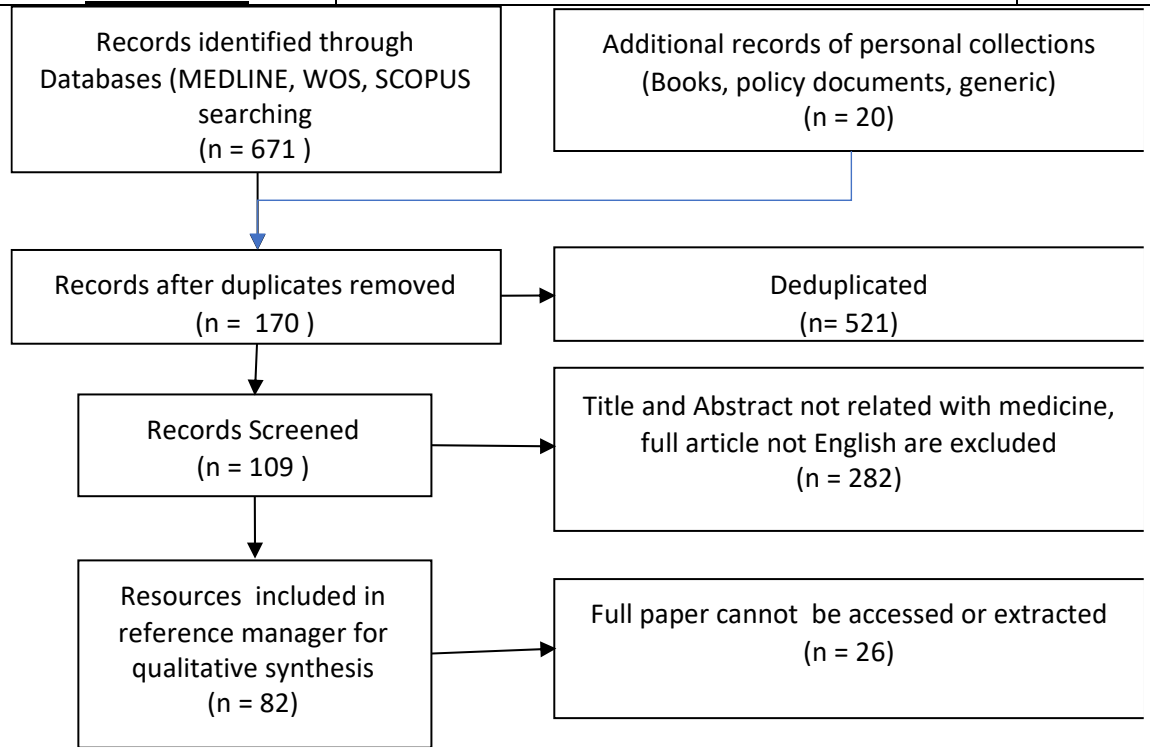
Appendix J Literature Review Strategy

Table J-1 Compilation of Literature Review Strategies

Searching Content		**Searching Query**		
		Weboscience https://www.webofscience.com/wos/	**MEDLINE**	**SCOPUS**
Medical Professionalism		**Medic* and professionalism** (Topic) Time Span: 1970-2020	1. (medical or medicine).m_titl.1384527 2. professionalism.m_titl. 9727 3. 1 and 2	--
	Number Records	**2715**	2616	
	Visual Analysis	Analysed by using bibliographic analysis in creating Figure J-1 and J-2		-
Definition of MP		**medical professionalism** (Topic) and **definition** (Topic) Time Span: 1970-2020	1 (medical or medicine).m_titl. 1384527 2 professionalism.m_titl. 9727 3 1 and 2 2616 4 definition.mp. [mp=ab, hw, kw, ti, ot, bo, bt, id, cc, tx, bc, cb, ds, ge, gn, mc, mi, mq, or, ps, sq, st, tm, tn, rn, ct, sh, de, dm, mf, dv, kf, fx, dq, rw, nm, ox, px, rx, an, ui, sy, on, tc] 715544 5 1 and 2 and 4 134 6 remove duplicates from 5 82	(medical AND professionalism AND definition) AND PUBYEAR > 1969 AND PUBYEAR < 2021
	Number Records	222	82	262

Searching Content		Searching Query		
		Weboscience https://www.webofscience.com/wos/	**MEDLINE**	**SCOPUS**
	Screening & Inclusion for Review			

Searching Content		Searching Query		
		Weboscience https://www.webofscience.com/wos/	**MEDLINE**	**SCOPUS**
Teaching-learning of medical professionalism review		**medical professionalism** (Topic) and **education OR training** (Topic) and **teaching OR learning** (Topic) and **Review Articles** (Document Types) Timespan: 2000-01-01 to 2020-12-31 (Publication Date)	11 (learning or teaching).mp. [mp=ab, hw, ti, tx, kw, ct, ot, sh, tn, dm, mf, dv, kf, fx, dq, bt, id, cc, nm, ox, px, rx, ui, sy, tc, tm] 2562375 26 medicals professionalism.mp. [mp=ab, hw, ti, tx, kw, ct, ot, sh, tn, dm, mf, dv, kf, fx, dq, bt, id, cc, nm, ox, px, rx, ui, sy, tc, tm] 2621 30 11 and 26 889 31 limit 30 to english language 862 32 limit 31 to yr="1910 - 2020" 810 33 limit 32 to "review articles" 340 34 remove duplicates from 33 260	(medical AND professionalism AND teaching OR learning) AND PUBYEAR > 1969 AND PUBYEAR < 2021 AND (LIMIT-TO (DOCTYPE , "re")) AND (LIMIT-TO (SUBJAREA , "MEDI") OR LIMIT-TO (SUBJAREA , "ARTS"))
	Number Records	**111**	260	300
	Screening			

Searching Content		Searching Query		
		Weboscience https://www.webofscience.com/wos/	**MEDLINE**	**SCOPUS**
	& Inclusion for Review			

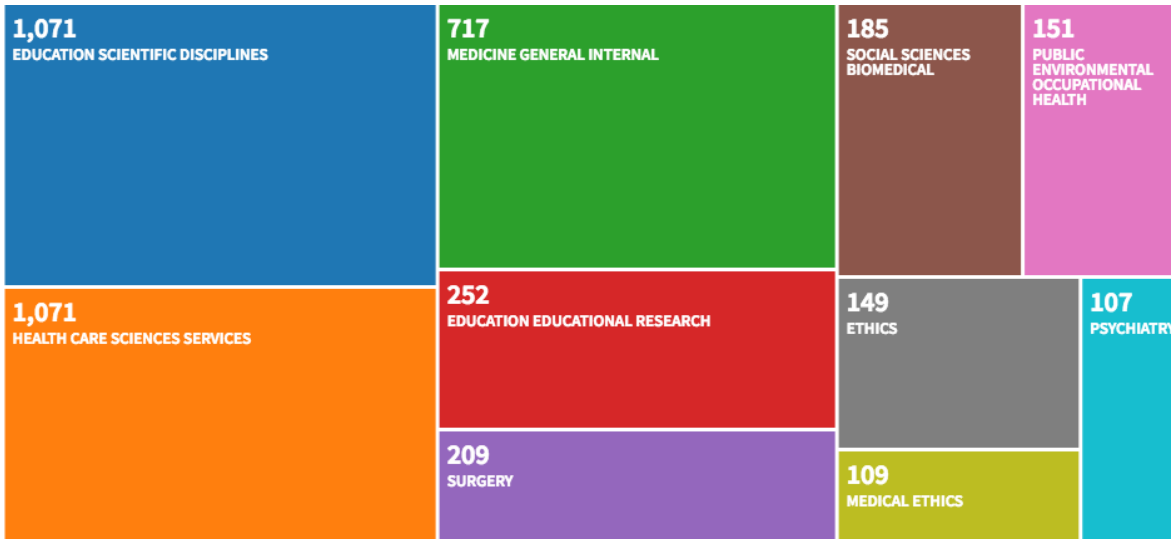


Figure J-1 Journal's Subject Sub-Headings that included medical professionalism topic

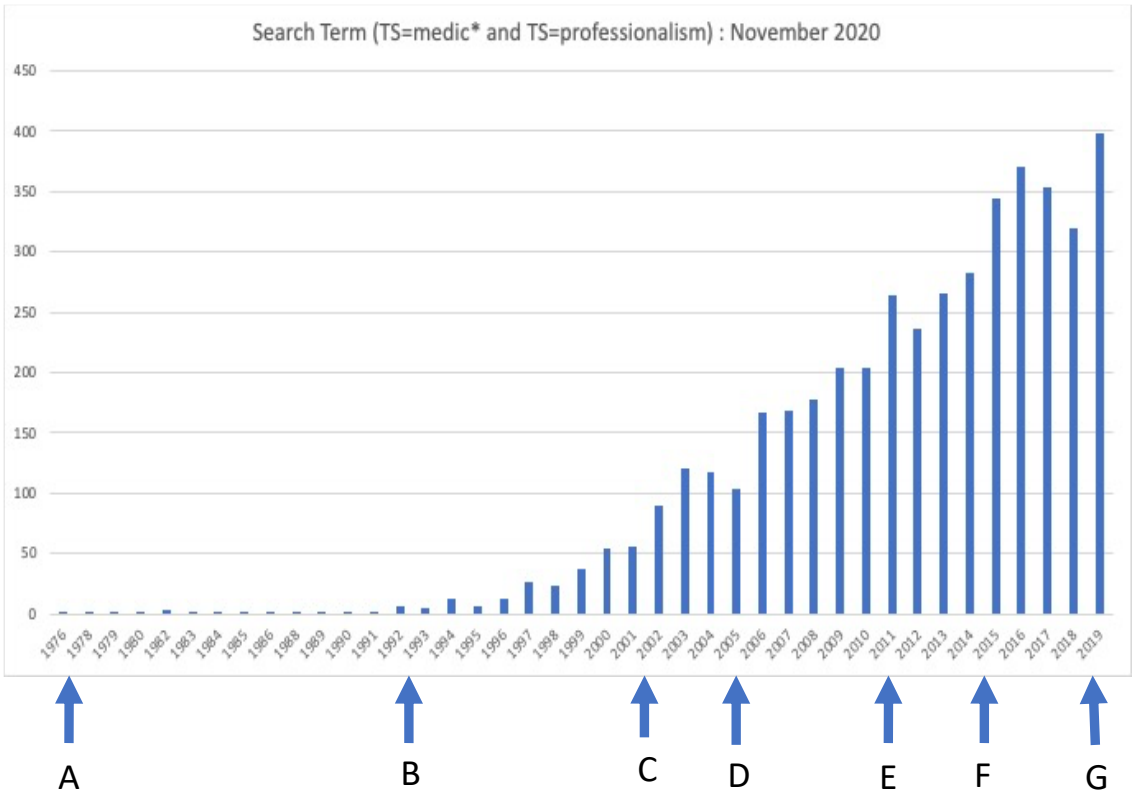


Figure -J-2 Amount of paper on Medical Professionalism and some surging moments in publication number (See some related events in Table J-1 below)

Table J-1 Critical Events that happened in some resurging MP publication noted by capital letters in Figure J-1

Nodes in Figure J-1	Year	Critical Events
A	1970s	Early writing on Professionalism by sociologist e.,g., Friedson, Merton, Larson etc.
B	1992-1995	First Edition of GMC's Tomorrow Doctor (1993) First Edition of GMC Good Medical Practice (1995)
C	1999-2003	• NAP's report *Tor Err is human* (1999) • ACGME Core Competency Introduction (1999) ➔ MP as one core competency • NAP's report *Crossing Quality Chasm* (2001) • WFME Trilogy Standard (2003)
D	2005-2006	• MEDINE Project EU ➔ Formalisation of degree in medical training ➔ National qualification framework • Royal College of physician' recommendation: Doctor in society (2005) • First Edition of CANMEDS (2005) • Toolbox for ACGME Core Competence (2005) • AAMC MSOP on Professionalism (2005) • David Stern's Book Measuring Medical Professionalism (2006) ➔ Collection of Definition, Theory and Assessment tools for MP
E	2010-2011	• Academic Medicine special edition on medical professionalism Vol 1 (2010) • The Lancet's Commission Paper (2010) ➔ Suggesting competency-based approach & new perspective of professionalism • Ottawa Conference recommendation on Assessment of MP (2011)
F	2014-2016	Implementation of ACGME Next Accreditation system (2014) ➔ Overarching audit, measurement of professional performance ➔ reemergence of MP issues
G	2018-2019	Royal College of Physician renewal of its 2005 recommendation (2018) Topol Recommendation for NHS Reform in utilizing Technology 4.0 (2019)

Appendix K. ITTD Bibliography of Literature Review

Table K-1 Bibliographic Reference to ITTD

Ref. Number	Author / Country	Year	Type Publication	Title	Study Design	Profession being studied (Field Study background)	Study Aims	Data Gathering Method	Data Analysis	Summary of Result + Notes to ITTD
1	Silvia Gherardi Italy	1995	Article Journal Studies in Cultures, Organisations and Societies 1(1):9-27	When will he say: “Today the plates are soft”? the management of ambiguity and situated decision-making	Ethnographic Study	Shop Workers	Examining the cognitive process of decision-making in managing ambiguity of professional life.	ITTD - SSI	Thick Description	ITTD has enabled researcher to elicit the cognitive framework of "being at work" which may differ from one community to another, or even within the same one, but with a complex stucture of meanings. The ITTD has also helped researcher to identify how professional knowledge is created through cognitive decision-making, both in individual and collective levels, which are focused on the mapping of relational space and the stipulation of the contract with work.
2	Davide Nicolini UK	2009	Management Learning Vol. 40(2): 195–212	Articulating Practice through the Interview to the Double	Perspective	Midwives GP	Provide theoretical and practical description of ITTD	Observation SSI ITTD	-	The theoretical background of ITTD and the practical how ITTD is used.
3	Bouchamma,	2012	Journal Article:	Supervision	Participatory	School	This study to	SSI - ITTD	Mixed	The in and out action

Ref. Number	Author / Country	Year	Type Publication	Title	Study Design	Profession being studied (Field Study background)	Study Aims	Data Gathering Method	Data Analysis	Summary of Result + Notes to ITTD
	Yamina Basque, Marc Canada		US-China Education Review: B 7	Practices of School Principals: Reflection in Action. (The use of Instruction to the double ➔ written instruction)	Research Positivist	Principals	explore how the school principals perform a reflective analysis of action, in and out of action by enabling school principals to better articulate their teacher supervision practices.		Qualitative Coding method (Thematic & Emerging Content Analysis)	are represented as instruction about: Knowledge Being Doing
4	Gorli, Mara Kaneklin, Cesare Scaratti, Giuseppe Italy	2012	Journal Article: Qualitative Research in Organisations and Management: An International Journal 7(3):	A multi-method approach for looking inside healthcare practices (Written instruction ➔ Instruction to the double)	Methodology evaluation through Organization Participatory Research	Health Care professional who had role as managers	Exploring the utility of multi-method research approach in detecting and analysing professional practice that support organisational reflection and change	ITTD ➔ Concept Map Ellicitation +. Triptych poster	Thick Description	ITTD as written exercise : Advantages: Sharing written instructions allows both the author and the reader to gain insights into their own practices. Drawbacks: Participants may reject the exercise because they are asked to do the written task away from the workplace (resistance, feeling of “having to do homework”)
5	Marius Pretorius Pretoria,	2013	Journal Article:	Tasks and activities of the business rescue	Research paper	Business rescue practitioner				

Ref. Number	Author / Country	Year	Type Publication	Title	Study Design	Profession being studied (Field Study background)	Study Aims	Data Gathering Method	Data Analysis	Summary of Result + Notes to ITTD
	South Africa			practitioner: a strategy as practice approach						
6	Lloyd, Annemaree Australia	2014	Journal Article	Following the red thread of information in information literacy research: Recovering local knowledge through interview to the double	Research Paper	Aged-care worker	How aged-care workers developed their understanding of safety in the workplace	ITTD – In-Depth Interview	Grounded Theory, Constant comparison (Charmaz)	Provide Strength and Limitation of study but they are likely repeating Nicolini's (2009) observation
8	Uribe-Jongbloed, Enrique Colombia	2014	Journal Article: International Journal of Qualitative Methods 13(1): 135-150	A qualitative methodology for minority language media production research	Methodology Introduction based from an Ethnography Research	Minority Ethnic Radio broadcaster	How the professionalism characteristics and identity are to be understood in the context of minority media production becomes relevant to understand the type and impact of media	ITTD - Observation - SSI	Thick description	The three-step approach were considerably successful at pinpointing the way in which identity, and language as part of it, affects media production practices.
	Marius Pretorius South Africa	2014	Acta Commercii 14(2): 1-15	A competency framework for the business rescue practitioner profession	Qualitative	Business Rescue Practitioner	Investigate the competencies that underlie the activities of a business rescue practitioner	ITTD only	Grounded Theory Content analysis	The study suggest a structure to the competencies underlying the activities of a BRP to navigate a rescue.

Ref. Number	Author / Country	Year	Type Publication	Title	Study Design	Profession being studied (Field Study background)	Study Aims	Data Gathering Method	Data Analysis	Summary of Result + Notes to ITTD
										In this study the researcher modify the instruction by using slide because the ITTD was performed in a group meeting (Workshop) Researcher is also inviting participants to write 7-10 key tasks for the double.
9	Mathias Decuypere & Maarten Simons Laboratory Belgium	2014	European Educational Research Journal Volume 13 Number 1 2014	On the Composition of Academic Work in Digital Times	Qualitative	Professor	To explore how academic activity is being composed in everyday life and how digital devices play a role in this composition informed by ANT.	ITTD only	Social Network Analysis by using Gephi	Data from ITTD is treated to identify actors that influenced the academic activity of a professor in using digital device.
10	Davide Nicolini UK	2014	Book Chapter	Surfacing the multiple: Diffractive methods for rethinking professional practice and knowledge	Review	Midwives	Arguing the Ontology and Epistemology Ground of ITTD	-	Thick Description	The singularity and multiplicity of professional learning ITTD as a promising method to surface the multiplicity of professional knowledge
11	Ivaldi, Silvia Scaratti, Giuseppe Nuti, Gianni	2015	Journal Article: Evaluation 21 (4): 497-512	The practice of evaluation as an evaluation of practices (Instruction to the double)	Participatory Research paper	Administration Manager	to illustrate how conducting an evaluation within an organisation becomes an	ITTD – Participant reflection concept map – Impact Observation	Content analysis	Redefining context of learning → fortify Engestrom concept of boundary crossing

Ref. Number	Author / Country	Year	Type Publication	Title	Study Design	Profession being studied (Field Study background)	Study Aims	Data Gathering Method	Data Analysis	Summary of Result + Notes to ITTD
	Italy						opportunity to produce knowledge thus reflecting on and transforming the existing system of activities and practices			
12	Gorli, Mara Nicolini, Davide Scarlatti, Giuseppe Italy	2015	human relations 2015, Vol. 68(8) 1347 – 1375	Reflexivity in practice: Tools and conditions for developing organisational authorship	participatory action research	Healthcare managers (doctors, nurses, charge nurses and psychologists) Health Care Manager directors of studies, (programme directors, subject coordinators and group leaders): nurses, psychologists, psychiatrists, medical assistants	to foster the agential orientation of organisational members and to enhance their capacity to produce meaningful changes.	Instruction to the double (Individual Written form of ITTD) + Collective mapping of critical concepts in professional work and their connections + Actionability chart + Action plans	Thick Description	ITTD eliciting critical aspects of work
13	Jennifer Scoles	2017	Research Thesis	Exploring professional engineers' knowings-in-	Research	Wind turbine Engineers	how engineers enact competent knowing and	ITTD + Map Illustration (thinking map) + Photo	Thick Description	Notes on ITTD: Difficulty of participant to maintain the detail of

Ref. Number	Author / Country	Year	Type Publication	Title	Study Design	Profession being studied (Field Study background)	Study Aims	Data Gathering Method	Data Analysis	Summary of Result + Notes to ITTD
	UK			practice in an emerging industry: An Actor-Network Theory approach			learning strategies to respond to and navigate the complexities and tensions.	Ellicitation + SSI		activity during the day.
14	Cher M. Hill Canada	2017	Teacher Learning and Professional Development 2(1):1-17	More-than-reflective practice: Becoming a diffractive practitioner	Reflexive diary	Teacher	explores three interrelated ways of going beyond reflective practice and inviting diffraction into the field of professional learning.	ITTD	Narrative description	Multiplicity of professional identity. ITTD is considered as a method to peel the diffractive entity of professional identity.
15	Reed, Kathleen Hoffman, Cameron Ecclestone, Meg Canada	2017	Book section	Interview to the Double: Uncovering Student Motivations in the Library Book: The Library assessment cookbook	Practical Guide	University Student	Provide a practical guide to perform ITTD	ITTD	-	A very short version of how to perform ITTD with an example to investigate student's motivation and behaviour in library.
16	Cormac McGrath, Torgny Roxå & Klara Bolander Laksov	2019	Higher Education Research and Development	Change in a culture of collegiality and consensus-seeking: a double-edged sword	Qualitative	Lecturer	Research question: (1) How do collegial leaders, that have undergone training,	SSI + ITTD	Thematic Analysis	No reflection on ITTD Five categories were identified that show how collegial leaders experience change, process change and organise the practice

Ref. Number	Author / Country	Year	Type Publication	Title	Study Design	Profession being studied (Field Study background)	Study Aims	Data Gathering Method	Data Analysis	Summary of Result + Notes to ITTD
	Sweden						experience the practice of change, (2) How do they bring about the process of change, and (3) What role does theory play in collegial leaders' practice of change?			of change
17	Wellton, Lotte Jonsson, Inger M. Svingstedt, Anette Sweden	2019	International Journal of Hospitality and Tourism Administration 20(4)	"Just trained to be a chef, not a leader": A study of head chef practices	Ethnography	Head Chefs	to show how daily leadership practices are enacted by head chefs in small craft restaurants.	ITTD + Field note Observation	Thick Description	Identification of three daily work practices: mastering the materiality, showing and guiding, and overview and foresight, in which all contain activities of leadership
18	Ann Langley & Nora Meziani Canada	2020	Journal of Applied Behavioral Science 56(3):370-391	Making Interviews Meaningful	Theoretical Review	- Field: Management	To elucidate the complexity of interview method by identifying five different genres of interviewing, each with its specific ontological assumptions and purposes	-	Narrative	Five Interview Genres: - Investigative - Apprentice - Interpretive - Discursive - Interventionist ITTD is included in the Apprentice genre, where its main purpose is to articulate tacit knowledge. It is argued to be under

Ref. Number	Author / Country	Year	Type Publication	Title	Study Design	Profession being studied (Field Study background)	Study Aims	Data Gathering Method	Data Analysis	Summary of Result + Notes to ITTD
										practice perspective ontological assumptions.
19	Théron, Christelle France	2020	M@n@gement 23(3)	Enhancing In Situ Observation with the SCI Design (Shadowing-Conversations-Interview to the Double) to Capture the Cognitive Underpinnings of Action	Ethnography Participatory–Multiple case studies	Organisation manager	to capture action and cognition together and to surface both the situated and structuring facets of cognition underpinning action	Shadowing + conversation + subjective re-situ) + ITTD	Thick Case descriptions	Synergistic methodological use on understanding cognition underpinning action. ITTD able to surface both the situated and structuring facets of cognition underpinning action

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