NOTES FROM THE FIELD

Insider Dilemmas

An Ethnographic Study on Community-Based Medical Education in Aceh, Indonesia

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Abstract
*This article draws upon two dilemmas which I encountered during my fieldwork in post-disaster areas and regencies (*kabupaten*; second-level administrative subdivision in Indonesia) in Aceh, Indonesia twelve years after the 2004 Indian Ocean tsunami that killed more than 230,000 people and left more than 600,000 persons injured and displaced from their homes. I highlight two persistent challenges regarding my position as an "insider" in this research: navigating between multiple identities (researcher, educator, and medical doctor), and gaining trust from medical colleagues.*

Hold My Hand

I was in the middle of an observation on a group of sixth-year medical students practicing at a health center[1] in a tsunami-affected area when a fisherman walked toward us. His clothes were dirty and the small, the under-equipped emergency room quickly filled with the smell of fresh fish. Sitting in the room, the fisherman told us that his right foot was wounded by the sharp edge of a shell while he was coming down from his boat to the shore. It was a very deep wound. He showed us.

The students tried to stitch the wound, but the man kept moving his foot. He looked terrified and both of his hands were waving in pain when the needle pierced his skin. As a participant observer conducting PhD research, I was there as a researcher. Yet I am also a trained doctor, and a medical educator.[2] I could not stop myself from trying to calm him down by standing beside his bed and offering my

[1] Healthcare in Aceh was one among several sectors affected post-tsunami due to a huge loss of human life, as well as physical resources.

[2] I have been a medical teacher for ten years.

hand. "Hold my hand, sir, it won't be long. The pain will be gone after a while." He squeezed my hand very tight, as if it could ease the pain. It was painful for me, both because of his tight squeeze, and because of the smell from his clothes. I could barely keep myself from vomiting. However, holding his hand worked and he was able to keep his foot still until the procedure was done. I remember the smile from his face as he left the health center and he nodded to me. It was rewarding for me to see him smiling; saying "thanks" is not common in our culture.

The Conflict of Multiple Identities: Researcher, Teacher, or Doctor?

The case presented above offers a depiction of my struggle with the multiple identities that I had during the fieldwork. On the one hand, as a medical teacher I need to give the students opportunities to work independently. I should not interfere too much with their work. On the other hand, as a medical doctor, I feel responsible to provide appropriate service for the patient. Furthermore, as a researcher, I am curious to know how the students and the patients progress through their imperfect interaction. From that I will be able to analyze and synthesize a recommendation for curriculum improvement in the future. The juxtaposition of the three roles creates a dilemma: whether I should interfere or limit myself and sit there as a pure observer. I decided that during participant observation, I would work alongside at least one of the students. I tried to obtain as much information as I could while sometimes assisting the preceptor to "teach" the students, as the preceptor could not be around all the time due to administrative tasks. Nevertheless, as a medical teacher in work-based learning, I kept reminding myself that I should not interfere, frequently, with the performance of history taking, physical examination, or procedural action, and that I should enable the students to have greater opportunities to manage common conditions to make mild mistakes.[3] The access to common conditions is an exclusive advantage of community-based medical education as it is rarely provided in hospital-based rotation due to highly filtered cases; most of those cases are of high severity and complexity.[4] However, due to their limited exposure to those commons conditions, the students were not aware of the ways to manage them; and they needed further instructions from a teacher as a role model. In the case above, I was trying to be conscious of the teacher role that I was playing.

I am also aware that there are many ways to perform bedside teaching, including a patient-centered model, an apprenticeship, grand rounds, business ward rounds, teaching ward rounds, the report-back model, clinical conference, and the training ward model. In order to give greater opportunities to see physical signs, hear aspects of the case history, and perform

[3] See Clinical Education and Training Institution (2010).

[4] See Worley, P. et al. (2000).

procedural actions, I avoided the "demonstrator" model of teaching and took an "observer" model.[5] This model allowed me to distance myself from student-patient interactions and provide feedback to all students at the end as they discussed their findings and clinical interpretations. It also helped me to decrease "tensions in the learning environment" by making myself open to any of their questions. I also occasionally played the role of indirect observer for other students who I was not able to observe directly, as this is also a possible way to conduct teaching in ambulatory care settings. Regardless, the role of teacher sometimes conflicted with the role of researcher.

Research that employs participant observation as a method situates the researcher in a dynamic position. In other words, the position of the researcher is never static; it shifts among total insider, partial insider, partial outsider, and total outsider roles. At the same time, the position of the researcher also shifts among total participant, partial participant, partial observer and total observer roles, back and forth in a "continuum of participation." [6]During my field research, I tried to navigate my position among these different quadrants according to the changing situation. When the students performed adequately, I positioned myself more in an outsider/observer position. Still, when I felt that they were in need of suggestions or considerations, I positioned myself as a member of their team and acted accordingly. Despite the dynamic shifts, I insisted on avoiding a total insider role, in order to prevent the effect of "going native"[7] and losing my ability to "make the familiar strange."[8]

From the ethics point of view, I would also argue that the principle of "beneficence" in ethics should be applied in this case; this means that the researcher should act in ways that benefit participants. [9]Since the local community and medical students were both my participants, I considered that my interference benefited both sides, as opposed to the situation if I had not participated. The patients benefited from better medical care, and the students were able to observe an example of practicing emotional care -- as well as practical help in calming down a patient during the stitching procedure. Therefore, holding the patient's hand provided a better quality of research in terms of paying respect to every person involved.

The White Coat and Collegiality: Privilege or Disadvantage?

When I was trying to answer one of my research questions: how experienced doctors (with 10 to 12 years of practice) interact with post-disaster communities in health centers, I faced the challenge of

[5] See Worley, P (2005).
[6] See O'Reilly (2009).
[7] See O'Reilly (2009).
[8] See O'Reilly (2009).
[9] See Watts (2010).

recruiting them. Most of the doctors I wanted to recruit as participants had moved to hospitals or other provinces outside Aceh after their two years of post-graduation mandatory service in disaster-affected areas (Aceh and Nias) were completed. Only a few of them decided to keep working in those devastated, ill-resourced, and remote areas. Fortunately, through the snowball recruitment method, I succeeded in locating some doctors who were willing to spend some of their precious time for one or more interviews.

When trying to obtain consent, some of the doctors turned down my request to be a participant of the research due to time constraints. My identity as a medical doctor did not necessarily help me in attaining the consent: the doctors asked that I understand the reasons for their rejection, assuming that I was capable of understanding how busy they were with their work as it involves intense emotion, constitutes a high workload, and entails great responsibilities. Hence, I treated them as "busy informants."[10] I waited until they offered me a time to meet. Despite the challenges of locating and setting the interviews (for some interviews, I needed to travel more than 600 km[11] to reach them), it was worth spending time talking to them since most of them were able to raise the issues that I considered central to my topic of research.

Some other doctors asked me to wait and provide some time for them to deal with the potential emotional discomfort caused from remembering their experiences in the aftermath of the traumatic events of the tsunami. Talking about experiences regarding disaster, death, and suffering is almost always considered a "difficult conversation" in the medical world that needs a careful mental preparedness.[12] I expressed my understanding and patiently waited for their consent because I realized that gaining access to disaster-affected participants is indeed one of the challenges encountered by disaster-focused researchers. Most of my participants eventually agreed after we discussed the information statements and they understood the risks and benefits associated with their involvement in the research. Nevertheless, the recruitment of these busy informants requires constant commitment and persistence.

Then I searched for another opportunity to obtain consent by contacting other medical colleagues to facilitate the encounter with my targeted informants. I found a very senior medical doctor and had a meeting with her. She agreed to help me out. Finally, I succeeded in establishing some interviews with my targeted participants through the help of the doctor who acted as a gatekeeper. It is important for an ethnographer to have a gatekeeper's help in ethnographic research, such a position held by the 'Doc' in the classic ethnography piece 'Street Corner Society.'[13] The

[10] O'Reilly (2009).

[11] 600 km is 373 miles (1 kilometer = .62 miles).

[12] See Souza (2007) and Indah (2018).

[13] See Whyte (1996).

A medical student with artistic effect to ensure anonymity.
Image: Rosaria Indah

facilitation provided by key persons within the context will give a researcher an easier entry to the field. In my case, the doctors admitted that they conducted "research" on my identity and credibility before granting their approval in setting up the interviews. Doctor P, one of the participants, told me:

> I have to apologize for my belated confirmation for the interview scheduling. I admit that I have researched your identity before deciding to have this interview. I have not heard your name before. Some of my colleagues and also my daughter -- in fact, she is one of your students -- have told me that you are a good teacher in the local university. That information made me decide to connect with you and agree to have this meeting.[14]

This "research on a researcher's credibility" is partly due to the assumption that I might be obtaining financial gain from the research or that I might be a "spy" investigating their best practices, which commonly happens when the researcher comes from a similar workspace.[15] Fortunately, my experience as a teacher provided me with a network of former students. They acted as gatekeepers and, thus, verified my identity and credibility. Therefore, I succeeded in obtaining consent from most of my planned participants.

Conclusion

Researchers who immerse themselves in studies within their community, or insiders, may face challenges. In this paper, I argue that being an insider does not mean these researchers automatically have an easier identity formation or easier access.[16] However, it is possible for a researcher to navigate through the challenges presented by employing certain strategies, including dynamic positioning and involving influential key informants/gatekeepers. Being aware of the dilemmas experienced by other researchers, such as the two dilemmas presented in this paper, may help researchers to improve their preparation prior to their fieldwork, thus leading to successful data gathering.

[14] Doctor P, female, 56 years old, personal communication.
[15] See Simmons (2007).
[16] See Labaree (2002).

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