Chapter 7
Cultivating and Nurturing Medical Professionalism in the Cultural Context

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Abstract Professionalism has been one of the essential topics in medical education in the last decades. Although much research about professionalism has been published in medical education journals, most of them are written by authors in the Western context. There are still few studies exploring medical professionalism from the Eastern context. This chapter 16 uses socio-cultural and socio-material research perspectives to redefine "context" and explore the context-specific aspect of medical professionalism in two Eastern countries to feature how medical professionalism is cultivated in the Eastern context. The authors argue how language and discourses mediate cultural and spiritual virtue and form the context-specific conception of medical professionalism.

7.1 Introduction

7.1.1 Conception of Medical Professionalism

What do we mean by professionalism? Or for more specific, medical professionalism? In a short answer, it is "ism" about professionals. In the simplest term, medical professionalism is all attributes, characteristics, beliefs, and conceptions related to the medical profession. However, in the last three decades, a study on medical work and professionalism has evolved dramatically. This is mainly because people's interest in the medical profession has been evolved from just an intention to define the character of the profession and its relation to the community to more complex and specific inquiries such as how this profession learns and how the

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profession develops the most efficient teaching–learning and assessment to produce the better ones. While the former inquiry was set by sociologists in establishing the basis for research in the profession, the latter has been the core inquiry behind the birth of medical education as an academic field where professional learning and professionalism become one of its core research topics. These developments made people's understanding of the medical profession and how it is defined have also evolved and getting more complicated. Especially when defining medical professionalism has become a contesting area not just for the profession but also for agencies outside the profession.

The profession is a type of occupation that closely linkages with public services. Medicine as a profession, therefore, is also bounded with this generic destiny. Scholars have argued that the role and function of the medical profession are centrally lied in the unwritten contract between society and the profession to facilitate the healing process of ill people. This concept is known as the social contract of the medical profession. In the past, medical associations became a powerful representation of the medical profession in establishing and maintaining the credibility and sustainability of the social contract. However, both the medical profession and the society they are served are changing. Medical knowledge and healthcare technology have evolved, allowing the expansion of new modes of care and specialties. The medical profession has become more specialistic, and people's expectation to medical profession has also steadily shifted. In turn, defining medical professionalism involved many competing parties and interests, and this has become a challenging task for medical education society. Defining and maintaining medical professionalism in the public discourse is tempting, relevant, and encouraging both for internal and external professional agencies. For internal agencies (medical and health profession researchers), developing medical professionalism discourse based on research-based evidence will strengthen the accountability discourse of the medical and health societies in maintaining their identity and special privileges in the community and at the same time finding the most acceptable form of social/moral contract. For external stakeholders (e.g., government, health authorities, and wider public stakeholders), keeping the professionalism discourse alive in society would enable these agencies to exercise new models of relationship (e.g., regulation or social control), which unlikely occurred in the previous days.

As a research topic, professionalism has played a critical role in the development of medical education both as a professional education practice and a distinctive academic field. Historically, the medical profession is the research subject in which the classic definition of a profession is emerged, and thus study on professionalism is grounded. The pioneers of professional and professional studies like Parson and colleagues have grounded their research on the medical profession. These early professionalism studies signify the expansion of research and education practices that help the professional development and learning of the medical profession. Moreover, the establishment of medical education as an academic discipline also cannot be separated from epistemic journeys of exploring and understanding how medical and health workforces, as a profession, learn to grow and develop. It is recorded in history that the earliest development of medical education as a research interest among medical educators was initiated by research inquiries such as "how

doctors learn?" and "how is the nature of doctor's clinical decision making?" (Norman 2002, 2012; Kuper et al. 2010). Research in medical education history has also shown that four topics: curriculum development, teaching and learning, assessment, and professionalism itself, have become four major research topics published in renowned and high impact medical education journals (Azer 2015; Atluru et al. 2015; Hafferty 2017; Rangel et al. 2017).

As time unfolded, studies on professionalism in medicine have evolved to be a big theme, not just an area of research interest for medical education researchers, but it also becomes a global movement to maintain and sustain the social contract of the medical profession in the changing society. Medical education as both emerging academic and practice fields become the main actor and the reactor (source of energy) of this movement. The medical education and the professionalism movement should have strengthened each-other existence. We believe research on the professionalism that allows us, as medical educators, to understand more how professionals learn and develop and nurture in a set of teaching–learning and assessment is a never-ending agenda in medical education practice. This is because the society and context where (and which) we develop our understanding of the profession are always changing. The big question is, however, how can professionalism be cultivated and nurtured in different multifaceted contexts, and what can medical educationists do to catch up with these changes?

This chapter is an attempt to cultivate the current conception of medical professionalism in the countries with hierarchy and collectivism, especially in the Asian context, the origin of the authors of this chapter. From this understanding, medical education researchers project away to nurture professionalism or professional development contextually. As two Asian origins of medical doctors and medical educationists, the authors come to a reflexive observation on the importance of redefining context and the critical role of socio-cultural and socio-material approach in researching and nurturing medical professionalism. The arguments to support the undertaking were mostly drawn from recent studies and the relevant emergent underpinning theories.

7.2 Revisiting Context in Conceptualizing Professionalism and Its Teaching–learning

Professionalism is a complex concept and has a multidimensional social construct (Ginsburg et al. 2000; Cruess and Cruess 2004; Hodges et al. 2011). Research showed that how people conceive professionalism is evolving over time and across different disciplines (Fenwick 2016). The feature of the conception shift of professionalism is summarized from the literature (Royal College of Physicians et al. 2005; Thistlethwaite and Spencer 2008; Martimianakis et al. 2009; Wynia et al. 2014; Burford et al. 2014; Levinson et al. 2014; Zukas and Kilminster 2014) and shown in Table 7.1.

Table 7.1 The different conceptualization of professionalism

Conceptions of Professionalism
Professionalism is the virtue (worldview, values, and ethics system) and ideal desirable qualities of medical profession (e.g., professionalism as realizing compassionate care; reflective practice)
Professionalism is a protected role of medical profession as a privileged community in society
Professionalism is a set of functional traits consisting of behaviors and competencies of individual profession that is entrusted by society to be committed by professional organization body
Professionalism is one among Identities (consists of set of values, attributes, and relationship) of medical profession that developed through special education and practice
Professionalism is a social movement to create new relationship between society and medical profession (e.g., professionalism as a social responsibility of profession to the community)
Professionalism is a discourse of controlling profession either exercised by professional body or external parties other than member of professional body

There is also ongoing debate in professionalism studies on what extent it is universal and to what extent it depends on local context (Ho et al. 2011; Jha et al. 2015). Although both authors of this chapter are among those who had evidence that the professionalism is contextual and culturally specific, we don't think extending this contestation would offer a productive outcome for a common vision to promote better professional learning. Rather, we see a big challenge (a common enemy) faced by medical educationists in every nation in the world on how we are facing disruptions in many sectors of the medical and healthcare system. These disruptions not only change how medical professionals work and function in the healthcare services and system, but the society in which the professions are serving is also disrupted. This should have made us aware that our understanding of the context in defining professionalism might be no longer relevant and therefore need to be redefined.

We used to call that the workplace, the home, and the community, as well as school, colleges, and universities, are profound examples of context for professional learning. That is true, and we call this the first definition of context, i.e., context as a container. This definition is possibly our dominant view of conceiving context for professional learning as Lave (1996) quoted from Mc Dermott:

> In all common-sense use of the term, context refers to an empty slot, a container, into which other things are placed. It is the 'con' that contains the 'text', the bowl that contains the soup. As such, it shapes the contours of its contents: it has its effects only at the borders of the phenomenon under analysis … A static sense of context delivers a stable world.
>
> (Mc Dermott, quoted in Lave 1996:22-3)

However, this understanding becomes problematic when we further believe on a discourse that professional learning should be lifelong. If professional learning is lifelong, then it cannot be about "container" anymore. Following work on situated learning (Lave and Wenger 1991), workplace, home, community, social media, and any other form of learning institutes can all be regarded as a level of learning within which there are specific situations. In this notion, there are other levels of learning contexts distributed across the associational order of each level, and they are embedded in practice to such an extent that this order is itself already a learning context. For example, if we say the workplace is a level of learning context, then there is always a possible question in which this context can still be broken down into several workplace situations such as "which workplace?", "which schedule?", "when working with who?", etc. Imagine what would be the answer for a physician who is working in an internationally networked hospital or those who are working in a teaching hospital, non-teaching hospital, and those who are just working in their private practice only. Here, the answer to these questions would refer to an order, and this associational order becomes what so-called a learning order in which all are linked as a meshwork of learning contexts. The boundaries of the workplace in this example become subtle, and therefore its understanding as a container for professional learning becomes no longer relevant (Edward 2009). We modified an illustration from Russell's work (2009) to feature the distinction between context as the container and context as the meshwork in Fig. 7.1.

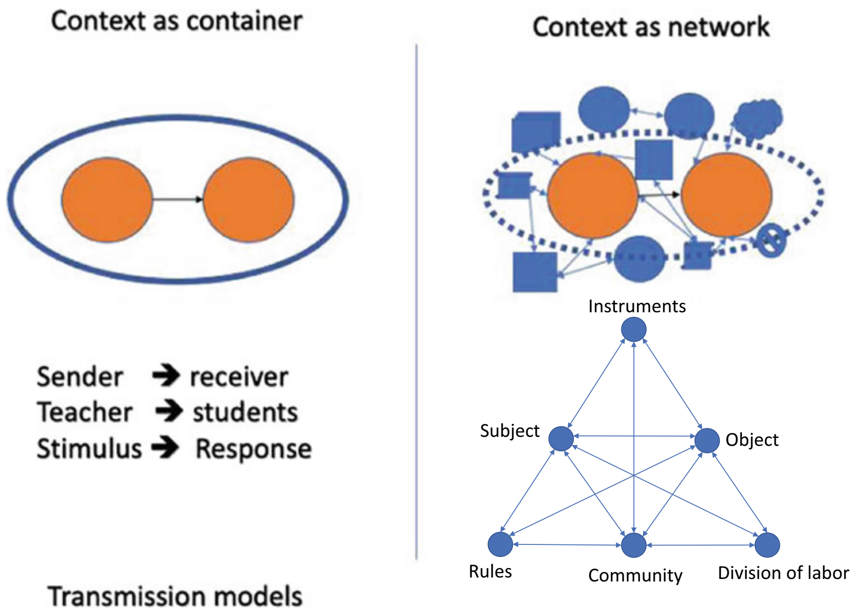

Fig. 7.1 Context as container or network, and their particular knowledge transmission model (Modified from Russell 2009. p. 19)

Russell's work (2009) is inspired by the work of Vygotsky on Activity Theory. Russell argues that the stimulus–response model of learning is no longer adequate in explaining the learning process that occurred in the current student–teacher interaction, especially in explaining the role of textual literature on teacher development at school. Therefore, he proposes the importance of bringing Cultural-Historical Activity Theory (CHAT) as the most plausible way of conceptualizing context to understand the complexity of knowledge transmission. Although Russell's conceptualization of context is in the field of the teaching profession, this illustration is also applicable in other professional learning situations such as medicine.

In Fig. 7.1, the transmission models of learning and communication, which are mostly suggested in behaviorism and information-processing cognitive psychology, generally focus on the transmission between individuals inside the container and grouping other than this interaction as context (the upper left side of Fig. 7.1). The socio-cultural perspective of learning, like CHAT approaches to learning, tends to use "network" as a metaphor for context. In this perspective, what people think (represented by language and symbols), what they do, and the tools they are using (material object, rules, community, instruments) are seen as a complex threading meshwork of interaction of human which all are manifested as activity or culture (Fenwick and Nimmo 2015). Therefore, the meshwork itself is the context (the right side in Fig. 7.1). It is interesting that etymologically, context (con-text) is derived from a Greek term that means weaving, as in textile or texture (Russell 2009).

In professional learning literatures, other emerging socio-cultural learning approaches such as communities of practice (Lave and Wenger 1991), actor networks (Fenwick and Edwards 2010), activity system (Zukas and Kilminster 2014), and complexity framework (Bleakley 2010) have emerged to the fore and have offered a potential to help our understanding of professional learning. These emerging approaches offer a new perspective as well as opportunities on how we define and conceive the relation of professionalism, professional responsibility, professional learning, and the context in different situations involving both space (place, nation, region, etc.) and time (past, current, and the future).

7.3 Exploring Asia Medical Education as a Context for Conceptualizing Professionalism

It is impossible to define Asia Medical Education as a context of this chapter because currently, the term "Asia", based on the United Nations, is representing a region occupied by 48 countries with different social, cultural, political, economic, and historical backgrounds. As an illustration, if we say "Asian" countries, it might mean we would generally be referring to Japan, Korea which are being original members of OECD (developed nations); and at the same time, we are referring to China, India, Indonesia, which become partners of OECD (a country with emerging

markets); and Bangladesh, Myanmar, Cambodia, which are listed as least developed countries; and Afghanistan and Yemen which are struggling in warfare. However, in order to bring forward the discussion of cultural background in professionalism narrative, inevitably, we should make a boundary of what we mean by Asia Medical Education. Facing this difficulty, we found Hofstede's national culture classification come up to the fore when discussing the role of culture in medical education studies. Hofstede's national culture classification is believed to be one of the most plausible explanations depicting how cultural discourse might affect the social system and therefore become a factor distinguishing the social practice of Asia from the rest of the countries in the world.

In Hofstede's narrative, culture is defined as "…. *the collective mental programming of the human mind which distinguishes one group of people from another"* (Hofstede 1986, p. 25). Through extensive studies in organizational studies, Hofstede proposes a model consisting of six domains that characterize the cultural difference of the world's country. They are called power distance index (PDI), individualism-collectivism (IDV), masculinity-femininity (MAS), uncertainty avoidance index (UAI), long-term or short-term normative orientation (LTO), and indulgence-restraint (IND). Based on Hofstede's model, countries in Asia have several characteristics in common, especially when they are compared to European and American differ significantly in all areas (Power Distance, Individualism, Masculinity, Uncertainty Avoidance, Long-Term Orientation, and Indulgence). However, if we used two domains (e.g., power distance and Individualism) as the differential factors to countries in other world regions (Europe, Africa, and North America), there is a significant mean difference among this region. Despite the result of some grounded study in doctor-patient communication, this might be the insight of why some medical education researchers originated from Southeast Asian country, arguably, in favor of using "hierarchical" and "collectivism" terms as the proxies to identify the cultural context of their society (Claramita et al. 2013; Claramita and Susilo et al. 2013; Suhoyo et al. 2014; Rahayu et al. 2016; Claramita et al. 2019).

Another possible approach to represent Asia Medical Education is by adopting a narrative used in postcolonial studies called postcolonial perspective (Bleakley et al. 2008, 2011). From a postcolonial perspective, the interest is on the examination of social-culture dynamics of former Western colonies and how they relate to the international relationships in the current days (postcolonial time). In this perspective, the main concern is the advancement of liberation and democratization that support decolonization and engages subaltern (colonized society) experience, which involves the perspectives of dominated, marginalized, oppressed, and subordinated peoples. The way to achieve this is by deconstructing assumptions about the nature of language and texts by critiquing the new modes of imperialism and master narratives of dominant like white, Christian, Western, and patriarchal (Hammer 2005). Using postcolonial perspective in representing Asia's Medical Education has a meaning that Asia Medical Education either as a practice of professional education or epistemic practice of medical education research, can be seen as a contested socio-political field between western, developed nations, expatriate

(Somewhat called Occident) culture and indigenous, developing nations, Asian (somewhat called Orient) culture. Through postcolonial lens, medical educators need to engage with the critical framework as they want to bring western medical education to Asia. Medical educators in Asia need to put aside the anxiety that appears when comparing their current medical education with medical education literature that national medical schools are not up to date if they do not (uncritically) adopt the latest learning approaches engineered in the metropolitan West. For example, Onishi and Yoshida argue that Japanese medical schools must catch up with the latest undertaking in medical education innovations such as PBL, the objective structured clinical examination (OSCE), and outcome-based education if they are to transcend the historically binding feudal *ikyoku-koza* system of apprenticeship based on strict hierarchy. However, many reports have informed that the quality of health care in Japan is outstandingly able to provide better outcomes for its citizens compared to many other countries, including Western nations at any number of points along the age spectrum (Rao 2006; Reich et al. 2011). Although many have criticized the long due of medical education leading to super specialization health-workforces, health-care in Japan is consistently better than health care in the USA or most of the Western-European countries (Rao 2006; Ban and Fetters 2011).

Hodges et al. (2011) offer a conceptual framework to help the researcher in mapping the current literature in professionalism and possible trajectories of how professionalism's conceptualization might be applied in teaching–learning and assessment practice (See Table 7.2). We believe that by using this conceptual framework, the exploration of context (e.g., cultural, organizational, social values, etc.) is encouraged as the space for discussion since this area is still underdeveloped in the medical education field.

According to some review on professionalism (Hodges et al. 2011; Birden et al. 2014; Jha et al. 2015; Wang et al. 2016), only a few researchers have been publishing papers under socio-cultural paradigm and thus trying to capture and elaborate professionalism discourse as a social practice or social dynamic which is constantly changing through the social system (represented as areas 3,6, 8, and 9 in Table 7.2). Two possibilities come up to the mind of why these areas become less traveled paths. First, subjectivist-constructionist—which is also called socio-cultural research paradigm—although becomes a trend in educational research and practice, is representing a minority among medical and health profession. Second, to capture professionalism under a social-cultural paradigm is methodologically challenging. For instance, a group of creative ethnomethodology approaches in understanding the nature of professional learning, such as video-reflective ethnography and image elicitation, are still facing the thickness of ethics-legal provisions in health care and data privacy and protection issues. However, these approaches inevitably offer a versatile methodology for dealing with the complexity of the workplace and professional practice.

There are studies to define the conception of professionalism and its components across cultural contexts. Among these attempts to consolidate some conceptions of professionalism written by Non-Western medical education researchers,

Table 7.2 Discourses in professionalism conception (Redrawn from Hodges et al. 2011)

		Order of Discourse		
Epistemology/Research Paradigm		Individual Discourse	Interpersonal Discourse	Societal/Institutional Discourse
		Professionalism as an individual characteristic, traits, behavior, or cognitive process	Professionalism as an interpersonal process or effect	Professionalism as a socially constructed way of acting or being, associated with power and agencies
Positivist-Objectivist	Generalizable	1	4	7
		Professionalism is an objectively definable phenomenon to be found in individuals, generalizable across culture and contexts	Professionalism is an objectively definable phenomenon to be found in interpersonal interactions, generalizable across culture and contexts	Professionalism is an objectively definable phenomenon to be found in social groups, generalizable across culture and contexts
	Limited generalizable	2	5	8
		Professionalism is an objectively definable phenomenon to be found in individuals, but shaped by cultural values and contexts	Professionalism is an objectively definable phenomenon to be found in interpersonal interactions, shaped by cultural values and contexts	Professionalism is objectively definable phenomenon to be found in social groups, shaped by cultural values and contexts
Subjectivist-Constructivist-Critical Realist		3	6	9
		Professionalism is subjectively constructed within individuals, arising from or shaped by culture and contexts	Professionalism is an interpersonally constructed phenomenon, arising from or shaped by culture and contexts	Professionalism is a socially constructed phenomenon, arising from or shaped by culture and contexts
		Think about: Professionalism conception that applied in most current undergraduate medical education program Professionalism in most of competency framework	**Think about:** Professionalism that applied and measured in certain residency program with patient-care services	**Think about:** Professionalism that applied in a warfare or conflicted nation, or in a rural community program which demand situated adjustment of professional standard due to socio-political-economic and cultural context

Al-Rumayyan and colleagues have identified three cultural conceptions of professionalism referred to as Arabic, Chinese, and Japanese conceptions (Al-Rumayyan et al. 2017). In this scoping review study, a consolidated ideal conception of professionalism among influential figures in the representing countries and cultures is presented based on four key articles. However, social culture as a source of context difference of professionalism conceptualization in the review is conceiving that professionalism is a reproducible construct that will provide some interpretation and understanding in a different time and practice contexts.

In the following sections, we will provide some cases of how the socio-cultural and socio-materiality perspective catalyzed the emergent understanding of professionalism in two professional contexts (undergraduate and postgraduate medical education). The case studies might help us to project how professionalism is contextually learned and possibly nurtured/taught. The first case study will elaborate on the national cultural heritage as a perspective in defining professionalism, which will take Bushido principles as the central discourse. The second case took a study in two medical specialties in Indonesia that render the emergence of spirituality/religiosity, multi-organizational influence, and social artifact discourse that influences the conception and application of professionalism in medical practice (the following case).

7.4 Socio-Cultural Perspective in Conceptualizing and Applying Medical Professionalism

7.4.1 Lesson Learned from the Bushido Principles to Build a Post-Modern Medical Professionalism

Using a constructivist paradigm, Nishigori described seven elements of Bushido principles in the Japanese medical professional practice that posit an indigenous cultural heritage value which cover almost all western-based conception of professionalism (Nishigori et al. 2014). The seven principal virtues in Bushido are rectitude (gi), courage (yu), benevolence (jin), politeness (rei), honesty (sei), honor (meiyo), and loyalty (chugi).

Although rooted in the historical tradition of Samurai spirit, it seems Bushido principles still enshrine most of Japanese medical professionals and inherited from generation to generation through a social practice of virtue ethics system. In this ethical system, the main concern of the society is the character of the actor. In ethical systems based on duties and rules like mostly applied in Western society, one judges whether a course of action is ethical or not according to its adherence to ethical principles, focusing on doing. Meanwhile, virtue ethicists judge whether an action is ethical according to the character trait the actor embodies, focusing on being. These seven virtues function as a moral compass that guide medical practitioner to perform excellence but with compassionate and respectful care.

While the ethical system on duties and rules needs a deliberate nurturance of the ethics principles and teaching. The virtue ethics on the contrary relies on the social structure that applied in layered levels of society and community practices. There are few numbers of formal teaching sessions or medical courses on Bushido principles in medical schools across Japan. But almost all medical practitioners naturally understand all seven principal elements of Bushido because they already applied in the society and day-to-day practice.

Here, we would like to focus on the concept of rectitude (Gi) in Bushido. In the sixteenth century, during Japan's Warring States period, the warlord Uesugi Kenshin was a man who believed in rectitude (Gi). At the time, Uesugi Kenshin's nemesis, Takeda Shingen, ruled over a land surrounded by mountains. The Takeda clan was allied with the Imagawa clan, who ruled the land facing the sea, but relations deteriorated and war broke out. When the Imagawa clan imposed an embargo on salt, Uesugi Kenshin is said to have sent salt to the Takeda clan, saying that if they were going to fight, they should do so on the battlefield and that the people living in Takeda territory were innocent. This episode was passed down as a proverb: “Send salt to your enemy”. Uesugi Kenshin is considered to be a rare warrior who valued rectitude (Gi) at a time when it was considered natural to fight for personal gain and even deceive one's opponents.

The opposite concept to rectitude (Gi) is that for profit. In today's world, where the capitalist value system is dominant, it is said that doctors tend to choose specialties that require less workload and make more money. However, there are still many doctors in Japan who consider it their “rectitude (Gi)” to “work for their patients”. As we have already seen in the Bushido article, this concept of “rectitude (Gi)” is equivalent to the professionalism of doctors in Western cultures.

On the other hand, rectitude (Gi) is very much a matter of values, and sometimes there is a difference of opinion about what is right. Readers may have already known that it is often difficult to decide what is right in medical practice, as in the trolley problem posed by Philippa Foot. When we engage in dialogue on the concept of rectitude (Gi), there is an argument to be made for “greater or lesser rectitude (Gi)”. This is based on the idea that we should consider rectitude (Gi) from a larger perspective, and this perspective may be useful when we have difficulty in deciding which rectitude (Gi) we should follow.

Virtue ethics as a basis of Bushido is one among the many genres in educational philosophy that related with the emergence of reflective practice discourse. The reflective practitioner is regarded as an emerging professionalism conception post-modern professionalism discourse. General Medical Council and other health stakeholders in the UK issues a guideline that advocating of the professionalism teaching in medical school in the UK is to realize the production of reflective medical practitioner that could improve the quality and patient safety in nation’s health care organizations (Academy of Medical Royal Colleges 2018; GMC 2020).

The elucidation of Bushido principles in the development of professionalism conception in Japan is an example of how context-based exploration of

professionalism provide a promising way forward to promote and nurture medical professionalism in all possible medical education continuum (undergraduate, post-graduate, and continuing professional education) in a country.

7.4.2 *Spirituality/Religiosity Discourse in Medical Professionalism Conception*

We chose the following definition of spirituality as we regard this definition covers the most features of components related to it:

> Spirituality is a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose, and transcendence, and experience relationship to self, family, others, community, society, nature, and the significant or sacred. Spirituality is expressed through beliefs, values, traditions, and practices (Puchalski et al. 2014).

In the above definition, Spirituality embraces both secular and philosophical perspectives, as well as religious and cultural beliefs and practices. Religiosity specifically relates to certain beliefs in a transcendent power or religious teaching (Koenig et al. 2010; Puchalski, Blatt, et al. 2014). Although spirituality and religiosity had their distinction, the use in healthcare and professional education context is mostly interchangeable. That's why we wrote it as a single-dual term by using a slash (S/R).

S/R theme has also emerged in professionalism studies. The main relational discussion of S/R and professionalism is especially on the perspective that professionalism conception is associated with the personal worldview and cultural belief which strongly influence how professional as an individual or as community member behave (Tilburt and Geller 2007). Recognizing the growing attention to the S/R in professionalism study and educational practice, Hodges et al. (2011) included S/R in the subjectivist-constructivist discourse, especially in the societal/ institution columns (cell no.9 in Table 7.2) that it is part of the complex socio-cultural aspect that construct professionalism conception (Hodges et al. 2011).

In the study performed by one of the authors, the S/R theme has emerged among undergraduate medical teachers in a developing country when they are invited to define professional doctor's characteristics that need to be nurtured at medical school (Bekti et al. 2018). Spirituality and religious belief are among the influential discourse in both defining and applying professionalism in the everyday life of specialist medical practice. A study involving international medical teacher participants has also informed that the S/R theme is typically emerged among Asian origin medical teachers compared to their European counterparts. The Asian origin medical teachers assert that spiritually healthy professionals should be present as role models for students. Getting insights from these studies and other relevant literature, there are some ways S/R are related in professionalism conceptions.

S/R as a supernatural power that determines health

S/R discourse gives space for the personal belief in supernatural power (e.g., God in Abrahamic religion, spirit connection, miracle, etc.). This is popularly termed as transcendence in the healing process of disease beyond the bio-psycho-socio mechanism. This belief led to a perspective that the professional role in the doctor-patient relationship is a healing facilitator rather than being a healer itself. One among the statements made by a participant in a study reveals that belief in a supernatural power (e.g., God) see the health and cure from illness is a prerogative right of God and therefore should construct one's understanding of being professional.

This belief has long been recognized in the biopsychosocial-spiritual model of care. Recognizing the Spirituality of the patient in their possible transcendence belief plays a critical role in the care of patients with complex, serious, and chronic illnesses. In this notion, the S/R narrative is also being used to reason many unexplained cases when some medical problems are resolved without any complicated medical interventions. A historical story of the first successful surgical operation on the Siamese twin in Indonesia becomes a reference of how S/R discourse emerged when the modest neuro-surgical technology could overcome the complicated problem (at that time in Indonesia context) by involving the confidence in the presence of God. One Neurology professor participant replied his dialogue with the Neurosurgeon who successfully did the operation.

S/R as an individual-transcendent professional act.

S/R-belief is perceived as part of personal well-being that transcends professional acts (doctor-patient acts, work activities) as mediation to achieve personal happiness and life satisfaction. Al-Eraky and colleagues conceived Spirituality—dealing with God—as one of their four gates model of professionalism. In the "dealing with God" conception, self-accountability (*taqwa*) and self-motivation (*ehtesab*) are grounded in Islamic-Arab culture and, similarly, interpreted from the dominant Islamic culture, "barakah" and "Ihsan" concepts emerged in one of Bekti's study. While Arabic is not an official or first language in this country, Barokah is a Bahasa Indonesia translation of Arabic noun B*arakat or baraka (*بركة), *and Ihsan forms the translation Ihsan (*إحسان). Barokah is a concept rooted in Islamic Sufism, which means something is blessed with spiritual power or glory, while Ihsan means excellent deeds because of being continuously watched by God's surveillance (Nasr 1977; Schimmel 2011). Medical Specialist practitioner who believed in barokah concept perceived that good professional deeds (e.g., to the patient, to work accomplishment, etc.) are requisite for the transmission and achieving *barokah* life. This barokah life has become the feature of modern Moslem spirituality interpretation of a good life which is typically conceived as personal health, family happiness, financial satisfactory, business success, etc. (Schimmel 2011). In one instance, the barakah concept has a shared principle with the concept of Karma in Indian (Hindu religion) ethics, where it is believed that a good deed will be

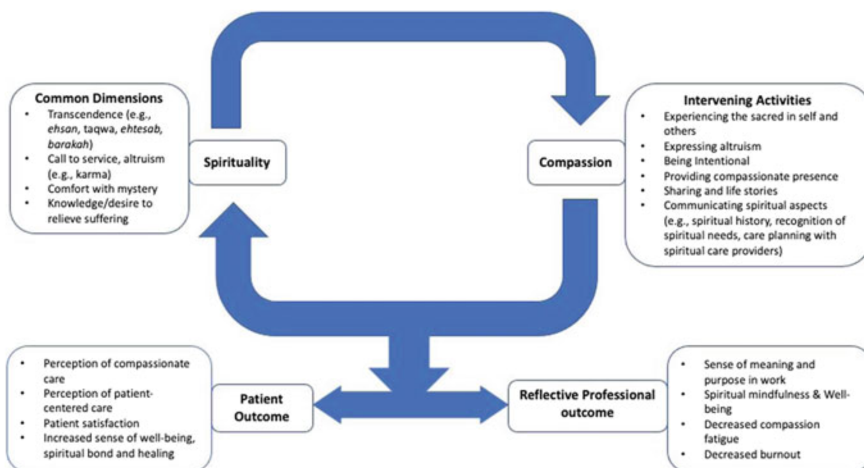

Fig. 7.2 The conceptual model of relational model between spirituality/religiosity, compassion, patient outcome, and professionalism (modified from Puchalski et al. 2014)

resulting in good life or a good impact in life. Conversely, evil deeds will negatively impact one or whole individual life (Olivelle 2014).

With these transcendental ethical reasonings, a religious or spiritual professional develops their compassion, contributing to the quality of patient care and/or professional well-being. This transcendental conception of compassionate work is parallelly conformed with a model developed from the United States National Consensus Conference on Creating More Compassionate Systems of Cared reported by Puchalski et al. (2014). In this model, spirituality is related to the ability of the professional to provide compassionate care. Compassion is an attitude that makes professionals able to approach other's need and thus help in their suffering. However, more importantly, compassion is a manifestation of spiritual thrust and practice, a way of being, a way of service to others, and an act of love. This model is redrawn in Fig. 7.2, depicting how spiritual care is entirely relationship-based where the spirituality and health model informs compassionate care.

S/R as a norm and governance in society

Confirm with the definition of Spirituality previously stated. S/R is not just localized in personal worldview, but it also represents a communal belief. As a communal belief, S/R is to be the reason behind the enactment of informal learning or hidden curriculum activities in student or residency training. In one of the specialist groups in Bekti's study, a group of religious teachers has involved a non-formal religious-based teaching activity (a weekly sermon) for their residents. These activities are believed to be significant in shaping and improving the resident's professional performance during the program. In justifying their acts, participants argued that the activities have been able to change the attitude and everyday behavior of residents in providing more humanist patient care.

7.5 Socio-Material Perspective in Conceptualizing and Applying Professionalism in Everyday Medical Practice

Socio-material approaches are broad terms named after some emergent theories and methodological approaches that take into account the non-human component of things (matters) as critical active components that matter in the development of knowledge (Fenwick and Nimmo 2015). The approaches help to make visible the material dynamics such as the relationship of agencies, tools, technologies, and settings as well as human intentions, expertise, and communication in professional practice situations (Fenwick et al. 2012). Therefore, socio-material researchers tend to approach the whole system, appreciating human/non-human action and knowledge as entangled in systemic webs, and at the same time, acknowledging the dynamic process of boundary-making. In other words, socio-material approaches are not only interested in human consciousness or intention but also explore how knowledge, knowers, and known (representations, subjects, and objects) emerge together with/in activity/ies or system. In the following sections, we provide two examples of emerging discourses in professionalism conceptualization that relate the presence of matters or objects in everyday professional practice. The examples were drawn from current studies where one of the authors is involved.

7.6 The Emergence Role of Matters in the Conception and Utilization of Medical Professionalism

What we mean by matter or materiality in this section is the non-human component of society. Some scholars, especially sociologists, used to call matters cultural artefacts. Materiality in a socio-material perspective might include tools, technologies, bodies, actions, objects, work arrangements, and organizational structure. Materiality might also include texts and discourses, but not in ways that over-privileged linguistic, intertextuality, and cultural circulations. There is emerging evidence from the different professionals (e.g., doctor, midwives, military leaders, organizational managers) that matters play a critical role in professional learning hence constructing conceptualization of professionalism and its learning (Zukas and Kilminster 2014; Johri 2014; Fenwick and Nimmo 2015). For example, Zukas and Kilminster (2014) examine how blue form in the Intensive care unit involve in the decision-making and the development of the reflective ability of medical practitioners. Nimmo (2014) observed how the arrangement of people, room, and tools during handover in the emergency unit participate in the development of reflective health professionals.

Through the socio-material lens, for example, toward Actor-Network Theory (ANT) sensibility, matters have already surpassed its nature as “a mere material” and become one among actors that embodied human values, meaning and transform

these values to human and the particular professional society (Fenwick and Edwards 2010). In his study, Bekti et al. (2020) also found that National Board Specialist Examination (NBE), as an event, in two studied specialties has been regarded as a critical matter in the development of professional specialist identity. NBE has been seen as not just an educational event, but it reflects the specialist tradition and pride that should be preserved as it is symbolizing the historical development of specialists (Bekti et al. 2020).

7.7 Upholding Professionalism in Multi-Organizational Hegemony of Medical Practice

In one segment of his doctoral study, Bekti found that despite providing a strong sense of ideal-spiritual/religious belief, medical specialists in a developing country acutely suffered from conflicting multi-organization interests in defining and applying professionalism in their professional practice. These conflicting interests create dilemmatic conditions which are difficult to be managed by only upholding the ideal conception of being professional. This made his participants come up with the idea of professional flexibility, a condition where merit, evidence-based knowledge of practice could not be applied; hence, adaptive context-based decision-making and situational acts should be done. The reason is that the professionals perceiving the condition are beyond their professional authority. However, the compassion made them seek the most plausible way beyond the professional knowledge they gained from teaching and experience. This is where organizational dispute becomes a new way of learning.

Inspired by Martimianakis et al. (2009), we provide a case illustration of a junior doctor who had a situation that challenges our understanding of professionalism and how the power relation in layered organizational interests might offer a different perspective of what being professional mean (see Box 7.1).

Box 7.1

Case: The emergency department is brimming with activity. Doing his best to distribute the many clinical tasks, Dr. Lee sends a clinical clerk, Marta, to assess Ms. Aminah, a pregnant patient who has had some bleeding. Dr. Lee is telling Marta to hurry so that they can discuss her final clerkship evaluation afterward. Marta finds the patient in the draughty and busy hallway. What could be the possible professional conduct Marta could perform in this situation?

Possibility 1. With an understanding that being professional means an ability to recall and apply the ethical principle in such a hapless situation. Marta thinks professional is to balance patient's right and belief system and personal efficiency as part of health provider. While she cannot find a proper private place to perform gynecology examination to respecting the patient

religious belief, she performs gynecological and vaginal examination quickly in the current place, covering the patient as much as possible, then report back to Dr. Lee. Despite the patient might being tearful. Instead, the patient still blessing Marta for what she did. She might decide not to mention the awkwardness of performing a vaginal examination in an open hallway. Instead, she would receive a positive evaluation from Dr. Lee for able to perform the task completely.

Possibility 2. Marta tells Dr. Lee that she is unwilling to examine patients in the hallway because it is against ethical principles and the school's diversity value. Dr. Lee agrees that the situation is less than ideal. He assists, helping Ms. Aminah to feel less embarrassed and showing Marta how to keep the patient unexposed. Empowered by her experience as a student activist, Marta later writes a formal letter to the Head of Emergency, declaring her concerns about hallway examinations. While Dr. Lee gives her a positive evaluation, he privately decides that he would not be keen to have her back in the ED. He may admire her professionalism but does not wish to be reminded by junior staff how many times he has tried and failed to correct the inadequate ED facilities. Meanwhile, Marta's letter arrives at the ED Head in the same batch of mail as a memo from hospital administration outlining further budget reductions in the coming year.

Possibility 3. Marta collaborates with the patient's nurse to find a more suitable location for the examination. This allows her to examine Ms. Aminah in a private situation like how she has learned. However, this made Marta lose Dr. Lee's time that day to perform her clerkship evaluation. It means she has to perform remediation on other days. As an influencer, she writes anonymously about her experience on Facebook’s fan page in order to inspire her followers. Inspired by Marta's story, one of her social media followers carried the story to local health authorities, making the current religious Province Governor increase the hospital's budget to perform physical renovation in ED to add more spaces for doctors and nurses to perform more private examination space.

The condition encountered by Marta is likely to happen among the current situation of a problem in professionalism teaching and application in everyday professional life. In Possibility 1 in the Box 1, Marta’s reaction is possibly representing the normative-adaptive of professionalism where she made a dialogue with her mind, recalling a memory of ideal ethical principles which help her act with rectitude and respecting patient’s religious belief in fulfilling her professional duty. However, Marta’s case is not “just” a journey of the individual learner in finding proper choice and balance between core professional, ethical principles (e.g., autonomy, non-maleficence, beneficence, and justice) to face such dilemmatic real

problem. Moreover, the practice situation is frequently more complex than this scenario, allowing students to reflect and act something different from the common normative belief. There are a number of solution possibilities for Marta's problem, which enmeshed in a number of interaction and relational possibilities of her and power structure distributed in stakeholder interests and conflicting articulation of being professional. The practice is connected not only with multiple human interests that professionals must try to prioritize and juggle but also with diverse non-human entities. Power is not limited to the human actors but is co-produced and distributed through the relations among all the human/non-human participants, which is often unheeded in ways it can materialize in surprising demands. Professionals often struggle with an array of negotiations and conciliations to achieve legitimate compromises (Fenwick 2016).

Another situated example of a possible different array of understanding professionalism in context is the existence of competing organizational influence appears in clinical and specialist training governance. Possibility 2 in the Box 7.1 might represent this situation where many workplace sites for teaching and learning professional skills are not deliberately designed and conditioned for educational purposes. Very often, doctors find themselves drowning in difficulty to adhere to guidelines for best practice because of the limitations they faced in the context of their work (lack of funding, under-staffing, under-resourced facilities, etc.). Frequently clinical workplaces are not all designed in an integrated provision to nurture future medical professional professions. Therefore, it is important to have a moment to discuss with trainees, the strategies for thinking about and working towards reconciling these competing priorities, particularly as they pertain to professionalism. The current wave of the Academic-Health System campaign might inspire an ideal vision of integrating Education-Healthcare services. However, the currently dominant practice of professional education is still a plethora of contestation of interest, struggling on efficiency and juggling with governmentality from one to other stakeholders (Rangel et al. 2017; Martimianakis et al. 2020).

As an illustration, we took Indonesia as a case to discuss this multi-organizational governmentality phenomenon. In Indonesia, specialist training has to be a degree-granting program that should be run by the Faculty of Medicine in a University where all medical teachers and educational infrastructure should be made available based on higher education provision. However, the education and competency standards are exclusively determined by the college of specialty, and almost all teaching–learning activities are held in a designated teaching hospital (usually an accredited tertiary referral hospital) or networked teaching hospitals owned by the Ministry of Health authority or provincial government (WHO 2017). Therefore, there is three-partite governance that overlooks specialist education in Indonesia, where each partite has its formulation and expectation of what a professional doctor should be. Referring to Foucault on governmentality, professionalism in this context has become a governmentality tool of different organizations to rule individual profession, and vice versa, it is also a governmentality tool for a professional organization to retain back their diminishing self-governance as one of social privilege (Evetts 2003; Martimianakis et al. 2009; Martimianakis and Hafferty 2013). This three-partite governance is featured in Fig. 7.3.

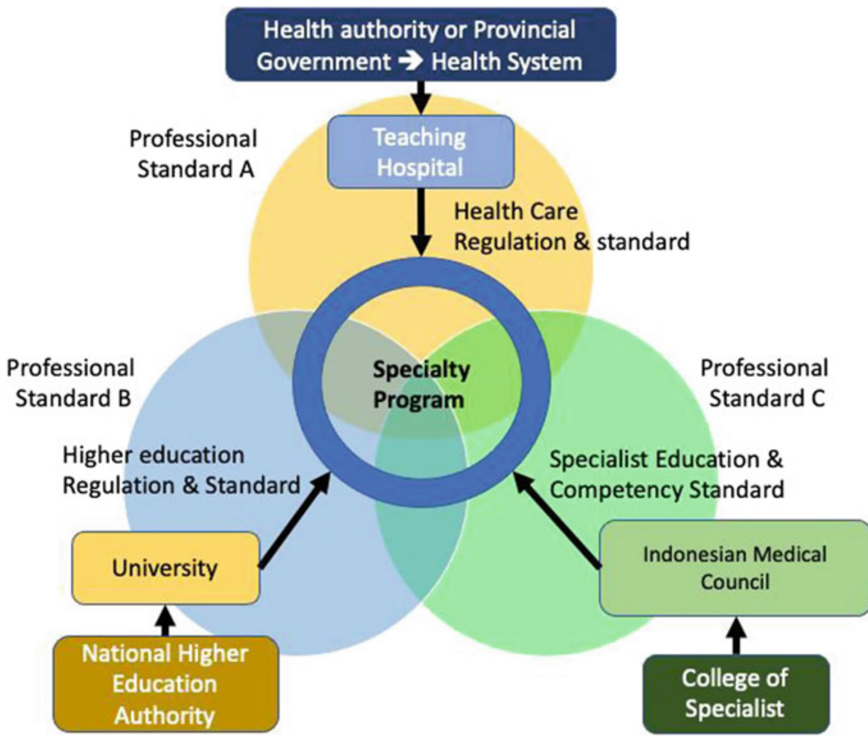

Fig. 7.3 The multi-organizational governance in specialty program in Indonesia

The issue of organizational governance in medical education is an emergent topic in professionalism discourse. Notifying this phenomenon, Martimianakis et al. (2020) assert that managing these competing organizational entities and creating a compassionate organization should be the new possible way to enable the nurturance process of the next generation of medical professionals in their identity formation. Teaching professionalism is no longer adequate, only relying on pouring students with the idealism of morality or Ethics principles when at the same time educational organizations do nothing on their educational policy and clinical ecology (Martimianakis et al. 2020). Consequently, the medical education institute needs to expand its function from a container of professional learning to be an active actor in aligning all possibilities and context to nurture professional development and produce the generation that is ready to fight to realize professionalism.

The fast development of information technology (IT) and the internet of things (IoT) inevitably disrupts medical education. Not only it changes the way professionals do their routine, but IT/IOT also offers a possibility of a different way of learning and being. In possibility 3 in Box 1, as a virtual activist, Marta aware that if in real life she could not do much to change anything, she wishes to do differently by the power of her virtual charisma of her as a virtual influencer. A new discourse

of 'professionalism has emerged with potentially significant effects, particularly for professional education. Some medical teachers might see posting anything about work on social media as strange behavior or even unethical conduct. However, the development of new research interests such as Data Science Ethics and Data Science literacy has created a new norm of the use of Data in the internet of things. New codes for online conduct appear in higher education and service-based institutions with long lists of prohibited behaviors. New training modules in mitigating the risk of social media users are becoming popular and thus offer a new landscape of how we define ethical and professional conduct of data use which may lead us to re-questioning whether there is shifting in our understanding of professionalism concerning the role of digital media and how they might potentially expand a professional practice. Here is where a socio-material approach is illuminating.

7.8 Impact on Teaching–learning and Assessment of Professionalism

As a research interest, professionalism has been widely studied and inspiring the formation of a social movement (Wear and Kuczewski 2004; Lynch et al. 2004; Mann 2006; Frenk et al. 2010; Birden et al. 2013; Wynia et al. 2014). This movement enables the institutionalization of professionalism in medical education practice. As a consequence, almost all competency frameworks or standards in the current hegemonic practice of competency-based medical education (CBME) are bringing professionalism as one of the domains, areas, or components of the competency framework.

Nevertheless, delivering professionalism as a learning outcome, learning a subject, and assessment method in CBME practice is still challenging for some students, faculty members, and even for medical educationists (Gaiser 2009; Bryden et al. 2010; Chaytor et al. 2012). The enactment of outcome-based education (OBE) or competency-based medical education (CBME) demands more defined learning outcomes (Holmboe et al. 2010; Frenk et al. 2010). Contrary, the evolving and fluid definition of professionalism align poorly with the provision of OBE/CBME, and this becomes a challenge for faculty members and medical educationist in translating professionalism in teaching–learning and assessment practice. A number of works on formulating professionalism as a learning outcome frequently produced an overarching ideal concept of professionalism. Despite this ideal framework is necessary, if we rely solely on the ideal professionalism in teaching–learning, it is insufficient and, in some instances, raised contra-productive outcomes such as distress and burning-out among students (Bryden et al. 2010; Doukas et al. 2013). The importance of teaching and assessing professionalism lead to the embedding of professionalism component in high-stake examination following medical licensure provision and accreditation process, which complicate the challenge of teaching professionalism (Whitehead et al. 2014). The reductionist

view on competence-based education, medical licensure, and accreditation demands more tangible evidence, which somewhat distracts students and educators from conflicting with the longitudinal-development nature of professional identity or professionalism learning.

Another challenge in realizing professionalism in teaching–learning practice is the incompatibility of the professionalism paradigm with the chosen teaching–learning practice and assessment. As it is shown in Table 7.2, professionalism conception that can be adopted in teaching–learning practice can be divided into nine areas of definition. Each area (cells with numbers 1–9) requires a different set of teaching–learning and assessment approaches. Like we discussed before, some medical educators might have agreed to adopt the most sophisticated definition of professionalism (say areas 6, 8, or 9), which is currently more popular with the term "nurturing professional identity formation". However, in practice, because of accreditation provision, or certain higher education policy, medical schools had to rely on lecturing sessions as the major modality of the teaching–learning method and the multiple-choice question examination as the sole assessment method. Consequently, the expected outcome will unlikely be achieved, and even this might become a lousy example for students of how unprofessional is a medical educator in teaching professionalism.

The framework offered by Hodges et al. (2011) presented in Table 7.2 highlighted the importance of aligning the educational paradigm with the teaching–learning and assessment approach of professionalism. Although adopting the available professionalism framework is tempting, cultivating and building an educational approach based on the professionalism conception that is plausible with the local context of the healthcare system, professionals, and the society is much more encouraged (Hodges et al. 2011; Al-Eraky 2015). This is because current reviews on teaching–learning and assessment in professionalism argue that there is no single teaching–learning and assessment method above and fit for all (Ernemr 2010; Wali et al. 2011; Cruess and Cruess 2012; Birden et al. 2013; Cruess et al. 2014). Although role modeling (and its similar approaches such as mentoring, coaching, apprenticeship, etc.) became the top preferred learning method on professionalism in some review, translating professionalism into teaching–learning and assessment practice need more complex consideration due to different contextual situation. Al-Eraky identifies 12 themes which are clustered in four aspects to consider in teaching professionalism which involves context, Teacher, Curriculum, and Networking (Al-Eraky 2015). Therefore, teaching professionalism efficiently would involve many social processes such as mission and structure alignments, commitment building and maintenance among the doers, and multi-institutional harmonization are needed to realize the education of professionalism (Al-Eraky 2015; Frederic W Hafferty 2017).

In previous sections, we have provided arguments that socio-cultural perspective in teaching–learning professionalism offered versatile ways of exploring the context-based or conception of professionalism. This will likely help in closing the gap between the ideal and real practice in nurturing professionals to serve their community better. In the following paragraphs, we will provide evidence from the

field of how medical educationists bring the socio-cultural and socio-material approaches into educational practice.

Claramita and colleagues developed an adaptive partnership communication model for teaching communication skills in family physician practice (Claramita et al. 2013). The model was developed based on the exploration of patient and family physician practice perspective of the doctor-patient relationship in Indonesia (Claramita et al. 2013). Other studies informed that a significant portion of the patient population still demands more vertical relation with their doctors. This might be in somewhat conflicting the patient-centeredness approach; one adopted western professionalism concept, in which physician is demanded to develop more horizontal health professionals-patient relationship (Sari et al. 2016; Claramita et al. 2019). If this study was not performed, and teaching professionalism is by adopting the available standards which are mostly presented under Western worldview, the teaching professionalism would potentially produce social conflict in practice. It might potentially hinder the ultimate goal of professional teaching, which is balancing between supporting professional development and better patient care.

In another study, believing that professionalism is a never-ending and multiple identities developments of professional roles, Bekti and colleagues developed overarching longitudinal development courses in undergraduate medical school called "doctoring" and "social entrepreneur" courses (Bekti and Barlianto 2013; Bekti and Astrid 2020). The later course was inspired by a student-led indigenous project—later become a renowned national project called Garbage Clinical Insurance (GCI)—in developing a garbage-based health insurance system. This GCI helped the underrepresented community to get healthcare access by exchanging garbage with insurance prime credits (Siemens-Stiftung 2021).

We argue that a socio-cultural and socio-material research approach that aligns with educational practice offers a promising methodology in cultivating and nurturing professionalism in the current changing context and society. In the given case studies presented in the previous sections, we assert that the Cultural-historical activity theory (also previously known as the Constructivist approach) and actor-network theory sensibility offer possibilities to support medical educationists in establishing their context- and evidence-based medical education research in professionalism. These cutting-edge epistemic approaches will allow medical education, as an emerging field, to see many possible determinants that influence the generation conception on professionalism and therefore identify the most plausible approach to nurture the professional development of the current (faculty members) and next generation (learners) of professionals.

7.9 Summary

In this chapter, we discussed the importance of revisiting our conception of context in understanding professionalism. This brought us to discuss the socio-cultural and socio-material methodological perspectives as emerging epistemic approaches in

our research to cultivate and nurture professionalism in context-dependent situations. Drawing from studies on the conceptualization of professionalism in two countries, we brought four cases in which culture, spiritual/religious belief, organization, and artifacts influence how professionalism is conceived both as an ideal and applied conception of professional life. Bushido principles and Religiosity/Spirituality were examples of the indigenous ideal (ideological) conception of professionalism, which could be the local (emic) ground for contextual social contract among the medical profession and society. At the same time, we brought in the critical role of matter and multi-organizational structure of professional practice, another possible situational context that might require a different set of professionalism. The socio-cultural and socio-material perspectives introduced in this chapter, namely, Cultural-Historical Activity theory and Actor-Network Theory sensibilities, allow us to see context as actively engaged actors, networked and situated in different social structures and professional role (diffractive roles of the professional community). These, in turn, placed professionalism as a Glocal (Global–local) phenomenon, consisting of a trace of local-cultural-contextual (emic) wisdom and featuring shared-global (*etic*) problems in medical professional practice. With these perspectives, the medical educationist community has an unlevelled position to cultivate their own context conception of professionalism and transform it into a more situated and creative form of teaching–learning and assessment practice. As Bleakley et al. (2011) conveyed, this is an approach in which professionalism as a research field could play its function as a democratizing force in the medical education field and closing the gap of the binary-ideal and reality (Bleakley et al. 2011).

Key learning Points

- Medical professionalism has a context-specific component that needs to be addressed by medical educators before deploying it as a learning outcome and teaching–learning activity. However, our understanding of context is frequently referred to the cultural and/or country difference. Hence, methodological approaches to address and cultivate the context-specificity of MP are mostly consensus-based which tend to be influenced by hegemony and ideological discourses.
- Redefining the meaning of context in medical professionalism research to surface and emancipate the critical aspect of medical education and medical service practice in which MP is conceived, acted and applied in everyday life need to be considered. Especially in the current interdependent but fragmented medical education and service.
- The socio-cultural and socio-material perspective on medical education research has the potential to help medical educators to cultivate and nurture medical professionalism amidst the complexity of context and ever-changing medical practice and its education continuum.

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