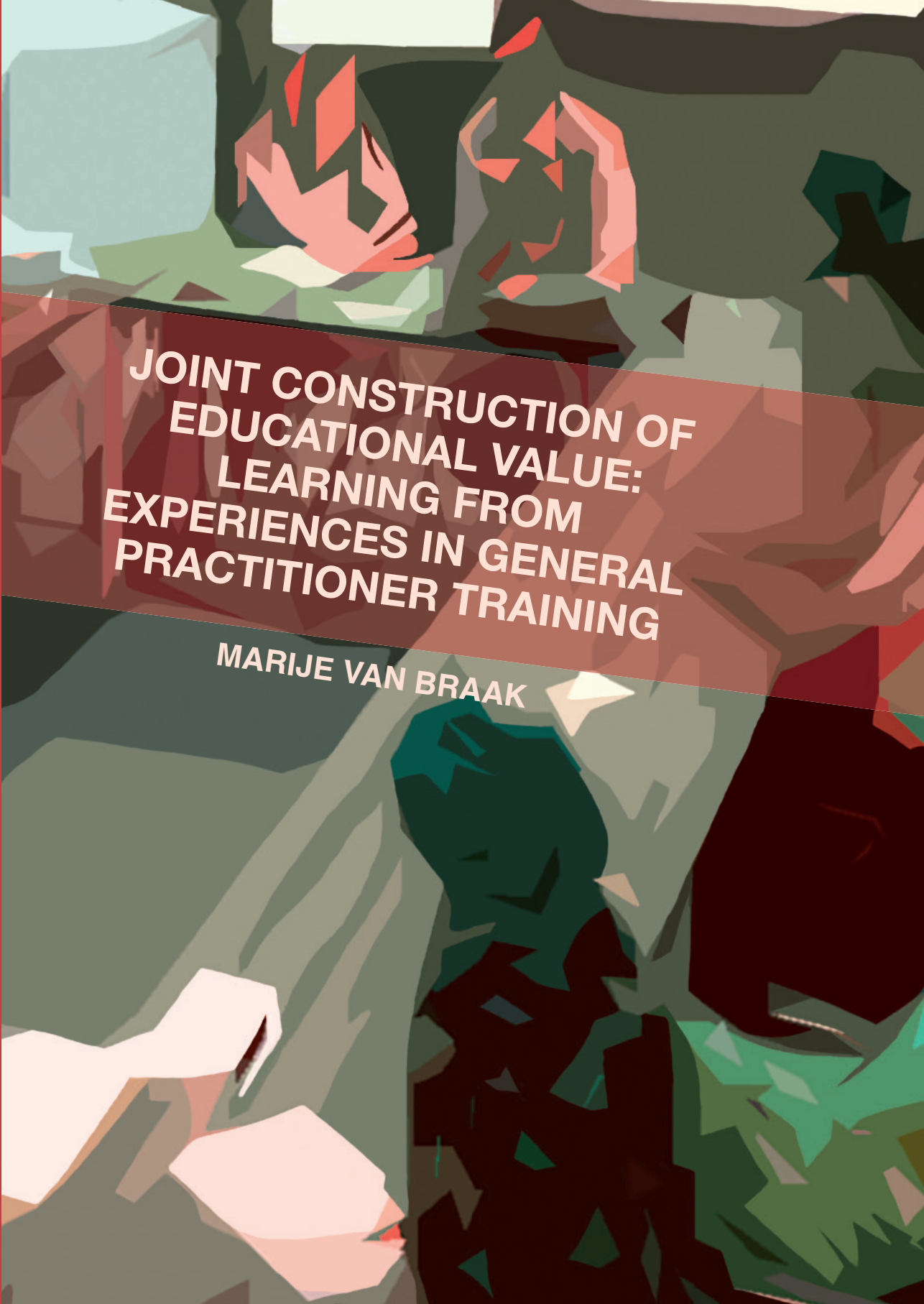

JOINT CONSTRUCTION OF EDUCATIONAL VALUE: LEARNING FROM EXPERIENCES IN GENERAL PRACTITIONER TRAINING

MARIJE VAN BRAAK

JOINT CONSTRUCTION OF EDUCATIONAL VALUE: LEARNING FROM EXPERIENCES IN GENERAL PRACTITIONER TRAINING

GEZAMENLIJKE CONSTRUCTIE VAN EDUCATIEVE WAARDE:
LEREN VAN ERVARINGEN IN DE HUISARTSOPLEIDING

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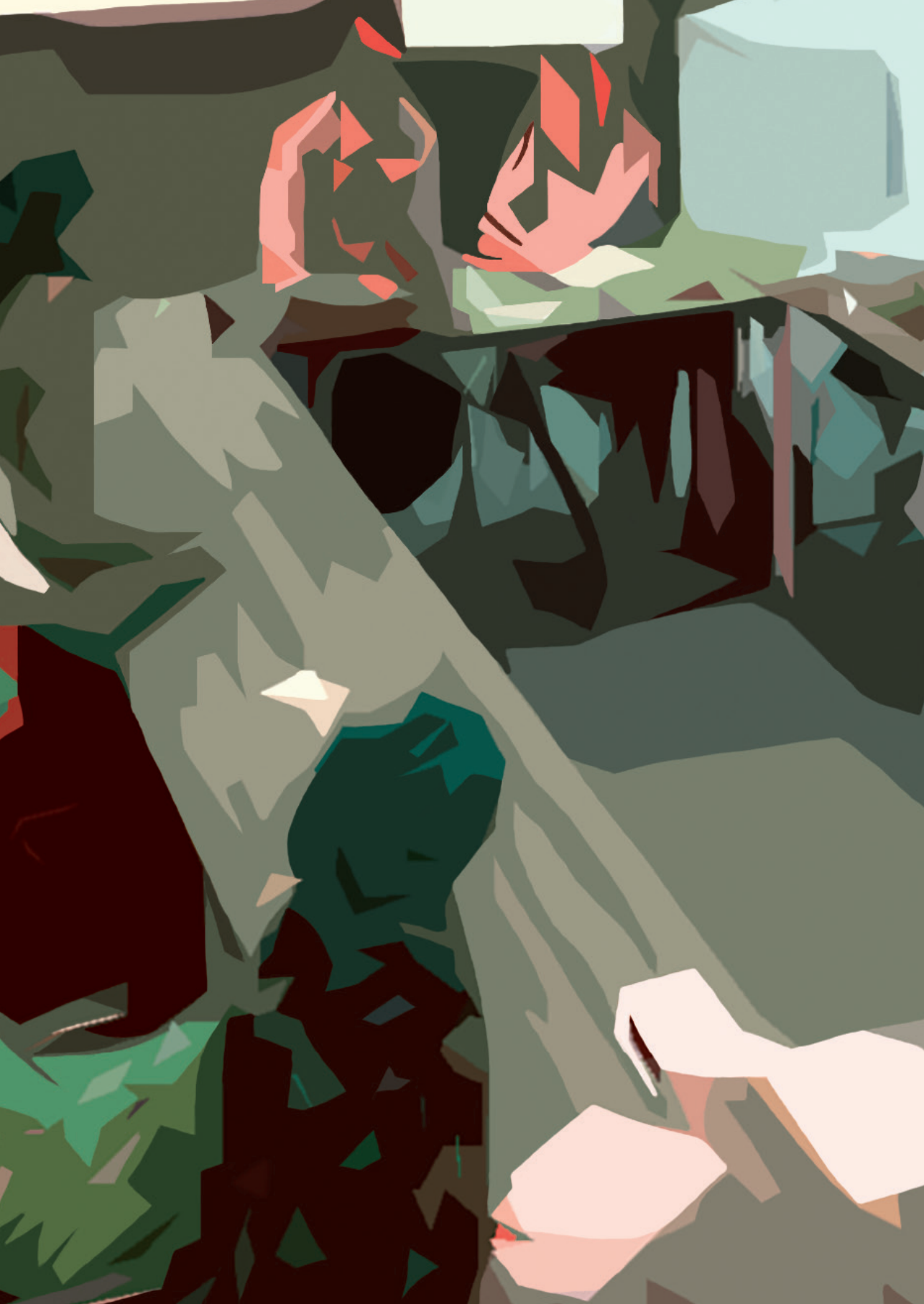

CHAPTER 1

INTRODUCTION

> *"[W]hile lots of people figure that experience is a great thing, and apparently at least some people are eager to have experiences, they are extraordinarily carefully regulated sorts of things. […] And, insofar as part of the experience involves telling about it, […] the telling of it then constitutes one way in which what you might privately make of it is subject to the control of an open presentation, even to what you thought was a friend. That is to say, your friends are not going to help you out, by and large, when you tell them some story, unless you tell them a story in the way anybody should tell it to anybody." (Sacks, 1995, Lectures, Part IV, Lecture 4, p. 248)*

This thesis originates in practice. In educational practice, to be precise. It is situated in the Dutch training for General Practitioners (GPs), particularly in a form of education that is a key part of that training: Learning from Experiences. During Learning from Experiences, GPs in training and teachers collaboratively construct educational value from discussing experiences from clinical and training practice. In essence, this thesis focuses on how teachers (co-)construct educational value during the educational activity Learning from Experiences. Let's take that apart. First…

… this thesis is about a form of education called Learning from Experiences.

In this form of education participants collaboratively discuss experiences from practice. Throughout the Dutch three-year program, trainee GPs begin their weekly training day at the GP institute with a one-hour session devoted to sharing experiences from *clinical* practice as well as from the daily practice of being *in training*: a difficult medical case, a problematic doctor-patient interaction, issues with a clinical supervisor, to name but a few. They discuss these experiences in groups of on average ten trainee GPs with one or two teachers, an expert GP and/or a behavioral scientist. The session's aim? To help our future GPs construct the knowledge, experience, and understanding that one day will justify their established membership of the professional GP community.

In the Dutch context of training GPs, this form of education has a variety of names: Learning from Experiences, Exchange of Experiences, Mutual Consultation, and Reflection Round. I will refer to it as Learning from Experiences, for reasons explained below. More than just using a label that hints at its educational aim, I use this expression to talk about this form of education in terms of what it is centered on: experiences. Experiences that are, first, *told*, and second, *discussed*.

The idea to use experiences in training GPs has its roots in the 1950s, when the psychoanalyst Balint introduced sessions where medical professionals (mostly graduates) explored challenging patient encounters through case presentation and discussion (Balint, 1964; Pinder et al., 2006; Van Roy, Vanheule, & Inslegers, 2015). If organized well, such "Balint Groups" (Horder, 2001) provide a safe environment to explore experiences from practice with the aid of tutored reflection

(Torppa, Makkonen, Mårtenson, & Pitkälä, 2008). Participants of Balint Groups have reported to benefit from listening to the reflections of group members and comparing their own experiences to those of 'similar' others (Torppa et al., 2008).

The centrality of experiences is not unique to Balint Groups: experience is central in many forms of education that build on experiential learning. Experiential learning theory posits that knowledge is created "from the combination of grasping and transforming experience" (Kolb, 1984, p. 41; Kolb, Boyatzis, & Mainemelis, 2014). Reflection is considered an essential component of this process (Trivate, Dennis, Sholl, & Wilkinson, 2019) and its importance is indeed reflected in some of the names of the form of education described here. Yet, what I am researching here is *not* reflection. I cannot tell whether or not reflection takes place when trainee GPs tell and discuss experiences (cf. de la Croix & Veen, 2018). What I can tell is what I observe them doing, and how they do that: telling and discussing experiences from practice.

The vehicle that GPs in training use to tell and discuss experiences from practice is *the story.* Stories are units of discourse that invite negotiation of the tension between self and other. It is through "telling and responding to personal stories [that] group members craft their identities and take on others' perspectives" (Black, 2008, p. 93). Personal narrative "simultaneously is born out of experience and gives shape to experience" (Ochs & Capps, 1996, p. 20; Black, 2008; Bruner, 1990). If stories are the vehicle for expressing, understanding, forming, and reproducing professional identities (Black, 2008), what takes place during Learning from Experiences is the construction and negotiation of established membership of the GP profession in the future (Lave & Wenger, 1991; Ochs, 1991; Storey, 2012).

On the way to established membership of the GP profession, telling and discussing experiences from practice serves an educational purpose – or so it *should* as part of a training program. More than just about Learning from Experiences itself, therefore…

… this thesis is about *educational value* constructed during Learning from Experiences.

Taking a broad perspective on educational value, I depart from the three domains of educational purpose described by Biesta (2009, 2020; see also Chapter 2 in this thesis) to contextualize what participants could and indeed do aim for during Learning from Experiences. Building on work by Lamm (1976), Bruner (1996) and Egan (2008), Biesta describes how education can be described as aiming for *qualification, socialization,* and *subjectification*. In the context of GP training, professional qualification refers to construction and provision of knowledge, skills and understanding to do the job of being a GP. Professional socialization refers to becoming acquainted with the norms and values, the ways of doing and being, of being part of the GP professional community. Professional subjectification refers to discovering one's own

way of being within this community, the unique self that is responsible and comes to the fore in situations where that very person is called for.

These three domains of purpose are not unique to GP training. In fact, "[h]elping students form, and successfully integrate their professional selves into their multiple identities, is a fundamental of medical education." (Goldie, 2012, p. e641). The value of this classification of educational purpose is in the way it sketches the breadth of what can be achieved and could be worked toward during Learning from Experiences in terms of educational value. The telling and discussing of experiences through stories from practice functions not just to construct participants' professional identities (compare the research on Professional Identity Formation, e.g., Cruess, Cruess, Boudreau, Snell, & Steinert, 2014; Monrouxe, 2013). Together with other parts of GP training, it functions to form qualified, socialized subjects in the GP profession.

However laudable, realizing this endeavor is notoriously difficult. Or so teachers of Learning from Experiences tell us. Their institutionally assigned task is to facilitate the sessions for optimal educational value (see also Chapters 4 and 5 in this thesis). Their interactional task while doing being a teacher during Learning from Experiences is realizing educational value. Their concern is "the educational desirability of the opportunities for learning that follow from their actions" (Biesta, 2007, p. 10). What is really at the heart of this thesis, therefore, is not so much Learning from Experiences itself, or what the exact educational value is that can be created during these sessions. At its core…

… this thesis is about *how teachers (co-)construct* educational value during Learning from Experiences.

Despite the ubiquity of Learning from Experiences in the training of Dutch GPs, we know very little about what teachers do during Learning from Experiences. We know even less about what teachers could – or even should – do to create educational value while teaching these sessions. Part of this void may be due to the complexity of being a teacher of Learning from Experiences. If in education generally, "classroom events are only partially predictable and controllable (Wolff, 2015), and guidelines that adequately prescribe what teachers should do in specific situations do not exist (Bakx, 2015)" (Sipman, Thölke, Martens, & McKenney, 2019, p. 1186), then tailoring interventions to educational value in the messy dynamics of group discussion of often emotionally-laden experiences from professional practice is challenging at best and unpractical at worst.

General suggestions on teaching group discussion (e.g., in Problem-Based Learning; Azer, 2005; Hmelo-Silver & Barrows, 2006; Kindler, Grant, Kulla, Poole, & Godolphin, 2009; Lekalakala-Mokgele, 2010; Storey, 2012), do not address the specific interactional dilemmas that teachers face in Learning from Experiences sessions. In their capacity as expert GPs or behavioral scientists, teachers are at the onset often only minimally equipped to teach with group

discussions. The educational context calls on whatever group facilitation experience they may already have (and may gain as they go on) to deal with whatever educational situation arises. Teachers encounter situations where trainee GPs talk for minutes on end about an experience, while the point or issue or question remains hanging. Teachers encounter situations where trainee GPs hesitate to share their experiences. Teachers find themselves in interactions that take off smoothly but are 'not going anywhere'. They find themselves in interactions that feel like walking in quicksand. They find themselves in conversations that reach a conclusion before they have properly touched upon anything worthy of exploration. They take part in conversations that are both enjoyable and valuable without much ado. They take part in discussions involving only a very small selection of those present. They participate in discussions in which anyone who wants to take a turn does so, too. Teachers, in fact, meet whatever the group creates and they are expected (see Chapter 5) and feel obliged (see Chapter 4) to turn that 'whatever' into something valuable for everyone present. That's no picnic.

Precisely this situation is the starting point of this thesis. By documenting teachers' strategies to deal with a variety of educational situations while working toward the moving target of educational value, I aim to build a showcase of practices for future and present teachers facing the many challenges or questions that teaching Learning from Experiences may raise. This showcase is not intended to be an evidence base (Davies, 1999; Pirrie, 2001) for 'proper' teaching in Learning from Experiences. It is not meant "to make teaching more effective with regard to the production of learning outcomes […] but to make teaching more attuned to what is encountered in the always new situations in and through which teaching takes place" (Biesta, 2019, p. 12). This aspiration points to one other nuance to be made in the formulation of what this thesis is about:

… this thesis is about how teachers (co-)construct educational value during *the educational activity of* Learning from Experiences.

Rather than researching Learning from Experiences as a form of education, I approach it as an educational *activity*. I see education as a collaborative activity that is inherently *interpersonal* and fundamentally *interactional*. Interaction, the constant flow of meeting points between the self and others, people and things, materials and immaterials, is the conduit of the educational enterprise. It is the sequentiality of adjacent actions and interlinked performativities that make up the interactional work of education. That fundamentally *interactional* nature is what makes education inescapably *interpersonal*, an encounter between participant voices (Koschmann, 1999), a social enterprise. In this enterprise, teachers are just participants who, in interaction with other participants and from moment to moment, jointly construct their particular rights and responsibilities (see Chapter 7) – hence the *co*-construction of educational value.

This view of education as a social process taking place in interaction is anything but new. Quite the contrary. One of the oldest forms of education we know, Socratic dialogue, is interpersonal interaction *par excellence*. The thought that talk is the *modus operandi* of education is the basis for all current socio-constructivist thinking that builds on Vygotsky's theory (Vygotsky, 1980) of "language as the medium of social life" and interaction as "the primary site" for constructing knowledge (Stokoe, 2000, p. 184). Similarly, views that consider teaching as discursive action are not uncommon, too, as evidenced by statements such as "to truly teach, one must converse" (Tharp & Gallimore, 1991, p. 3) and research describing the sequential organization of encounters between teachers and students (Gardner, 2019). What learning is, I will not linger on. At the very beginning of this study, I pitched my research as "I'm exploring how GPs in training can learn most during Learning from Experiences". But that is not what this research is about. It is about *teaching* in the context of a specific *educational activity.* Whether I can say anything about the learning that teaching is supposed to trigger, I am not at all so sure.

So, if this thesis is about how teachers (co-)construct educational value during the educational activity of Learning from Experiences, *how do we research that*?

First, the main analytic focus of this thesis is on the *interactional* procedures that members use to organize the telling and discussing of experiences (Sidnell, 2013). This focus is based on the fundamental understanding that language is the site of action and that social life is constructed in everyday interaction (Sidnell, 2013; Stokoe, 2000). What do teachers (and, inherently related to that, GPs in training) do when they participate in the educational activity of Learning from Experiences? The basis for this analysis are 41 video-recordings of Learning from Experiences sessions as representations of naturally occurring talk-in-interaction in this context (Mondada, 2013).

Second, I aim to build in ethnomethodological fashion (Maynard, 2013) an understanding of the participant's perspective (a member's view) on actual Learning from Experiences interactions. If we want to understand what is being constructed and achieved interactionally and educationally, "the analyst will have to get a grip on what the institution counts as an achievement and as a record. Only ethnographic background – gleaned from documents, interviews and observations of the site will provide that." (Antaki, 2011, p. 12). So, the second data set for this thesis is 37 interviews with teachers, aimed at identifying the goals and strategies they use to teach Learning from Experiences, and the institutional documents about teaching Learning from Experiences. The third data set contains 31 interviews with trainee GPs aimed at eliciting their views on the valuable and less valuable aspects of this educational activity. Both interview types are video-stimulated, which means that they are guided by replaying parts of the recording of the Learning from Experiences session that the interviewee was in. This grounds their responses (which may

be seen as “accounting practices, recipient-designed for the researcher” (ten Have, 2004, p. 72)) in actual practice.

Using these data sources, I develop an understanding of what it means to teach Learning from Experiences. In **Chapter 2**, I first describe the concepts of teaching and learning in medical education. Having set that conceptual scene, I move on to a methodological account of the interviewing approach in **Chapter 3**. In **Chapter 4**, I report the first empirical study on the aims and strategies that teachers use in teaching Learning from Experiences based on institutional documents and teacher video-stimulated interviews. Turning to the perspective of trainee GPs in **Chapter 5**, I describe the discourse that GPs in training use to talk about educational value and the activities that contribute to it. The next chapters describe actual teacher practices during Learning from Experiences, based on Conversation Analysis of the recordings: first teacher interventions in **Chapter 6 (**when, how, and to what end are they done?), ‘doing being an expert’ in **Chapter 7 (**how do participants construct teacher expertise and how does it function in this context?) and in **Chapter 8**, ways of dealing with the contingencies of the online environment in terms of participation in Learning from Experiences Zoom sessions. The last two chapters form the capstone of this thesis, where given what teachers and GPs report in the interviews and what we have seen happening in the recordings, I aim to describe how teachers can create educational value in this educational activity. The methodological approach I used to answer this question is reported in **Chapter 9**, and its empirical counterpart is presented in **Chapter 10**.

In sum, this thesis aims to address a practical question – or, if you will, didactical problem – with the strong implication, worked mainly out in the capstone studies, that it will identify possible solutions or suggestions for future teaching practice. Together with the integration of members’ perspectives and description of actual practice, this objective gives the research an interventionist applied conversation-analytic flavor (Antaki, 2011). I have tried to make it work toward teacher training (more on that in the General Discussion, **Chapter 11**), because that is how it began: with a deeply didactical and explicitly educational question on (dare I say, ‘good’) teaching of that one activity that is unique to GP training: Learning from Experiences. Even if all the voices in this thesis all give plus-one different answers, I hope these will be valuable entries in a non-cook book-like (Dornan & Kelly, 2021) showcase of what teachers do when they do what they do: teach.

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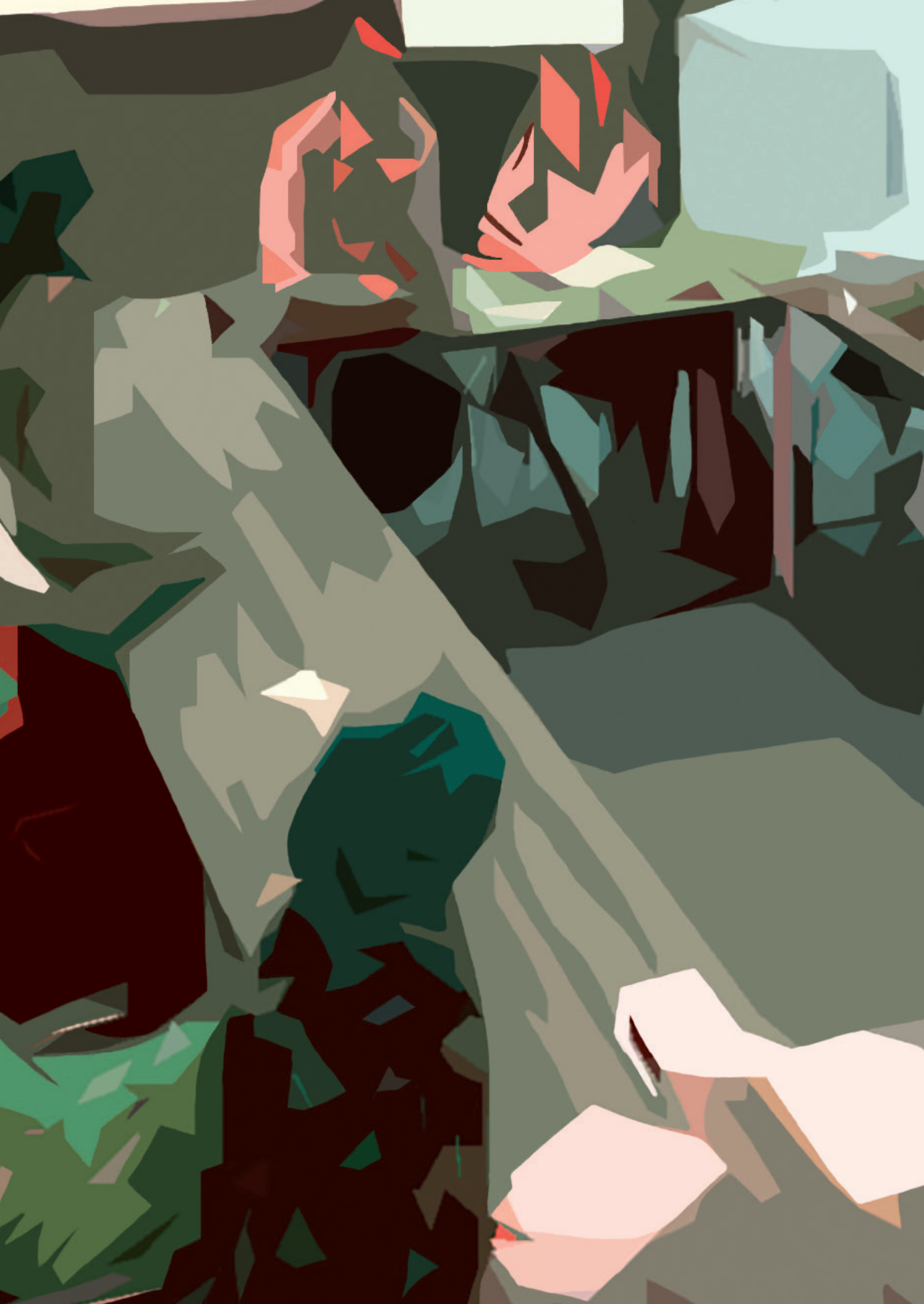

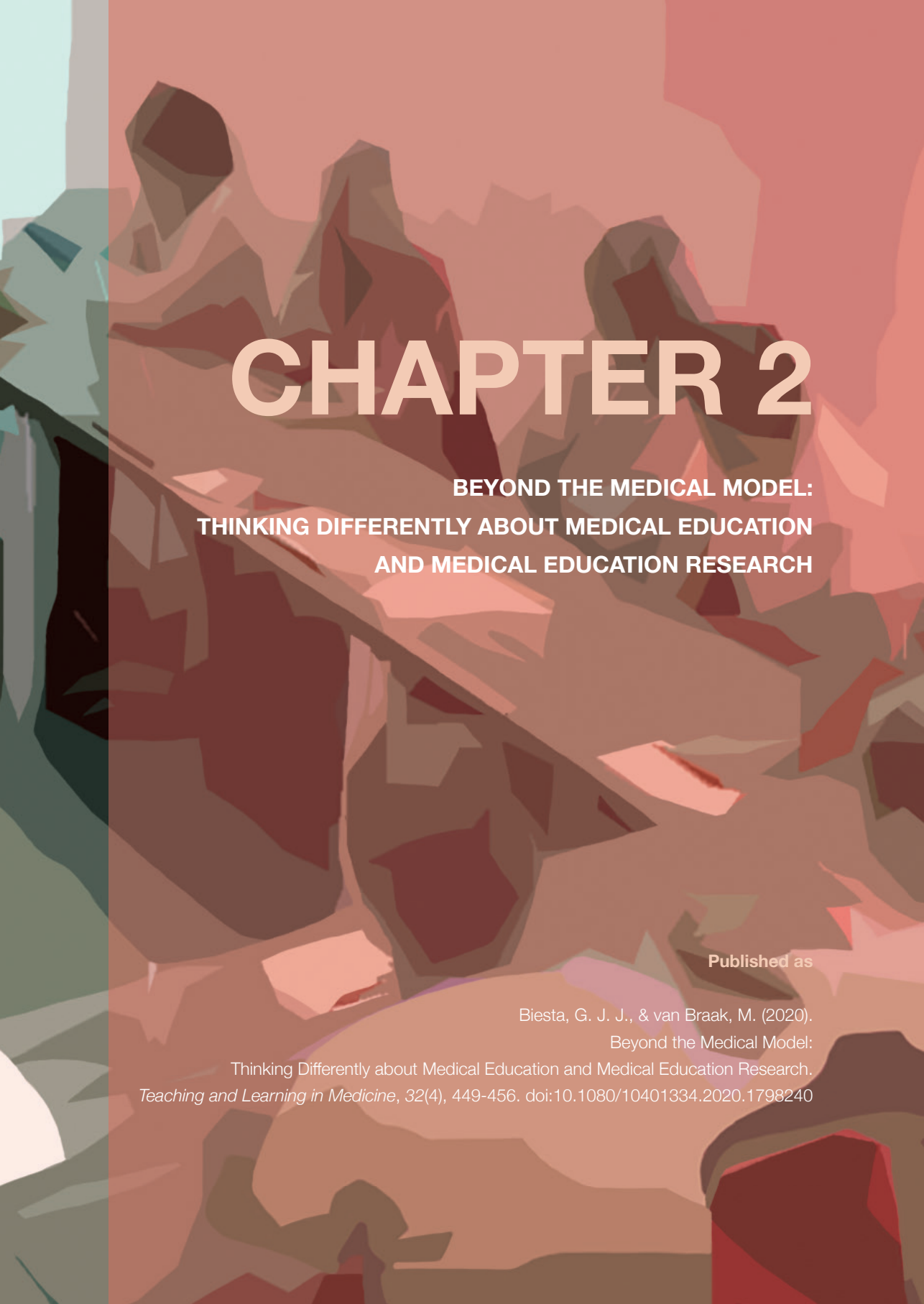

CHAPTER 2

BEYOND THE MEDICAL MODEL: THINKING DIFFERENTLY ABOUT MEDICAL EDUCATION AND MEDICAL EDUCATION RESEARCH

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Abstract

Issue

In medical education, teaching is currently viewed as an intervention that causes learning. The task of medical education research is seen as establishing which educational interventions produce the desired learning outcomes. This 'medical model' of education does not do justice to the dynamics of education as an open, semiotic, recursive system rather than a closed, causal system.

Evidence

Empirical 'evidence' of 'what works' – that is, what is supposed to affect 'learning' – has become the norm for medical educational improvements, where generalized summary outcomes of research are often presented as must-follow guidelines for myriad future educational situations. Such investigations of educational processes tend to lack an explicit engagement with the purposes of medical education, which we suggest to understand in terms of qualification (the acquisition of knowledge, skills, and understanding), socialization (becoming a member of the professional group) and subjectification (becoming a thoughtful, independent, responsible professional). In addition, investigations of educational processes tend to rely on causal assumptions that are inadequate for capturing the dynamics of educational communication and interaction. Although we see an increasing acknowledgement of the context-dependency of teaching practices toward educational aims, the currently prevailing view in medical education and educational research limits understanding of what is actually going on when educators teach and students participate in medical education – a situation which seriously hinders advancements in the field.

Implications

In this paper, we hope to inform discussion about the practice of medical education by proposing to view medical education in terms of three domains of purpose (professional qualification, professional socialization, and professional subjectification) and with full acknowledgement of the dynamics of educational interaction and communication. Such a view implies that curriculum design, pedagogy, assessment, and evaluation should be reoriented to include and integrate all three purposes in educational practice. It also means that medical education research findings cannot be applied in just any teaching context without carefully considering the value of the suggested courses of actions toward the particular educational aims and teaching setting. In addition, medical educational research would need to investigate all three purposes and recognize the openness, semiotic nature, and recursivity of education in offering implications for teaching practice.

Introduction: medical education and the medical model of practice and research

In the wider field of educational research and practice it has become quite common to refer to a particular understanding of the dynamics of education as the 'medical model.'[1–5] This phrase is used to refer to the idea that teaching is an intervention to bring about learning in students. Some formulations even speak about teaching as the cause of such learning and see education as nothing but the production of measurable 'learning outcomes.'

This view of education, which actually relies on a rather simplistic understanding of the complexities of medical practice itself,[6] has generated a prominent line of educational research. In this research, the focus lies on finding the most effective ways in which teaching can bring about intended learning outcomes. The idea here is that research should find out 'what works' and that teachers should base their classroom practice on such evidence, either by simply following what the evidence tells them to do or by making sure that their actions are informed by the latest research evidence. Within the field of education there are ongoing discussions about the possibility and desirability of such an approach.[4–8] Policy makers nonetheless often seem quite keen to steer educational research and educational practice in the direction of such a medical model.

Medical education and its related research field have, over the past two decades, also adopted the medical model.[1,2,7,9] Medical educational *practice* relies heavily on the idea that teaching in some way causes learning. In this view, teaching is understood as an intervention that produces learning outcomes (see for example the definition of teaching as "the design and implementation of activities to promote learning" in Fincher and Work,[10(p293)] based on Smith[11]). The customary rationale here is that better teaching causes better learning, which provides for better patient care, which in turn improves patient outcomes (see for example, Chen, Lui, and Martinelli;[12] Harden et al.[9]).

In keeping with notions of teaching as an intervention and learning as the effect of that intervention medical educational *research*, following the logic of the medical model, looks for correlations between interventions and outcomes.[13] Current medical education research is predominantly designed to provide proof that particular teaching practices 'work'. It aims for "generalisable simplicity" to foster application in a wide range of contexts.[13(p31)] Despite being contested for their limited significance in educational contexts,[4–6,8,13,14] randomized controlled trials are still held in high regard in medical education research.[3,15] Building on analyses of teaching effects on learning, meta-analyses, and systematic reviews are frequently presented as guidelines for future educational situations[16,17] – see, for example, the field's renowned AMEE guides.

At one level the medical model of education looks quite plausible. After all, teachers do intervene with their teaching and they do so for good reasons as they want their students to learn. Moreover, if teachers can enhance the effectiveness of what they do, students definitely are

to benefit. While at a superficial level this may make sense, a closer inspection begins to reveal several problems. In this paper we aim to identify two main problems of the medical model. The first has to do with the rather bland reference to 'learning' as what education is supposed to bring about. The second concerns the rather simplistic assumption that there is some kind of causal connection between teaching and learning and that the main task of research is to make this connection more secure and more effective.

We are raising these two points within the context of medical education, first and foremost in order to inform discussion about the practice of medical education. We are also concerned, however, that because much *medical* research focuses on questions about effectiveness, there may be a strong pull for *medical education research* to emulate such an approach where it concerns matters of education. Our paper is therefore also meant to open up a discussion about adequate forms of research for informing the practice of medical education *beyond* the medical model.

What is education? And what is it for?

To suggest that the medical model amounts to a too simplistic representation of the dynamics of education, raises the question of what these dynamics actually are and, before that, what education actually *is*. The now ubiquitous language of 'teaching and learning' – used so easily that it often feels as if 'teachingandlearning' has become one word – seems to be a concise and meaningful summary of what education is about. After all, education involves teachers and thus some form of teaching and it seems plausible to assume that the activities of teachers are intended to bring about learning in their students.

However, one key problem with the suggestion that teaching is there to bring about student learning is that the language of learning is not sufficiently precise. After all, students can learn many things when they are in educational settings, just as they can learn many things outside of those settings. The whole point of education, however, is not to ensure that students learn, but that they learn *something*, learn it *for a reason*, and learn it from *someone*. Education thus always raises questions about content, purpose, and relationships – the three 'elements' that in a sense constitute education. These questions are often absent when we just describe education in terms of 'teaching and learning', or when, in research, we seek to find out which factors impact on 'student learning'.

With regard to content, purpose, and relationships it can be argued that the question of purpose is actually the first question that needs to be addressed. If one is not able to articulate what particular educational activities and arrangements are *for*, there is no way in which one can decide which content students should engage with and what kind of relationships will be most conducive for what one seeks to achieve. What makes education particularly interesting is that it

is not oriented toward one purpose or domain of purpose, but that all education needs to engage with three 'domains of purpose'[1] (see, e.g., Biesta,[18] Bruner,[19] Egan,[20] and Lamm[21]). The first domain of purpose for education is that of *qualification*, which is about providing students with knowledge, skills, and understanding that will qualify them to do 'something.' This 'something' can be narrow, such as in the case of becoming qualified for a particular job or profession – which is, of course, key in the field of medical education – or it can be conceived more widely such as the role schools play in providing young people with the knowledge, skills, and understandings for living their life in complex modern societies.

The purpose of education is, however, not confined to qualification. Education also has an important role to play in the domain of *socialization*. Socialization is about providing students with an orientation in particular fields or domains including vocational and professional domains. It is about initiating students into the ways of being and doing, the norms and values of particular social, cultural, practical, or professional traditions. This is intended to give students a sense of direction in such traditions and practices and also contributes to developing a sense of identity by becoming part of particular traditions and practices. There are stronger forms of socialization where the ambition is to make sure that students follow the rules and regulations and adopt the particular norms and values of the practice or tradition. Here identities are prescriptive. Some medical specialist groups, for example, may be known for their specific ways of doing and being (e.g., Musselman, MacRae, Reznick, and Lingard[22] on surgical education). In those cases, medical education plays a key role in students' becoming part of such ways of doing and being. There are, however, also more 'open' forms of socialization aimed at giving students a sense of direction, but giving them opportunities to find their own role and position within such traditions and practices. In addition to becoming competent – the acquisition of knowledge and skills – such opportunities create room for questions about professional identity: how one wishes and should understand oneself as a competent practitioner.

It could be argued that qualification and socialization are, to a large degree, done 'to' students. We teach students knowledge, skills, and understanding and check through assessment whether they have acquired this successfully. Similarly, we teach them the ways of doing and being of particular practices and assess whether they have adopted these successfully. This, however, is not all there is to education. We do not want our students to end up as objects with knowledge, skills, values, and norms. We always aim for them to end up as subjects in their own right; as individuals who can make up their own mind, draw their own conclusions, and take responsibility for their actions. This is captured in the domain of *subjectification* where we encourage and support our students to become subjects of their own action. Subjectification thus has to do with key educational ideas such as agency, autonomy, and responsibility.[2]

1 In this regard education differs from many other practices which are often oriented to only one purpose or domain of purpose. Think, for example, of the orientation of medical practice on (the promotion of) health (acknowledging that what counts as health and how one promotes this are complex questions) or the orientation of the legal domain on justice.

2 For a more detailed discussion about the idea of subjectification as a core educational ambition, see Biesta.[33,34]

The suggestion that all education needs to work in relation to three domains of purpose is not only relevant for general education, but also helps to get more precision vis-_a-vis the purposes of professional education including medical education. It thus provides a much more helpful and precise discourse than the reference to 'learning.' Rather than asking whether students are learning, we need to ask whether their education addresses all three domains of purpose. The simple but nonetheless helpful insight here is that the purpose of such education is not confined to the presentation and acquisition of knowledge, skills, and understanding. In addition to *professional qualification* (becoming a competent doctor), there is also a need for *professional socialization*: providing and achieving orientation in a professional field. Professional socialization in medicine has to do with achieving a professional identity as a medical professional (which actually has been described by some as the main purpose of medical education).[23–26] Also, medical professionals do not just need to be qualified and socialized; they also need to become a subject of their own actions. That is, they need to be able to judge which knowledge, skills, and understandings need to be utilized in which situation and also when they should stick to the rules and when to question the rules or bend or sometimes even ignore them if a particular situation calls for this. There is, therefore, also always the need for medical education to focus on *professional subjectification*.

Instead of the bland and to a degree even meaningless suggestion that the task of medical education is to make students learn, we can now say that medical education needs to aim for *professional qualification, professional socialization,* and *professional subjectification*. It also needs to make sure that these do not remain separate compartments but actually become integrated in the knowing, doing, and being of professionals. This then suggests a framework for the development of curricula – the content and experiences that students should encounter and work with during their education. This includes a range of experiences students should 'meet' – one can think, for example, of the importance of encountering the limits of medical treatment, a first unexpected patient death, the ambiguity or uncertainty of a high stakes treatment decision, a first euthanasia, resistance (from patients or other medical professionals) to one's medical decision, a first consultation carried out independently and satisfactorily, etc. In addition to a framework for curricula, the proposed view on education also suggests a framework for the development of pedagogy – the ways in which medical teachers engage with their students in order to promote professional qualification, socialization, and subjectification.

How does education work? And how can we make it work?

To see that the point of medical education is not to make students 'learn' but to contribute to their professional qualification, socialization, and subjectification is helpful in overcoming the limitations of the language of learning but does not yet resolve the question of *teaching*. One could, after all, still argue that once we have a more refined understanding of what it is that we

seek to achieve, we should focus our research efforts on finding out which teaching interventions work for each of the three domains. This conclusion is helpful to the extent that it shows that asking the general 'what works?'-question is actually not very meaningful. Rather, we need to begin by asking *for which particular purpose or domain of purpose* a particular teaching strategy may work.

With regard to this it is important to acknowledge that the three domains of purpose do not exist separately but are always all three at play in the concrete practice of education. Teaching a particular skill, for example, motivational interviewing in General Practice consultations, is not just about acquiring that skill (qualification). It also communicates something about the importance of the skill in the profession (socialization) and simultaneously has an impact on the agency of the student: by mastering a skill one is able to act differently, which raises the question when it is appropriate to utilize this skill and when not (subjectification).

Whereas there can be synergy between the three domains, there can also be tensions and even conflicts. Think for example how 'teaching to the test' does very little in supporting students becoming responsible practitioners (subjectification) and also sends out the message that what really matters is passing the test (socialization). So the question which of our teaching strategies or wider educational arrangements 'work' is actually much more complicated than that – not just because the question of 'working' is a threefold question, but also because what may work in relation to one domain of purpose may actually work differently, or may not work at all in another domain of purpose.

Much educational research that seeks to generate evidence about 'what works' couches its ambitions in terms of factors that impact on students. It is here that reference is often made to the medical model on the assumption that teaching is an intervention that produces particular effects. The important question for education, including medical education, is whether this understanding is adequate for capturing the dynamics of education. Can it be assumed that under ideal circumstances teaching is a cause and learning – or with the language we prefer: students' professional *formation*[27] – is the effect? And is the fact that we have not yet established certain and secure connections between educational 'input' (teaching) and educational 'outcome' (learning; formation), just a matter of time and money? That is, would investment in more research eventually lead us to the evidence that will tell us once and for all which interventions will produce which effects?

This, we think, is unlikely. The reason for that lies in the fact that the strong causality that is assumed in this way of thinking actually only occurs in very specific situations: in closed, deterministic systems that operate in unidirectional ways. The paradigm case for this is the clockwork where each cogwheel puts the next cogwheel into motion so that, if we know the initial situation of the clockwork and have perfect knowledge of all connections between the cogwheels, we can predict with one hundred percent certainty how the machine will operate, and will continue to operate until eternity. This, however, is not the reality of education.[28] So the

first question to ask is what kind of system education actually is in order, then, to say something about how a system such as education works and can be made to work.[29]

The first thing to bear in mind here is that education is a relatively *open system*. What happens 'inside' education is significantly influenced by what happens 'outside' of it. Students have lives and experience outside of the classroom and are therefore influenced by much more than just the teaching they receive. What happens in the classroom is part of a wider social context with intended and unintended influences flowing in and out. Secondly, education is not a deterministic system of mechanistic 'push and pull,' but a *semiotic system*, that is, a system that works by means of communication and interpretation. Put simply, students need to make sense of what teachers tell them or present to them and this is a matter of interpretation, not of stimulus-and-predictable-response. Thirdly, unlike the unidirectionality of the clockwork, education systems are *recursive*, which means that the 'elements' in the system (teachers and students) can think for themselves, make up their own minds, and, based on this, can decide to act in a number of different ways. How the system evolves does, in other words, feed back into the system.

Acknowledging that education is an open, semiotic, and recursive system may make one wonder whether anything can work at all in education in that whether any connection between what teachers do and what students take from it can be established or secured. With so many uncontrollable factors, and so many complex, open dynamics, it seems as if education is almost impossible. Yet the point we wish to make is that understanding the dynamics of education in this way – that is, seeing education as an open, semiotic, and recursive system – is actually quite helpful because it allows to indicate with much precision what needs to be done to make such a system work in a more predictable way. Everything here comes to reducing the 'degrees of freedom' of the system: reducing the openness of the system (the influences from outside), reducing the semiotics of the system (the opportunities for interpretation), and reducing the recursivity of the system (that is, the way in which the system feeds back onto itself).

Interestingly, reducing openness, interpretation, and recursivity is exactly what educators do. We reduce openness, the interference from the outside, by putting students in classrooms or designated study spaces first and foremost in order to focus the attention of our students. The curriculum is a further step in reducing openness by specifying what students should focus on and what they should be doing. Similarly, while interpretation has, in a sense, no boundaries, the whole point of assessment is to limit the range of interpretations our students generate sometimes to make sure that they get it absolutely right, and sometimes to make sure that they remain within the boundaries of what is meaningful. Thirdly, as educators we also try to influence the recursivity that is happening in our classrooms, basically by helping our students to think in particular ways. In medical education, we encourage our students to think as medical professionals,[30] rather than 'just' as private persons so that, when they make up their minds about what to do with their education, for example, we try to 'frame' this within a particular context (medical practice) rather than let it go in any direction.

When we look at the dynamics of education in this way, we not just have an account of education that makes much more sense than the mistaken assumption that there is a causal connection between teaching and learning. Such connections simply do not exist in social systems such as education. We also have an account that shows how our educational endeavors – our school buildings, classroom settings, curricula, forms of assessment – all contribute to giving the whole process more direction and structure in light of what we seek to achieve with our students. Yet what this approach also brings into view is that if we go too far in all this by closing off the influences from the outside completely, telling our students that there is only one correct way to interpret the curriculum, and only one right way to think, act, and be, we have suddenly turned education into *indoctrination*. While this may be 'effective' from the perspective of qualification and strong socialization, indoctrination is the very opposite of what we should achieve vis-à-vis the domain of subjectification, that is, our ambition to make sure that our students can ultimately think and act for themselves and take responsibility for this. While it is of crucial importance that we generate structure and focus in our educational activities, it is also important that we never turn our students into objects of our control.

Lessons for medical education and medical education research

One important implication for medical education *practice* from the above discussion is that it provides a much more refined language for talking about what medical education is *for* than the rather empty but nonetheless prevalent language of learning. For *curriculum design* this approach raises helpful questions about what a medical education curriculum should look like. What kind of curricular content do we need to work toward the professional qualification, the professional socialization, and the professional subjectification of medical students? How can we design educational activities such that this content contributes to all three domains in an integrated fashion? The above discussion not just raises questions about particular content students should master in relation to the three domains, but also about what kind of experiences they should encounter during their medical education. Which encounters would create educational opportunities in terms of professional qualification, socialization, and subjectification? With curricular redesign would also come other forms of *assessment* to establish students' progress in light of each of the three domains. How can we design assessment in ways that address development in terms of qualification as well as socialization and subjectification? Can we address all three in an integrated assessment or do we need separate assessments for each? In addition, student *evaluations* of medical education would require a broader focus on all three domains of purpose. We would need to not just ask students about the knowledge, skills, and understanding they may have achieved, but also about ways in which the education has contributed to their professional identity formation31 and their ability for thoughtful judgment and decision making. To look at medical education in this way rather than in terms of the language

of 'student learning' thus gives more precision and more focus to the design and enactment of medical education. This is not to suggest, of course, that current medical education is devoid of these dimensions but the language of 'teaching and learning' is simply insufficient to have meaningful conversations about the aims, structure, and processes of medical education.

A second implication of this discussion is for teachers in medical education *practice* to carefully consider any research findings about the supposed effectiveness of particular teaching interventions or methods. What does existing research have to say in relation to each of the three domains of qualification, socialization, and subjectification? Also, any indication that a particular approach may work for one domain or aspect of a domain does not automatically mean that it will also work for the other domains or aspects of them and also not that it will be neutral with respect to (aspects of) the other domains. It may also be counterproductive, and this is crucially important in considering any alleged evidence at all. For example, a disproportionate emphasis in the domain of qualification on, say, knowledge retention and reproduction, may do little for developing informed, self-confident professional identities just as checking long lists of acquired competencies may do little, and may actually hinder, the formation of robust professional judgment. While the point may be obvious, it is crucial also not to forget that what allegedly has worked in one setting – which also means: under the particular conditions of that setting – may not do anything at all in a different setting, under different conditions.[1,3,13,32] Dealing with the local contingencies of teaching, teachers cannot but approach research evidence as suggestions to be translated and applied flexibly according to circumstance and context, but as nothing more than that.[5]

For medical education *research*, the main lesson to draw from what we have presented above is the need to move beyond one-dimensional research designs that either focus on just one domain – qualification, socialization, or subjectification – and 'forget' to explore the interactions between the three or, even worse, that continue to investigate the 'impact' on 'learning' without specifying about and for what the learning is supposed to be. Moreover, the ideas outlined above suggest a different focus for medical education research – not a search for correlations in order to identify 'effective factors,' but rather a thorough and thoughtful exploration of the construction of educational 'ecologies,' that is, of how, through arranging the openness, semiosis, and recursivity of educational practices, meaningful education can be established. Such an approach cannot confine itself to just looking at education from the 'outside' or looking for collections between inputs and outcomes, but needs to engage with teachers and students and their own meaning making and interpretation. Such research would not only tell us whether a new (or, for that matter, an established) practice would influence students' grades or help them meet professional standards more quickly or efficiently (qualification). It would also give us insight into the ways that this practice helps students be, do, and feel like professionals of their sort (socialization) and is significant for their ability to act and judge in meaningful and responsible ways (subjectification).

Conclusion

In this paper we have argued that there is a need to move beyond the rather simplistic 'medical model' of education that sees teaching as an intervention and learning as its effect, and that suggests that the sole task of medical education research is to find out which interventions 'work' to produce the intended effects. We have raised questions about the narrowness of the language of 'learning' and have suggested that more precision can be reached if we begin to discuss the purposes of medical education in terms of professional qualification, professional socialization, and professional subjectification. We have also raised questions about the causal assumptions that seem to underlie the medical model and that suggest a particular approach for medical education research. Here we have suggested that it makes much more sense not to understand education as a closed, causal system but as an open system that works through communication and interpretation and the thoughtful actions of teachers and students. In such a view, teaching, curriculum, assessment, and evaluations no longer appear as 'factors' to produce 'outcomes' but become meaningful aspects of the practice of educators to steer the educational process toward particular purposes – always bearing in mind that too much steering runs the risk of reducing meaningful education to problematic forms of indoctrination. Along these lines we hope to have made a contribution to the discussion about the future of medical education and medical education research away from the simplicities of the 'medical model' toward approaches that are able to grasp what is really going on when medical educators teach and students take part in medical education.

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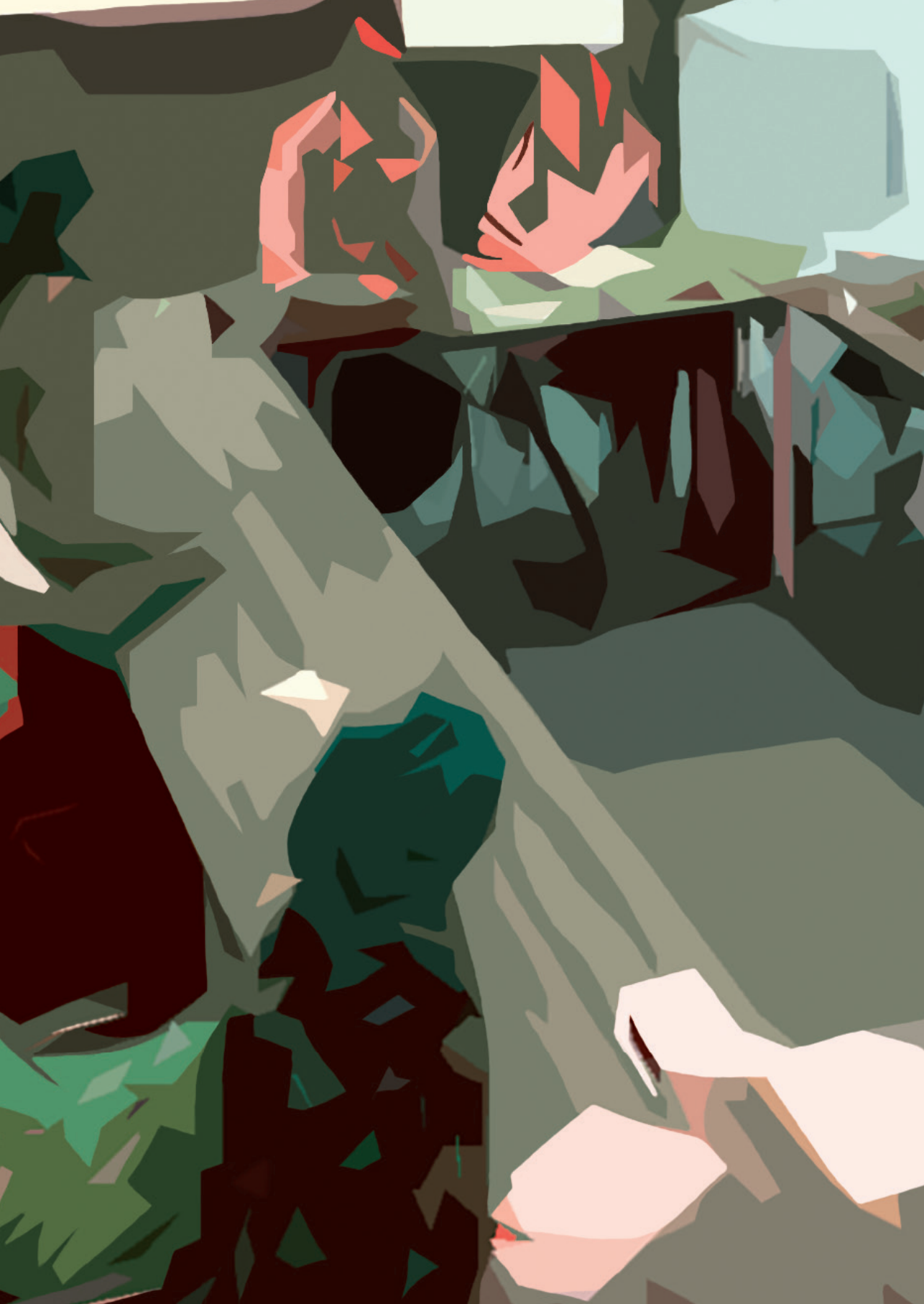

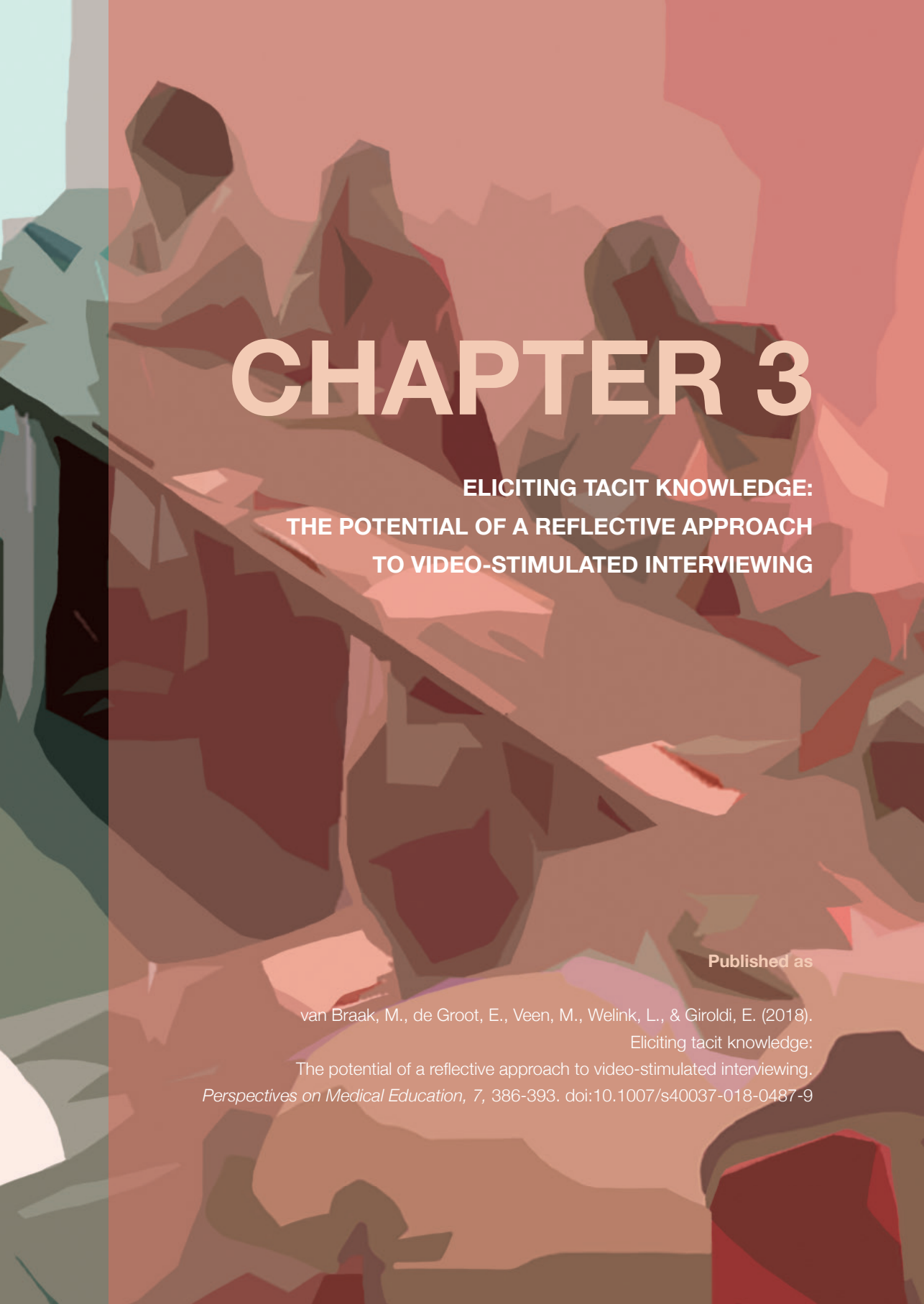

CHAPTER 3

ELICITING TACIT KNOWLEDGE: THE POTENTIAL OF A REFLECTIVE APPROACH TO VIDEO-STIMULATED INTERVIEWING

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Introduction

'How to know what others know?' is a pertinent question debated extensively in education [1]. The *tacit knowledge of professionals*, the seldom expressed knowledge that guides professional practice [2, 3], has received particularly ample attention [4] for good reason. Explicating tacit knowledge can aid professionalization in several ways: it can improve performance by encouraging professionals to reflect on their behaviour; it can help communicate knowledge to others; it can facilitate evaluation by linking aspects of behaviour to outcomes of that behaviour; and finally it can aid construction of 'artefacts' that can assist in daily practice [5]. Each of these benefits underscores the exigency of explicating the tacit knowledge of professionals, e.g., practitioners (whether or not in training) and teachers in the field of medical education (cf. [6]).

But how to elicit the tacit knowledge that informs professional practice? Mainstream research tools such as surveys and formal interviews, though employed extensively, are limited with respect to eliciting tacit knowledge. Formal interview questions such as 'What do you aim for in your teaching?' might be too abstract to answer and difficult to address given that they concern understandings that may rarely get expressed [7]. It has been argued that we need elicitation techniques that prompt participants to express their tacit knowledge by displaying the focus of interviews onto external stimuli, either visual, verbal, or written [7, 8]. These stimuli can facilitate the articulation of complex ideas in the participant's own conceptual categories, bringing to the fore understandings that would otherwise remain below the surface [7]. Despite their clear value, however, many elicitation techniques use stimuli that are only distantly related to actual practice (e. g. photo elicitation, drawings) or interfere with the very practices that are under investigation (e. g. think-aloud protocols) [7, 9]. Video-stimulated interviewing [10] (VSI, also known as video elicitation interviewing [11]) is a promising exception that avoids both disadvantages by having participants view a video of their own behaviour while being asked questions about the recorded situation [12]. As such, VSI is a promising tool for eliciting the tacit knowledge that informs professional practice, provided that, as we argue in this paper, the tool is used to stimulate *reflection*, not *recall*.

Historically, VSI has been used to elicit accounts of participants' thinking at the time of recording (hence the frequent mentions of the tool as video-stimulated *recall* interviewing) [7]. Notwithstanding its potential value to other research purposes, this approach to VSI is problematic in research aimed at eliciting tacit knowledge. Indeed, we argue, a *reflective* approach to VSI is more productive to that aim. In the following, we first place both approaches in historical context to show their distinct epistemological roots. We then explain why recall VSI is less suited to uncovering tacit knowledge and why reflective VSI is better suited to do so, drawing on research outside of medical education, the few examples of reflective VSI in medical education, and from our own experience. Finally, we discuss several challenges and best practices of reflective VSI. This will help researchers to unleash the potential of reflective VSI in their own medical educational

research, facilitating the search for answers to pressing issues that will aid progress in research and benefit implementation.

The historical context of recall and reflective VSI

Set in educational research, video-stimulated interviewing was introduced as a qualitative technique that facilitates a subject's reliving of a situation 'with vividness and accuracy if [...] presented with a large number of the cues or stimuli which occurred during the original situation' [13, p. 161]. Early applications of VSI appeared in the 1960s [14]. With the rise of cognitive psychology, many researchers used VSI to elicit reports of thinking (see Tab. 1; [9, 15]). Most of this research was conducted in general education settings (for an overview see [16]) and physician-patient interactions (see [11]). The research was based on the assumption that people have access to their internal thought processes at some level, that people can verbalize these (i. e., that *reliving* is a valid approach to stimulate accurate *recall*), and that these verbalizations are retrievable through video stimulation. This assumption, however, came under fire with the rise of constructivist thinking.

In the interpretivist research paradigm to which constructivism belongs, the aim of research applying VSI is not to introspectively elicit in-the-moment processes of thinking, problem-solving or decision-making. Instead, the researcher's intention is 'to produce an interpretation of the phenomenon as the informants conceive and understand it' [9, p. 185] (see Tab. 1). The focus is not on *recall* and the need for maximum validity and reduced researcher interference, as it is in post-positivist approaches to VSI. Instead, in constructivist approaches the focus is on *reflection* through constructing meaning and the need to respect the essential role of the researcher in producing the interpretation of the reality under investigation [9, 17]. From this perspective, the technique is suited to stimulate participants to give meaning to their behaviour, allowing for the unfolding of implicit theories, expectations, strategies and views [18].

Research using reflective VSI has only recently begun to emerge [16] and is scattered in educational research in general, but especially in medical education. It is in the interpretivist approach to VSI that we find the underexplored potential of VSI for eliciting tacit knowledge in medical education research. Before arguing for this potential of reflective VSI, we first discuss why recall VSI is less suited to eliciting tacit knowledge.

Table 1 A comparative summary of recall VSI and reflective VSI

	Recall VSI	Reflective VSI
Historical context	Post-positivism, cognitive psychology [9, 15]	Interpretivism, constructivist thinking [9, 16]
Aim	Gain insight into cognitive processes underlying and taking place during actual behaviour [7]	Produce an interpretation of a phenomenon (behaviour, practice) as the participant understands it [9]
Procedure	Stimulate participants' retrospective description of their cognitive processes [7]	Stimulate the participants' retrospective reflections on their situational understanding, routine procedures, and intuitive decision-making [4, 42]
Sample research questions	'What factors influence physicians' decisions to discuss smoking cessation with patients?' [40] 'What processes and stages of treatment decision-making do women with early stage breast cancer perceive?' [41]	'Why do physicians communicate with their patients about medication use and adherence the way they do?' [30] 'How does student nurses' reflective learning develop in the context of health counselling and promotion in the clinical training section of a 3-year nursing education program?' [26]
Sample interview questions	'What do you think of [behaviour, event]?' [12] 'What were you thinking when you decided to [behaviour]?' [12]	'How would you evaluate [behaviour, event]?' 'What do you notice when you watch [behaviour, event]?'

Why recall VSI is limited in eliciting tacit knowledge

If one's aim is to elicit tacit knowledge in the context of medical education, the recall approach to VSI is problematic for two reasons. First, recalled *cognitive processes* are not necessarily linked to the (often general) tacit knowledge that drove the actual behaviour. What one thinks *during* teaching, for example, does not necessarily relate to what one thinks *about* teaching. What one thinks *during* a patient consultation does not necessarily reflect one's ideas *about* patient consultations. Even if retrospective reports of thinking could reveal hints of tacit knowledge, stimulating concurrent cognitive processes to elicit generalized unspoken ideas is doubtful at best and invalid at worst.

The second issue with recall VSI is more general but fundamental to our evaluation of recall VSI as a tool to elicit tacit knowledge. The extent to which recalled thoughts accurately reflect thoughts that occur during the recorded event is unclear and widely criticized [7, 15]. Participants might consciously censor the recall while being interviewed [19] or unintentionally involve sense-making processes that produce convincing stories unrelated to their thinking processes during the event [9]. Despite 'mov[ing] analysis from a generalized response (...) to a specific, empirical situated focus, where the observed reality challenges the tendency to provide moral or ideal accounts' [20, p. 9], recall VSI cannot warrant capturing participants' past thinking [7, 21]. In fact, the 'luxury of meta-analysis and reflection' [15, p. 271], which is absent at the time of recording,

cannot but evoke interference in present thinking in reported verbalizations [7]. Various measures have been proposed to optimize recall accuracy, such as minimizing the time delay between event and recall and using the right type of (nondirective) question probes [22, 23]. Even then, though, we ought to be aware that applications of recall VSI merely yield retrospectively recalled, potentially unreliable memories that are possibly coloured by post-event reflections on particular, but not necessarily conscious behaviour.

If recall is unlikely to be accurate and thinking is only remotely linked to tacit knowledge, then recall VSI is not very well suited to eliciting tacit knowledge. Reflective VSI departs from another viewpoint, asks other questions, and provides different output, making it, as we argue in the next section, better suited to uncovering the tacit knowledge that informs professional practice in medical education.

How reflective VSI can elicit tacit knowledge

In contrast to recall VSI, reflective VSI asks participants to *make sense* of their own behaviour [7, 21, 24, 25]. This sense-making process, though grounded in a specific context, transcends the specific behaviour that occurred during the recording. The specific behaviour merely triggers participants to give meaning to their behaviour in general. By 'prompting explanation and justification of practices' reflective VSI spurs reflection on practice [7, p. 196]. Importantly, participants' reflections thus elicited are interpreted as constructed *in the moment of interviewing* [24]. Whether or not the reflections resemble cognitive processes that occurred in the recorded situation is not an issue in this interpretivist paradigm [9] and does not change the researcher's interpretation of the reflections.

Medical education research applying VSI as a reflection-stimulating tool is sparse. Those studies that explicitly report eliciting reflection with videos feature two uses of reflective VSI. First, some studies use reflective VSI as a way to investigate *reflection on (professional) behaviour* [7]. Liimatainen et al., for example, analyzed reflectivity levels in student nurses' reflections on their videotaped counselling situations at different time points to gain insight into reflective skills of nursing students over time [26]. They describe their interviews with the student nurses as reflection-on-action situations. Such situations, they argue, bring to the fore the 'students' personal ways of seeing phenomena and their interrelationships' [26, p. 651]. Similarly, Hewson had an attending physician and a resident in a regular staffing episode reflect on their videorecorded interaction in the context of professional training of physicians [27]. Participants of the study were invited 'to stop [the recording] at any time to reflect on [their] thoughts about what was happening' [27, p. 228]. This yielded both retrospectively reported thoughts and reflections-on-action, which appeared beneficial to the professional training of the medical staff involved.

In both studies, eliciting tacit knowledge was not mentioned as the primary aim. We now show two of our own studies as examples of how medical education research using reflective

VSI can uncover tacit knowledge. In one of our current research projects we use video-recordings of educational sessions for general practitioners in training to stimulate teachers of the recorded sessions to reflect on the tacit knowledge that guides their behaviour when they teach these sessions. These interviewee contributions can be seen as descriptions of professional craft knowledge [18]. When shared with teachers, these descriptions can facilitate teacher professionalization [5]. In another study, we asked clinician pharmacists to reflect on boundary-crossing conversations with their supervising general practitioner [28]. In both studies, we were interested in participants' *actual reflection on particular professional behaviour.* The reflective VSI functioned accordingly, stimulating reflective discussion on the issues of interest.

Besides the use of reflective VSI to investigate reflection on professional behaviour, the medical education literature features a study that used reflective VSI to shed light on the largely tacit *mechanisms behind behaviour* [7]. These mechanisms frequently remain implicit in recall of behaviour, but can be verbalized as participants make sense of recorded episodes of that behaviour [7, 29]. Van Dulmen and Van Bijnen used reflective VSI to investigate why general practitioners might refrain from talking to patients about medication use and adherence [30]. Analyzing general practitioners' reflections on a recorded visit that included segments about medication use and adherence, they identified various determinants that influence general practitioners' communication behaviour, thus revealing the general practitioners' tacit knowledge about a particular aspect of consultation communication.

Likewise, in an ongoing research project of our own, we use consultation recordings to ask general practitioners (in training) to reflect on the role of evidence in their decision-making. Since evidence-based decision-making is often regarded as a normative issue, using the recordings might stop the professionals from giving socially acceptable answers instead of reflecting on their actual behaviour. In another project, we used videotaped consultations in interviews with experienced doctors to stimulate them to reflect on their reassuring behaviour [31]. The level of detail in the doctors' reflections allowed us to uncover working mechanisms underlying the reassuring behaviour, guiding the reader to put this behaviour in context.

In each of the reflective VSI examples just described, researchers avoid the pitfall of assuming that interviewees' utterances provide a window to their former thought processes. Rather, they view the reflective interview as an opportunity (for interviewees) to 'review events in which they have participated from an outsiders' perspective but with an insider's insight into their motivations and intentions' [32]. The focus on reflection enables participants to construct meaning to behaviours applied unconsciously in practice [31], thus making the tool especially suited to uncover tacit theories, implicit ideas, and unspoken strategies behind learning and teaching in medical education.

Critical comments on reflective VSI

Although reflective VSI, as we have just argued, is well suited to elicit tacit knowledge in medical education, several characteristics make the tool either more or less apt for application to aims that particular studies might have. On a positive note, reflective VSI offers rich learning opportunities for participants [7, 25]. In our own studies as well as in at least one study mentioned above [27] participants expressed the value of receiving direct feedback on their professional competencies (such as clinical communication skills and teaching practices) outside the assessment context. Data resulting from applying reflective VSI can inform continuous professional development, provided that data collection follows appropriate informed consent procedures. In a time when researchers struggle to recruit enough participants, these learning opportunities serve as an incentive to participation. Thus, if the aim is to elicit tacit knowledge to facilitate learning, develop training courses, or improve education, the reflective VSI tool is particularly suitable.

However, reflective VSI also has its challenges. One possible risk is that participants can feel vulnerable and/or 'judged' [21]. In our work with triage nurses, for example, nurses were accustomed to listening to the recordings in an assessment setting with their supervisor. During the interviews, we had to assure participants repeatedly that they were not being judged, but that we were interested in their decision-making in a very complex context. In dealing with this issue, it is helpful to consider that (a) participants are more open and more likely to reflect on their emotions when interviewed by a peer, especially if that peer is less experienced [20, 33]; (b) the interviewer should not be involved in the participants' medical/professional training; and (c) it is important to repeatedly emphasize the goal of the study and that the participant will not be assessed [31, 34].

Second, time issues might arise if short extracts of recorded material facilitate extensive reflection [11]. The researcher might pre-select fragments of interest to show during the interview. Alternatively, during the interview the researcher could invite interviewees to select the fragments to keep data collection as participant-centred as possible. As Barton notes, ' [G]iving participants greater control can also yield data that more authentically reflect their conceptual categories. [...] Although researchers may believe that they can assemble tasks that allow perspectives to emerge, asking participants themselves to contribute to the process makes this more likely.' [7, p. 182–3]. If the recorded material is short, one might consider playing the material from start to end. In any case, carefully considering data selection and presentation is vital to aligning data collection design with the aim of the study.

At the other end of the spectrum, participants might struggle to produce reflections [21]. In our ongoing research with general practice teachers, for example, teachers sometimes find it hard to let go of describing their then-occurring thoughts and focus on constructing in-the-moment reflections (but see [35] for a report on participants' tendency to reflect instead of recall).

The researcher needs to be prepared to cope with this situation. Preparing reflection-stimulating, non-directive prompts and offering these if necessary will guard the success of reflective VSI.

Given these considerations, reflective VSI might not always be the best tool to uncover tacit knowledge. It might not be suitable for participant groups that, for whatever reason, have difficulty with reflecting. These participant groups require methods that are less demanding such that data collection is not confounded by the method itself. And secondly, it might not be suitable for research projects with limited time frames or budgets. Such projects require less challenging methods in terms of data collection time, resources, and ethical approval (for a discussion on ethical approval, see [36]).

For other medical educational research aiming to elicit tacit knowledge, however, we encourage researchers to explore the potential of reflective VSI. Reflective VSI is a promising option for research that seeks to produce participants' interpretations of a situation, since it allows participants to construct meaning and interpret reality as the recording is played. Reflective VSI is a promising option for research with professionals as participants, since it is well suited to uncover implicit theories, unconsciously made choices, expectations, expert strategies, and individual views [3]. And finally, reflective VSI is a promising option for research that aims to serve applied educational purposes [7, 21], since it can help participants develop useful insights into their own participation, interaction, and behaviour in the settings involved.

Best practice in reflective VSI

To aid medical education researchers to unleash the potential of reflective VSI in their research, a few comments on best practice are in place. Discussions on applying reflective VSI (although not always named as such) outside the medical education field offer various suggestions for good practice [9, 11, 21, 24, 30, 37–39]. From these discussions, we have identified three best practices. First, the researcher should *acknowledge their own nonneutrality*, since researcher background and perceptions (in fact, their own tacit knowledge) influence meaning construction during the interview [9]. As the aim is to produce the participant's interpretation of the recorded situation, the researcher's task is to assist the interviewee as an expert participant in the situation. As such, the researcher should listen actively, ask for clarification if needed, and avoid leading and evaluative questions [9]. Acknowledging one's own non-neutrality by actively considering steps to minimize biased interview guidance is core to this interview attitude. To envisage how that might work in practice, consider Rowe's reflection on her role as a music education researcher: 'The researcher in this study, who is also a piano teacher, was conscious of the necessity to withhold her musical and pedagogical reactions when observing the lessons and to focus on the interactions between teacher and pupil. Similarly, when interviewing the pupils she had to avoid falling into her accustomed 'teacher' role with its accompanying assumptions of power over a

child' [21, p. 428]. By being aware of her own bias and formulating behaviour to minimize its influence on the interview, this researcher acknowledged and dealt with her own non-neutrality.

Second, the researcher should *use apt prompts* [11, 24]. Apt prompting minimizes disturbance of sense-making processes during the interview [37]. Apt prompts in reflective VSI 'remain "neutral" while providing a context e.g. study aim or orientation for the participant to comment' [17, p. 16]. A prompt, then, should only hint at a particular interpretation of a situation if the participant gives reason to assume that interpretation. Besides, prompts should be free of formulations that induce interviewees to try to recall their cognitive processes during the recorded event (e. g., 'What did you think when X happened?'). As an example, Tab. 2 presents the prompt types we used for our interviews with teachers in general practice training in order of minimal to most directed guidance. We used the more guiding prompt types only when less guiding prompts did not yield the desired reflection, as themore guiding prompts risk potentially disturbing the participant's sense-making process.

Table 2 Types of prompts for interviewers

Stop the recording and ...
1. Remain silent;
2. Give a neutral description of something in the recording (e. g., 'You are saying X here.');
3. Ask a neutral, open question (e. g., 'What is happening here?');
4. Present an observation (e. g., 'You appear caught off-guard at this point.');
5. Ask for intentions/aims (e. g., 'What did you achieve with X?');
6. Ask an evaluative question (e. g., 'What do you think of X?').

Apt prompting, however essential it may be, appears to be difficult to implement. It is an unnatural form of communication, since we do not usually remain silent or unresponsive if our aim is to elicit talk in ordinary conversation. Our everyday inclination is to *ask* for an *answer* and not burden the responder with finding out what we are asking for. Apt prompting, thus, requires systematic practice on the part of the researcher. Nevertheless, we encourage researchers to carefully prepare a similar set of non-leading prompts and include them in an interview protocol. They structure the interview and will likely produce rich data for the study's research question [11, 17, 37].

Third, in the analysis phase the researcher should *view the interview as an opportunity for collaborative meaning construction* [24, 39]. As Holstein and Gubrium state, '[I]nteractional, interpretative activity is a hallmark of all interviews' [38]. Especially when the interview is meant to uncover participants' sense-making of particular situations, analyzing the interview as a collaborative achievement [39] between researcher and participant is crucial. Merely analyzing participant responses ignores the researcher's part in the collaborative construction. Consider, for

example, the extract of an interview with one of the teachers (T) of our research into a particular teaching practice in General Practice training (Tab. 3).

Table 3 Interview extract

1	I	and did that influence your behaviour in this case?
2	T	eh no, I thought: just let them talk for a moment
3	I	you just let them talk for a moment
4	T	[...] and sometimes it's good to let residents tell the
5		story in detail, because I also think that, you know,
6		that also makes the experience- experiences come
7		more to life so that we can discuss it with each other.
8		so that it isn't just a story, with some dry facts.
9		that's why I think it's also important to give feedback
10	I	ok. so that others can imagine it too
11	T	yes
12	I	then it gets more lively?
13	T	it gets livelier, yes
14	I	and that makes giving feedback easier?
15	T	it fits better
16	I	it fits better, ok
17	T	yes
18	I	fits what actually happened, you mean?
19	T	yes

In this extract, the teacher and interviewer construct meaning collaboratively. The interviewer summarizes the teacher's contribution and produces two interpretations to check her understanding of the teacher's interpretation of the situation (lines 10, 12, 14). The interpretation in line 14 elicits a slightly different interpretation from the teacher, which is clarified before this meaning-construction sequence is closed. Analyzing (and presenting) the contributions of the teacher without displaying the interviewer's contributions or summarizing the teacher's turns in a cogent quote would yield an incomplete representation of the interaction. What is more, such representation would not do justice to the source of certain interpretations: it would blur the interviewer's and interviewee's understandings of the situation discussed. When the researcher's contributions and possible influences are not made explicit while analyzing, the pitfall of attributing the interviewer's interpretations to the interviewee looms large, hampering an accurate analysis of the interviewee's meaning-construction process.

Conclusion

Reflective VSI, unlike traditional applications of VSI as a tool to stimulate recall, can benefit medical education researchers who aim to uncover participants' implicit theories, reflections on key events, or seemingly mundane, possibly unconscious, routines in a real situation of interest. By eliciting this tacit knowledge, reflective VSI captures the knowledge and expertise of educators, medical professionals, medical students, residents, and patients for later access by, for example, inexperienced professionals. Reflective VSI can also serve a powerful practical purpose, as it can help participants develop insights into their own participation, interaction, and behaviour in the settings involved, ultimately leading to improved medical or educational conduct.

Researchers applying reflective VSI, however, will encounter several hurdles along the way. For a good application of the reflective VSI tool, researchers should make explicit their own non-neutrality, design apt interview prompts, and analyze the interview as collaborative meaning construction. Each of these measures strengthens
reflection on past experience. These reflections can help us find answers to questions about the tacit knowledge possessed by others, thus making reflective VSI a powerful tool in the continuing debate on 'how to know what others know'.

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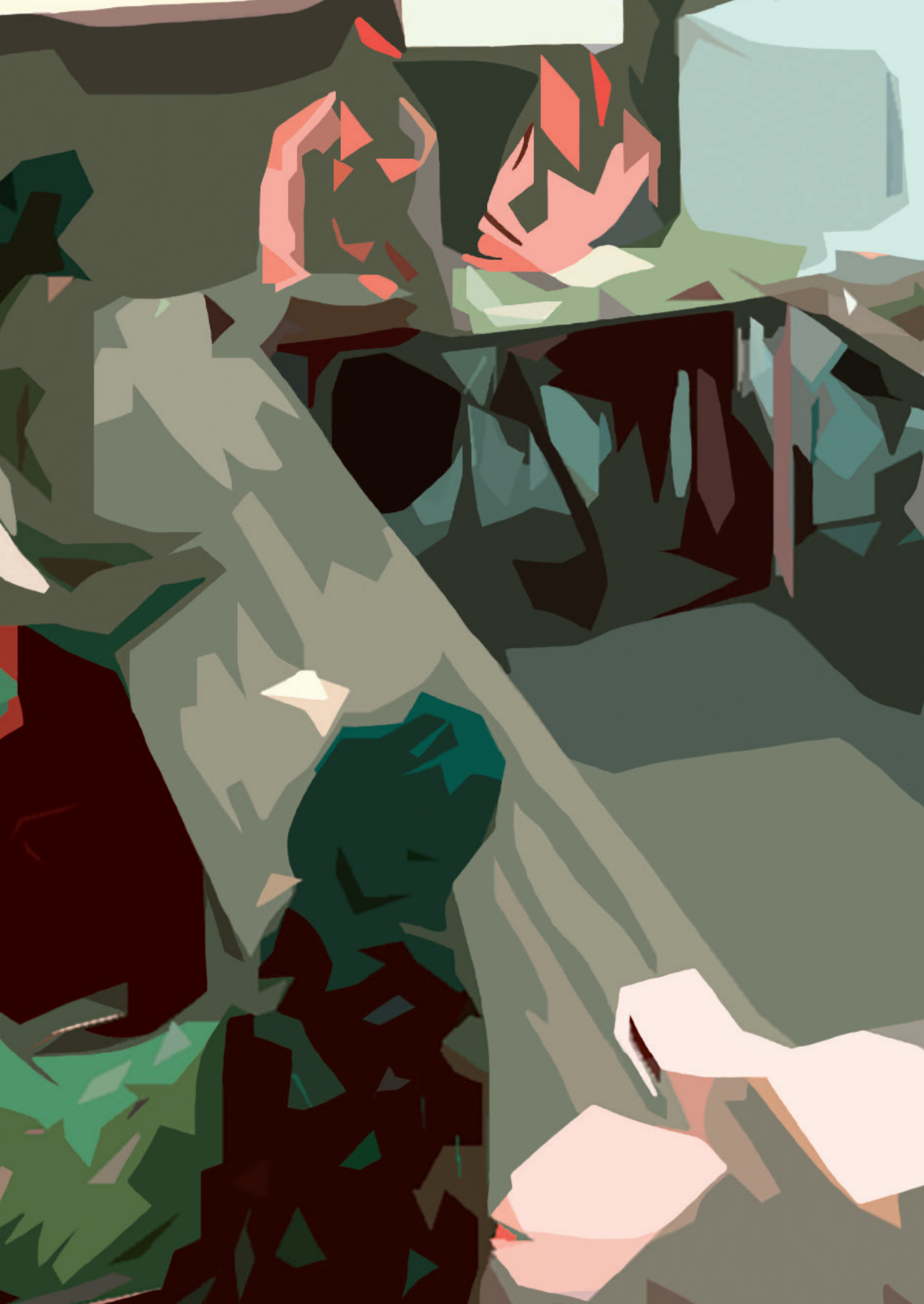

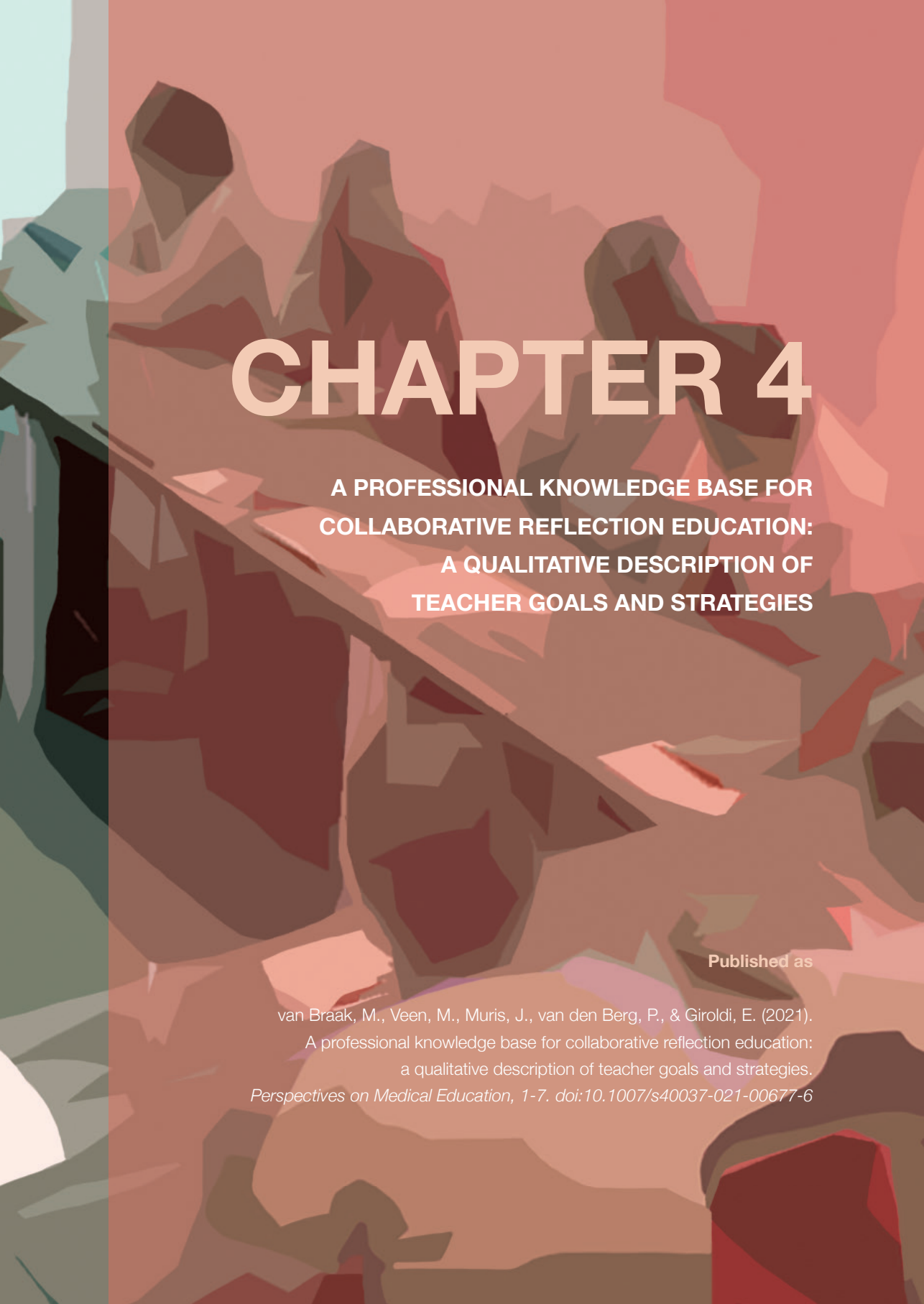

CHAPTER 4

A PROFESSIONAL KNOWLEDGE BASE FOR COLLABORATIVE REFLECTION EDUCATION: A QUALITATIVE DESCRIPTION OF TEACHER GOALS AND STRATEGIES

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Abstract

Purpose

For several decades, educational experts have promoted reflection as essential to professional development. In the medical setting, collaborative reflection has gained significant importance across the curriculum. Collaborative reflection has a unique edge over individual reflection, but many medical teachers find facilitating group reflection sessions challenging and there is little documentation about the didactics of teaching in such collaborative reflection settings. To address this knowledge gap, we aim to capture the professional knowledge base for facilitating collaborative reflection by analyzing the formal and perceived goals and strategies of this practice.

Methods

The professional knowledge base consists of formal curricular materials as well as individual teacher expertise. Using Template Analysis, we analyzed the goals and strategies of collaborative reflection reported in institutional training documents and video-stimulated interviews with individual teachers across all Dutch General Practitioner training institutes.

Results

The analysis resulted in a highly diverse overview of *educational goals for residents* during the sessions, *teacher goals* that contribute to those educational goals, and a myriad of situation-specific *teacher strategies* to accomplish both types of goals. Teachers reported that the main educational goal was for residents to learn and develop and that teachers' main goal was to facilitate learning and development by ensuring everyone's participation in reflection. Key teacher strategies to that end were to manage participation, to ensure a safe learning environment, and to create conditions for learning.

Conclusion

The variety of strategies and goals that constitute the professional knowledge base for facilitating collaborative reflection in postgraduate medical education shows how diverse and situation-dependent such facilitation can be. Our analysis identifies a repertoire of tools that both novice and experienced teachers can use to develop their professional skill in facilitating collaborative reflection.

Introduction

Collaborative reflection is a form of education pertinent to many aspects of the medical curriculum[1,2] but facilitating it can be challenging. How do you stimulate reflection? What can you, as an expert or experienced teacher, contribute to the interactional process of reflection? How can you ensure educational value when the result of group discussion depends largely on the input and dynamics of that specific group? Answers to these questions are part of teachers' professional knowledge base, defined as "all profession-related insights, which are potentially relevant to a teacher's activities" in a specific educational context[3]. Explicating the knowledge base for facilitating collaborative reflection would be beneficial in several respects: it would improve current teacher training[4,5], contribute to the professional development of novice teachers[3], and support conceptualizations of collaborative reflection that "take into account the complexity of real-world educational contexts"[6]. In light of these benefits, we aimed to describe the professional knowledge base for facilitating collaborative reflection by analyzing the goals and strategies formalized in documents and perceived by teachers in this context.

In general educational literature, the professional knowledge base for teaching is commonly referred to as teacher cognitions, traditionally understood as an individual teacher's beliefs, knowledge and thoughts that drive "classroom action"[5,7]. More recently, recognition of the influence of the social environment and professional community on these cognitions has grown[5]. Individual teacher's cognitions often draw on discipline-based theories and concepts, pedagogical principles, and situation-specific knowledge shared by the professional community[3]. Together, this shared knowledge and a teacher's practical knowledge of routines, procedures, and processes in actual educational situations constitute the knowledge base for teaching, which influences what teachers do in practice[8,9].

One feature of the knowledge base for teaching that has received little attention is its interactional nature. Teaching is an interactional activity consisting mainly of talk between participants[10,11]. This feature of the knowledge base has been described as the *professional stocks of interactional knowledge*[12]: a collection of partially normative and partially descriptive ideas concerning interactional processes shared by members of the profession[13]. In the following, we will use the term *professional stocks of interactional knowledge* to refer to all insights about interaction that inform teachers' professional activities during collaborative reflection education, where an explicit focus on the interactional nature of the knowledge base is crucial.

Since there are almost no descriptions of professional stocks of interactional knowledge for facilitating collaborative reflection, teachers currently do not have access to a shared resource for teaching practices. General advice on facilitating group discussion[14-16] provides a few indicators of good practice, e.g. ask thought-provoking questions, but what this entails for teachers in specific educational interactions remains unclear. In this study, we aim to bridge this knowledge gap by deconstructing normative guidelines of professional practice recorded in institutional training documents and the subjective expertise of individual teachers into a

repertoire of interactional strategies that teachers can use to achieve the educational aims of collaborative reflection. Our purpose is to make the knowledge formalized in curricular documents and individual teachers' practical knowledge available for prospective and practicing members of the professional community.

Methods

We focus our analysis on collaborative reflection sessions at all institutes for Dutch General Practitioners in training, which provides analytic depth and specific implications for practice.

Setting

In Dutch GP training, groups of around ten residents attend weekly sessions throughout their three-year training[17] to discuss patient cases, personal dilemmas, and other issues relevant to their training situation. One or two teachers (a practicing GP and/or a behavioral scientist or psychologist) facilitate the interactional process of collaborative reflection to generate educational value[18].

Data and participants

We collected two types of data, covering both formalized normative guidelines and individual teacher's practical insights on facilitating collaborative reflection. The first type of data consists of *institutional documents* from all eight Dutch GP training institutes. An overview of documents and approximate indication of their volume is presented in Table 1.

Table 1 Analyzed documents and their approximate volume in pages per institute (A-I; anonymized).

	Pages of document included per institute								
Type of document	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**
local or national training plan	43	-	-	-	43	24	23	16	-
information about collaborative reflection for teachers	5	19	25	1	18	12	3	3	22
information about collaborative reflection for residents	8	-	1	-	-	7	4	6	-
information about other reflection activities during the training (e.g. supervision)	75	20	38	2	47	35	20	41	-

The second type of data consists of 26 *video-stimulated interviews* about recorded reflection sessions with individual teachers from all eight institutes. These interviews were selected from a larger dataset of 37 video-stimulated interviews until saturation of analysis could be shown

(see below). Selection was done using maximum variation sampling in terms of institute, teacher experience and year of training. Participants in the 26 analyzed interviews were 11 GP teachers and 15 behavioral scientists with 0.5 to 18 (M = 7.5) years of collaborative reflection teaching experience. The recorded sessions about which the teachers were interviewed were from year 1 (7), year 2 (8) and year 3 (11) of GP training.

During the interviews, a teacher and interviewer viewed parts of a recent collaborative reflection session involving that teacher, which was video-recorded for the purposes of the study. The teacher was asked to select an interesting, difficult, smooth, or otherwise notable or memorable part of the video recording to watch together. While watching, the interviewer prompted the teacher to reflect on their actions and the underlying theoretical or practical grounds. In line with Muller[9], we view these video-stimulated reflections as in-the-moment constructions of teachers' reportedly relevant internalized interactional norms. We describe the procedural details and grounding of this reflective approach to video-stimulated interviewing elsewhere[9]. The interviews were transcribed verbatim.

All participants consented to the video-recording of the session and the interviews. Ethical approval for this study was obtained from the Ethical Review Board of the Dutch Association of Medical Education (NVMO), dossier 829.

Analysis

We used Template Analysis[20] to code both types of data in sequential order. Mirroring earlier work on the knowledge base for teaching in medical educational contexts[16], we decided to analyze the documents and interviews for goals (what is to be accomplished during the session) and strategies (actions that teachers can take to achieve these goals). Analytic steps and coding decisions were documented in an audit trail.

The analysis was two-phased. First, we inductively constructed an initial coding template of goals and strategies mentioned in the institutional documents. MB and MV independently coded two institutes' documents and conferred with EG for consensus about their coding. MB and EG then independently coded two other institutes' documents and conferred with MV for consensus. MB organized the codes into meaningful clusters of goals and strategies for facilitating collaborative reflection, discussed the resulting coding template with EG and MV, and adapted it into an initial coding template of formal, institutionalized goals and strategies for facilitating collaborative reflection.

Next, we adapted the initial template into a final template while coding goals and strategies in the video-stimulated interviews with teachers. MB coded all interviews and double-coded four interviews with EG or MV for consensus to ensure credibility. The preset criterion of saturation (no new goals and strategies in two consecutive interviews) was met after coding 26 interviews. The resulting coding template represents an organized and grounded description of goals and strategies in the data without compromising their diversity and messiness in educational practice.

Results

The institutional documents and teacher interviews revealed a wide variety of goals for collaborative reflection sessions and a myriad of strategies to achieve them. Our collection does not represent consensus across institutes or teachers but rather the *scope* of potential goals and strategies of collaborative reflection sessions at GP training institutes, including conflicting ideas about what to achieve and how. We first present an overview of the main goals and strategies (see Appendix A for a complete list) and then discuss a selection of these in more detail, with examples.

Main goals

Two types of collaborative reflection goals are discussed in the documents and interviews: educational goals for residents to attain, and teacher goals to help residents attain them. Table 2 lists the main goals in institutional documents and teacher interviews.

The main goal (from the perspective of institutes and teachers) is for residents *to learn and develop*. Learning and development is future-oriented, directed at gaining knowledge and skills to become a better doctor. While collaborative reflection sessions may seem to be "a lot of talking, not much practice," they are actually framed by some teachers as a setting that allows residents to *work on almost all the goals of GP training* and, in doing so, to develop their professional skills, knowledge and attitudes. This is reflected in the sub-goals, *to develop professionally*, *to consult peers or learn from peers*, and *to reflect or learn to reflect*. Each of these contributes in some way to the learning and development of competent GPs, who become socialized into the GP community as responsible and independent doctors. Asked her view of the main goal of collaborative reflective sessions, one teacher commented:

> "[The goal is] to stimulate people to reflect on their own conduct … with the eventual aim that, as a result of that reflection, they will do the things they can improve on better in future. So they will indeed become better doctors, … possibly even better people." (B851)

The role of the teacher is mostly facilitative, as reflected in the main teacher goal *to facilitate the learning process*. Teachers strive and are expected to strive *to have everyone participate in reflection* and *to integrate cases/stories into a theme* that is recognizable and valuable to all. These goals reflect the centrality of sharedness during collaborative reflection, not only in terms of engagement in the process, but also in the form of common experiences. Engagement in interaction is seen as positive behavior that may, some teachers argue, already be a sign of reflection. Many believe that teachers should stimulate participation and try to identify a general issue in specific cases to create educational value for all.

Table 2 Overview of main goals for residents and teachers.

Educational goals for residents	Teacher goals that help residents attain goals
TO LEARN AND DEVELOP	*TO FACILITATE THE LEARNING PROCESS* *to have everyone participate in reflection* *to integrate cases/stories into a theme*
A. to work on almost all goals of GP training	*to gain insight into relevant themes/areas of development of residents*
B. to develop professionally	
B1. to develop one's identity	
B2. to develop professional skills	*to show residents expert examples of professional behavior*
C. to consult peers/peer learning	*give residents content/process feedback*
C1. (not) to get answers/advice/solutions	
C2. to search for/provide (emotional) support	*to provide guidance/a foothold to survive/cope with the situation*
C3. to provide a frame of reference/to normalize	
C4. "to meet"	
D. to (learn to) reflect	
D1. to free up space for new learning experiences	
D2. to mention and use points for learning	*to recognize patterns in stories told/reactions to stories*
D3. to discuss learning goals of supervision/ connect experiences to supervision	
D4. to give meaning to conduct or situations	
D5. to learn to connect subjective experiences to those of others	
D6. to become aware of one's own conduct	*to "hold up a mirror"*
D7. to reflect on actual situations (no abstract discussion)	
D8. to deepen experiences	
D9. to connect practice experiences and theory	
D10. to learn to question oneself	
D11. to present one's vulnerability in a safe learning climate	*to create safety*

Main strategies

Teachers and institutes refer to a legion of teacher strategies for attaining the resident and teacher goals described above. We summarize three main strategies.

(Don't) structure and stimulate the learning process. In our two data sources, one of the main things teachers are thought or advised to *do* (hence, a strategy) to *facilitate the learning process* is to structure and stimulate that process – or not to do so if that hampers learning and development. Sometimes facilitation involves structuring and stimulating the interactional process, for example guiding the discussion back to the main point. Other times, teachers structure and stimulate the group process at the content level, for example by checking whether the discussion is leading to the learning goals or asking useful questions that contribute to learning and development. The type of structuring and stimulation of group processes reported by teachers commonly has a didactic purpose. One example is given in the quote below, where a teacher explains how he guides his group towards "good" questions:

> "[The group] has to provide content and ask explorative questions, preferably ones that help … to take on a different viewpoint … . So we try to teach them … to stick to the issue [at hand], and not ask off-topic questions but ones that explore, that deepen the issue." (C806)

This quote illustrates how teachers' strategies (in this case, teaching "good" questioning) are seen as a means to achieve a goal (in this case, to develop professional communication skills).

The relationship between teachers' structuring and stimulation and the quality of reflective discussion is evident in almost all teacher interviews. For example, one teacher remarks that questions clarifying the issue for reflection "facilitate in-depth discussion and help get to the resident's learning issues faster …" (D753). Role modeling of procedures (which provide structure, stimulate interaction) is common practice, according to some teachers, when groups have yet to familiarize themselves with collaborative reflection:

> "At the start, we paid a lot of attention to the procedures, so I stayed on top of things a lot and my co-teacher did too, like saying 'No, hold on, now you're offering a solution, you're giving advice, so no, hold your horses.'" (E805)

Less structuring is required once residents are familiar with the procedures that stimulate reflection. Some teachers believe in sitting back and letting the residents "do the work" once the group understands the goals and how to achieve them. There is no consensus, however, on when to sit back and when to intervene. It is a balance that must be negotiated in every single reflective discussion. Ultimately, the value of whatever teachers do lies in the degree to which their actions contribute to the goal of fostering the learning and development of good future doctors.

Guarantee active participation of residents. Returning to the perceived importance of participation to learning and development, we now give three examples of teacher strategies to motivate residents to participate. The first, related to the balance between structuring and letting go, is to encourage participation by *limiting one's own contribution*. For example, if a group is seeking to solve some problem, several teachers report not (absolutely *not*) stepping in to offer a potential solution. Also, if a group falls silent, several teachers purposefully maintain the silence instead of filling it in. That may be awkward, but it can also be very valuable for learning and development: it allows room for something to "settle in" (B851).

The second example, linked to the first, is to actively nudge residents to talk to one another, to discuss among themselves instead of with the teacher. In one institute's instructional documents, teachers are advised to avert their eyes when a resident is speaking as a nonverbal signal to address the other residents instead of the teacher. If that does not work, teachers are advised to ask the resident why they are addressing the teacher instead of the group. Many teachers, however, are adamant that active teacher participation is exactly what creates educational value. In their view, it is unproductive not to let residents solicit teacher contributions because the teacher is usually an expert on the topic at hand and even on how such discussions should proceed.

The third example is to actively engage residents in the discussion. This could involve encouraging a silent resident to participate, for example by telling them "I'm missing your input" (F897). An indirect invitation is probably more "elegant" than an explicit solicitation, according to one teacher:

> "[I]f I say 'Now you have to say something,' then I'm giving a command. Then they can be compliant or not, but then – then it suddenly becomes an issue of 'am I going to listen to this teacher?' But if I say to someone, for example, 'I'm missing your input,' 'I haven't heard from you yet,' then I give them a different message. And then someone can decide for themselves like 'oh hey, how does that feel, that apparently people would like to hear my opinion?'" (F824)

Indeed, teachers have numerous direct and indirect strategies for engaging residents in the discussion. Encouraging one resident to participate may involve hinting to others that they keep their ideas to themselves for now, or explicitly soliciting an individual's view on the topic at hand.

Whether participation must always be active, verbal and extensive to be perceived as supporting learning and development is an open question. One teacher's strategy for engaging residents was to allow room for limited participation (e.g. only nonverbal), for example when something intense has just happened and spoken participation is too much. In the end, stimulating residents to participate is as much a question of monitoring what *each and every* person needs and brings as of creating *group* discussion.

Allow room for similar experiences. The group nature of discussion is also reflected in the third main strategy, which teachers can use to integrate individual experiences into a common theme for discussion. Some teachers disagree about the value of such integration, as it generalizes away from specifics that may well be crucial to the problem arising in that situation. Other teachers point out the importance of identifying a common, recognizable theme to create educational value for all. One strategy mentioned in both data sources is to *allow room for similar experiences*, for example by mentioning potential themes for discussion arising from the specific experiences shared in the group, or by formulating a lesson learned at the end of a case discussion. These approaches help to identify the common thread in the issue under discussion, normalizing a potentially problematic experience while simultaneously creating opportunities for learning beyond the individual case. This, in turn, contributes to learning and development for future situations.

Discussion

Our analysis of institutional documents and teacher interviews to identify goals and strategies used in collaborative reflection sessions at the GP training resulted in a detailed, practice-based description of the professional stocks of interactional knowledge for collaborative reflection. This description serves two purposes: it informs us about the *complex structure* of that knowledge base, and it highlights the centrality of *sharedness* as a feature of interaction that can contribute enormously to the learning and development that is seen as the goal of collaborative reflection.

First, the myriad goals and strategies reveal the dispersed nature of the knowledge base for facilitating collaborative reflection. While there is consensus about the main goals (for residents: to learn and develop; for teachers: to facilitate these processes) and shared strategies, within that framework variation prevails. This variation may clarify why so few have attempted to explicate knowledge on facilitating collaborative reflection. If we were to devise a normative guideline, we would need to survey best practices that worked in one situation and assume that these will work in similar situations, too. Given the complexity of the educational situation[6,21], however, what to do to what end in which situation cannot be set in stone – and probably never should be if we want residents to reflect and learn[22]. The knowledge base is therefore nothing more than a contextualized overview of options showing the *scope* of collaborative reflection practice.

Second, though varied, the professional stocks of interactional knowledge suggest that practices of facilitating collaborative reflection are mainly informed by an orientation on *sharedness*. Experiences are made accessible and relatable to others by extracting common themes for learning, and stimulating active participation by all residents is crucial to the reported teacher strategies. Active participation has the potential to propound multiple perspectives and diverse information, benefiting the reflective process[23,24]. By talking about recognizable issues, residents can also become aware of their position towards full membership of the

profession[24-27]. Such professional socialization[28] appears to be the ultimate goal of collaborative reflection, as revealed in our overview.

A number of considerations must be borne in mind when interpreting these conclusions. First, the overview of goals and strategies does not tell us whether strategies have the intended effects – although their origin in institutional instructions and teachers' practice suggest perceived usefulness. Also, the goals and strategies in this synthesis are formulated in institutes' and teachers' own words and with reference to specific teaching situations, the latter being an artifact of the video-stimulated interviews[29]. On the one hand, this provides the necessary detail[12] and places the knowledge base firmly in practice. On the other hand, it implies that parts of the knowledge base are difficult to relate to scientific educational theory – and, therefore, have only weak substantiation in current theoretical knowledge on stimulating and engaging in collaborative reflection. That is precisely why our approach has the potential to initiate a dialogue between scientific theory and practical expertise. Additionally, integration of the perspectives of institutions and individual teachers can create an arena for connecting formal, informal and hidden curricula[30,31].

The multitude of goals and strategies gives novice and experienced teachers a toolkit of practices to experiment with. In our own GP training setting, we will make the knowledge base available to individual teachers as a comprehensive resource for addressing particularly challenging situations (e.g. involving passive students in the discussion). We will also use the overview for designing themed teacher training, for example about the desirability[21] of potential courses of action towards identity development. More generally, a comparison between the interviews and the institutional documents shows that the latter should be updated based on current descriptions of the knowledge base.

Moving beyond teachers' reports, our next steps are, first, to describe residents' perspective on what elements of collaborative reflection create educational value, and second, to analyze recordings of collaborative reflection interaction to build a repertoire of teacher actions, and show how they are used as means to particular ends. Our description of the stocks of interactional knowledge for facilitating collaborative reflection serves as a starting point for such analysis[12], as it highlights key practices and issues and suggests how to deal with them in actual educational practice[13]. For now, our overview allows teachers to peek into one another's "toolkit" without being physically present and while remaining anonymous – a simple way to learn the trade[32].

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Appendix A

Table 3 Resident aims, teacher aims, and strategies to achieve those aims during facilitation of collaborative reflection.

Resident aims	Teacher aims that contribute to resident aims	Strategies
TO LEARN AND DEVELOP	TO FACILITATE THE LEARNING PROCESS	(don't) structure and stimulate the group process - (don't) check whether process matches needs of residents e.g. test whether people learned something from the process e.g. ask whether group wants to discuss something further e.g. ask what theme residents want to discuss at start of year e.g. stimulate individual learning process > stimulate residents to pick up a reflection issue in year 3 > ask about learning needs - monitor/set goals and results (content-wise) e.g. check whether goals (content) are achieved > ask 'what is your take-away? / what will you remember?' > ask what this discussion has brought for the resident > ask whether this discussion was enough/beneficial > close up (evaluate, stop) >> mention that we have to close the discussion >> (don't) close/cut off discussion if it is not finished >>> ask the case/story teller: 'what else would you like to tell/discuss about this?' >> be alert to closing signals e.g. monitor level/progression of discussion e.g. analyze what's happening (if discussion does not run smoothly) e.g. focus > set boundaries > steer discussion back to teller/concrete situation discussed >> ask for reaction from teller on contributions from group > ask a structuring question >> ask for pro- and contra-arguments > put topic/contribution on hold if it is unrelated to issue at hand e.g. listen whether content of case/story is clear e.g. clarify question > check question/reason for telling case/story > ask 'what is your aim by bringing this case/story in for discussion?' > ask 'what is the reason that you bring this in for discussion?' > ask 'what is your question?' > by proposing potential issues to discuss > search for the issue that is most 'pinching'/the hook

e.g. set the agenda
> let the group structure/determine agenda (tempo/topics)
>> let a resident chair the session
> time management
>> start with announcements
>> leave room for practical issues (if necessary)
>> social talk prior to sessions to eliminate hindering factors
> individually discuss case/story with resident if something unclear/unsolved
> alternate intense themes/stories with lighter ones (e.g. anecdote)
> postpone a case/story to the next session
> go through the agenda of the day (prior to start of the session)
> propose plan/method for discussion
> make an inventory
>> stimulate as much as needed to get adequate picture of case/story during inventory phase
>> stimulate residents to formulate question/reason for telling
>> make an inventory using themes (e.g. collaboration)
>> (don't) ask to share content of case/story in one line
>> make inventory by first discussing week in twos, then share one issue for discussion per two
>> make inventory of everyone's first patient last Monday
>> ask who wants to bring something in for discussion
>> make inventory using adjectives (surprising, emotional, irritating, fun, intense)
>> give some time to think of something to share at start of session
>> (don't) prioritize shareables
>>> (don't) prioritize using red orange green
>>> prioritize by using a b c (variation on red orange green)
>>> prioritize by asking to score shareable on importance (0-10)
>>> prioritize by urgency
>>> prioritize by having residents with low participation go first
>>> prioritize based on way of presentation (emotional?)
>>> appoint someone to be the first to share case/story
>>> don't prioritize by asking 'who wants to start?'
>>> prioritize by having the group choose order
>>>> confer with group what to discuss first if all cases/stories to tell are red (urgent)
>>> prioritize update/feedback on cases shared earlier
>>>> ensure update/feedback on cases shared earlier go first
>>> prioritize in order of people saying they have something to share
>>> prioritize in order of seating

Table 3 Continued

		- post-discuss the session as teachers - discuss/align as teachers pre-session e.g. task division between teachers e.g. give room to other teacher to contribute in their way > solicit participation of other teachers (give turn/task) use theory - use the communication triangle - use paradox of change law (confirm someone's situation, that invites their own solution/advice) - use Kolb's circle of reflection use yourself as a measure (if you feel a certain emotion, others might too) - model reactions/contributions to discussion - share one's thought process use humor listen carefully write something down - initiate/stimulate variation in tools/ways to discuss - (don't) evaluate the used method of discussion/way discussion went/tool - situation trigger question - discuss case/story/experience just shared in twos - gossiping - something to be proud of and something to learn about / tip and top - everyone asks 1 question, person telling story/case chooses which questions (s)he is going to answer - everyone gives a tip - do an experiment/role play (what would you say to someone in your situation?) - everyone makes a wish for someone who has just told/experienced a heavy/intense story - thematic discussion e.g. ask which patient has stuck with you/do you still remember e.g. ask about things that went well or which you are proud of (positive incident mentioning) e.g. ask about learning moment that you would like to redo motivate residents to apply discussed issues in practice adapt to residents' world - take the temperature (measure how everyone 'is' today) - ask about current issues (difficult as well as easy ones) - adapt to terminology and way of thinking used by GPs (e.g. as a psychologist) - GP teacher transforms psychologist question to GP-relevant one - make contact prior to start of session to initiate a social learning environment - slow yourself down (don't move on too quickly) improvise, adapt to what is happening - stimulate spontaneity and liveliness e.g. strengthen what happens by hooking onto it

	to have everyone participate in reflection	guarantee active participation of residents - welcome a participant who comes in late and tell them what the group is at right now - limit one's own contribution to let residents have turns e.g. not have the first turn talking e.g. not do much (few teacher interventions) > dosing interventions > by leaning back in chair > leaving something/let something go (e.g. if you suspect it won't help the learning process) - have residents talk with each other instead of only with teachers e.g. take different seating positions as teacher / not have a seat next to each other as teachers e.g. make no (eye) contact with resident (to show that you are not available for input) e.g. hand gesture to signal to resident to tell the group, not the teacher - stimulate to make use of the group e.g. stimulate to try something out in the group - engage other residents e.g. stimulate group to provide input (not the teacher) e.g. ask for reactions of others > ask whether other residents recognize something > non-verbally invite residents to participate >> open palm to group >> look around >> (don't) give a turn > ask others 'what is the main thing you hear in this story?' - have everyone have their turn e.g. have everyone bring something in in seating order e.g. (don't) interrupt people who have long/many turns at talking e.g. give less room to frequent tellers/contributors e.g. don't force someone to contribute (telling/discussion) e.g. give silent resident room to participate > give turn > solicit reaction >> tell silent resident 'I miss you'/'I haven't heard you yet' > stimulate silent resident to contribute more (e.g. in individual mentor conversation) > leave room for someone to not verbally participate (e.g. if something has happened) - monitor non-verbal signals from group e.g. look around in group - don't intervene right away when group goes silent e.g. endorse/maintain a short silence (to let something settle in) e.g. prevent other residents to fill up silences - stimulate to bring in cases/stories/experiences e.g. ask 'so you haven't been at work last week?' if nothing is brought up for discussion e.g. stimulate residents to come to session with something to discuss

Table 3 Continued

	to integrate cases/stories (to be) told into a theme	(don't) provide room for similar experiences - thematize case/story told e.g. don't mention thematic relation between two cases/stories/experiences without doing something with it - mention potential themes for discussion during discussion - pick up on passing theme in telling, which is not in focus - formulate collaborative learning uptake at end of session
A. to work on almost all goals of GP training	to gain insight into relevant themes/areas of development of residents - to distill themes for future education - (not) to evaluate - to update	 to assess use reflection situations in assessment conversation ask everyone to give an update of the independent practice week
B. to develop professionally		
B1. to develop one's identity - to learn to discuss experiences that are important in your development as GP * to discuss and learn to deal with mistakes * to discuss successes * to discuss issues concerning training situation (GP trainer, learning path) - to become part of the profession * to explore the world of the GP(in training) * to learn to recognize own identity within professional identity # to learn to take more freedom to make own choices # to form own opinion - to get to know oneself		 stimulate teller of case/story to ask question to the group that stays close to self make mistakes discussable e.g. label mistakes positively e.g. invite group to collaboratively learn from mistakes ask about successes/fun anecdotes stress that positive experiences may also be brought up for discussion stimulate to explore task description of GP
B2. to develop professional skills	to show residents expert examples of professional behavior	be a role model e.g. (don't) bring in own experience e.g. use duo teachership as tool

- to develop communication skills		
* to develop advice-giving skills		
* to train to deal with conflict		
* to practice consultation skills (e.g. question clarification)		
* to develop feedback skills		stimulate feedback giving between residents according to feedback rules
* to learn to ask difficult/critical/emotional questions		ratify questions/interaction between residents e.g. come back to/address valuable contribution that was not picked up in discussion stimulate listening attitude e.g. stimulate residents to not foreground themselves in contributions that are to help others by asking 'what is your question to the teller resident?' e.g. cut off judgments e.g. make sure advice is not given too early e.g. put a question/response of another resident on hold e.g. provide a nuance / transform a contribution (e.g. from statement to question) stimulate to ask questions about core topic of discussion stimulate to ask open questions
* to learn to chair		
- to develop social skills		
- to learn to be open to other perspectives and understand these		
- to develop assertiveness	- to promote autonomy	stress agency of residents e.g. "you can CHOOSE, you don't HAVE to do something"
C. to consult peers/peer learning		
C1. (not) to get answers/advice/solutions	- give residents (content/process) feedback	ask for clarification of the advice given by residents correct (e.g. miscommunication) nod give a compliment encourage weak participants, slow down over non-confident participants use reactions of group to address emotion e.g. mention something you notice (e.g. agitation) formulate feedback as general feedback, not addressed at one individual give feedback by formulating it as your own feedback as teacher
- to learn to provide content in discussion		give non-teller resident feedback on their contribution (e.g. question, advice)

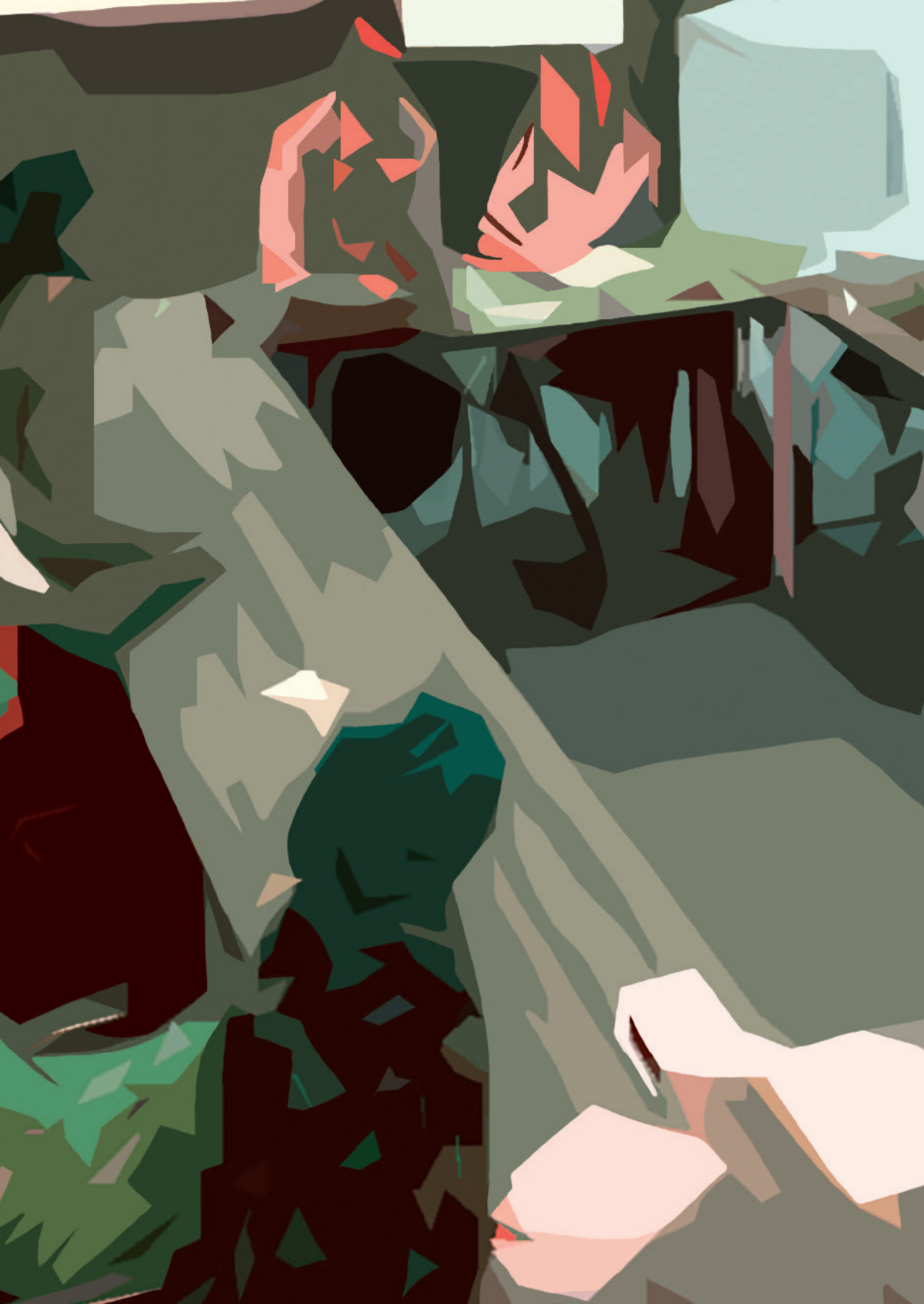
Table 3 Continued

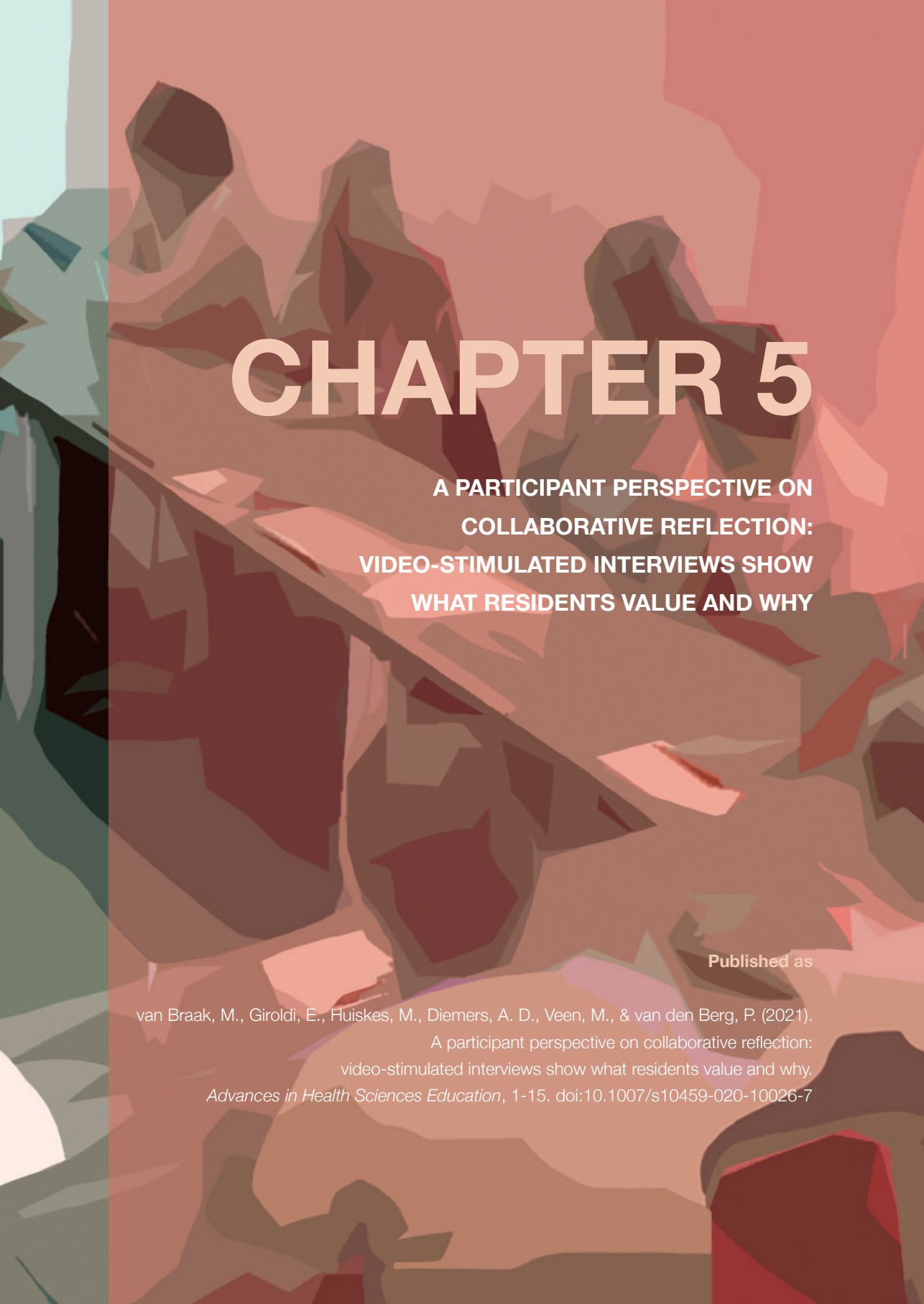
- to learn to use peers to find a solution	- to let residents find a solution on their own	provide room for exceptional medical cases use expertise of residents return question to the group return question to the one asking the question stimulate residents to ask for clarification of questions by other residents encourage resident to say what they themselves want (don't) provide content (solutions, tips, advice) e.g. (don't) bring in own expertise e.g. (don't) stress an important insight/advice/solution/etc. by resident e.g. consider whether a teacher contribution is functional (if only interesting for teacher, then don't intervene) > don't engage with blind spots and favorite topics of teacher e.g. (don't) interpret e.g. (don't) have residents look something up and get back to it next time e.g. bring in another perspective
* to learn from others' practice experiences by exchanging experiences		
- to formulate an action plan		
C2. to search for/provide (emotional) support	- to provide guidance / a hold to survive / cope in internship	make emotional connection provide room for feelings e.g. notice and ask about emotionally laden words e.g. ask about feelings e.g. give emotional reflections e.g. ask whether discussion of a case/story actually has more priority than resident indicates e.g. pay attention to (visible) emotions support, help
- to search for/provide recognition/ acknowledgement/ understanding		
C3. to provide a frame of reference / to normalize		(don't) comfort resident give confirmation (from GP experience, expert opinion) test against norm
- to normalize bizarre/complex/difficult situations (e.g. unexpected death)		
- to gain confidence in own competences		enhance resident confidence (in own competence/conduct) "strengthen" resident by encouraging, positive evaluation
C4. "to meet"		
D. to (learn to) reflect		(don't) explicitly discuss/let residents experience importance/value of reflection stimulate reflection

D1. to free space to for new learning experiences - to vent steam/to spout - to share wonder - not to just tell an experience/babble along		
D2. to mention and use points for learning	- to recognize patterns in stories told/ reactions	
D3. to discuss learning goals of supervision/ connect experiences to supervision		
D4. to give meaning to conduct or situations		
D5. to learn to connect subjective experiences to others'		
D6. to become aware of one's own conduct	- to 'hold up a mirror'	stimulate awareness of own conduct/attitude e.g. pause discussion, slow down
D7. to reflect on actual situation (no abstract discussion) - to gain insight in a situation * to discuss how you feel, think, act in a situation * to increase insight into thoughts/feelings/conduct of patient * to gain insight in communication between you and patient * to discuss different perspectives on the situation		 stimulate to make situation more concrete e.g. explore > ask questions >> ask open questions >> (don't) ask questions with suggestions for answers (own ideas) >> (don't) question/dig deeper e.g. ask for clarification e.g. repeat a word to invite someone to elaborate e.g. concretize by asking for meaning of specific word that someone uses > " 'holding back', what does that mean for you?" > address uses of "to try" by asking "did you do it? if not, why not? if yes, why did you fail?" e.g. steer and ratify explorations stimulate to take a different perspective bring various perspectives to the fore deepen the discussion

Table 3 Continued

D8. to deepen experiences		connect theory to an experience
D9. to connect practice experiences and theory		
D10. to learn to question oneself		
D11. to present one's vulnerability in a safe learning climate	- to create safety	introduction to each other at start of the group give room to residents to indicate own limits (during discussion) e.g. ask resident whether they want to discuss something in the group (invite to) come back to something in the next session check how a response is received by a resident create open/informal atmosphere e.g. make non-verbal contact with residents > position teacher chair such that teacher is directed toward resident e.g. prepare tea do not judge, respect each other's contribution/opinion e.g. discuss breaching of rules concerning safety, respect, etc.





CHAPTER 5

A PARTICIPANT PERSPECTIVE ON COLLABORATIVE REFLECTION: VIDEO-STIMULATED INTERVIEWS SHOW WHAT RESIDENTS VALUE AND WHY

Published as

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Abstract

The potential of reflection for learning and development is broadly accepted across the medical curriculum. Our understanding of how exactly reflection yields its educational promise, however, is limited to broad hints at the relation between reflection and learning. Yet, such understanding is essential to the (re)design of reflection education for learning and development. In this qualitative study, we used participants' video-stimulated comments on actual practice to identify features that do or do not make collaborative reflection valuable to participants. In doing so, we focus on aspects of the interactional process that constitute the educational activity of reflection. To identify valuable and less valuable features of collaborative reflection, we conducted one-on-one video-stimulated interviews with Dutch general practice residents about collaborative reflection sessions in their training program. Residents were invited to comment on any aspect of the session that they did or did not value. We synthesized all positively and negatively valued features and associated explanations put forward in residents' narratives into shared normative orientations about collaborative reflection: what are the shared norms that residents display in telling about positive and negative experiences with collaborative reflection? These normative orientations display residents' views on the aim of collaborative reflection (educational value for all) and the norms that allegedly contribute to realizing this aim (inclusivity and diversity, safety, and efficiency). These norms are also reflected in specific educational activities that ostensibly contribute to educational value. As such, the current synthesis of normative orientations displayed in residents' narratives about valuable and less valuable elements of collaborative reflection deepen our understanding of reflection and its supposed connection with educational outcomes. Moreover, the current empirical endeavor illustrates the value of video-stimulated interviews as a tool to value features of educational processes for future educational enhancements.

Introduction

Reflection education plays a key part in medical curricula of all sorts: from basic medical training to medical specialist training to continuous medical education for accomplished professionals (Hellermann 2009; Sandars 2009). Reflective activities in medical education take their importance from the assumption that reflection fosters learning, which renders competent professional behavior (Aronson 2011; Sandars 2009; Schei et al. 2019; Wilson 2020). Yet, this assumption is not consistently buttressed with empirical evidence: the efficacy of reflection for learning and professional development varies between studies and contexts (Sandars 2009; Uygur et al. 2019). Evidence for long-term positive effects on professional development is limited (Mann et al. 2009; Sandars 2009), but reflection has been shown to increase learning and professional development in the shorter term (Sandars 2009) and in specific contexts, such as complex patient cases (Mann et al. 2009; Sandars 2009).

In this paper, we describe *in participant terms* the educational value of particular features of the interactional process which constitutes the educational activity of collaborative reflection. Participant perspectives on the value of educational activities that are supposed to facilitate or foster reflection have been described as a valuable resource for understanding "how reflective learning within the curriculum can be better developed to increase engagement from learners" (Vivekananda-Schmidt et al. 2011, p. 1). To date, however, reports of what participants value in collaborative reflection are still uncommon. Studies describing participant perspectives mainly focus on students' perceptions of the *effect* of reflection on learning and development, not the *mechanism* that explains the relation. In research across the medical curriculum, students report that written reflection exercises improve their skills to formulate learning needs, integrate knowledge from different sources (Grant et al. 2006), and learn from experience (Larsen et al. 2016). Also, these exercises allegedly raised awareness of the students' learning (Larsen et al. 2016), boosted their confidence about already present knowledge and skills (Grant et al. 2006), and provided support and encouragement (Özçakar et al. 2009). As for peer reflection sessions, these have been reported to train students' skills in challenging and supporting others' views, improve their readiness for practice (Green 2002), reduce stress, improve patient care, and stimulate professional development (Lutz et al. 2013). Reflective activities are generally rated positively, but some researchers have reported students' evaluation of reflection as an unnecessary burden (cf. Vivekananda-Schmidt et al. 2011; Murdoch-Eaton and Sandars 2014; Veen et al. 2020). In summary, participants appear to value reflection for its various effects on learning outcomes, but are also critical of the investment required to achieve that value.

Findings on the perceived effects of reflection illuminate its potential benefits and pitfalls for learning and development. Yet, they shed no light on the mechanisms that explain *why* reflection contributes to learning. Other than data on general characteristics of reflective activities that appear to be valued (e.g., peer support in collaborative reflection sessions (Chou et al. 2011) and facilitation of reflective processes (McEvoy et al. 2016), we lack empirical data on the actual

mechanisms that lend reflection its educational promise. Yet, those mechanisms are crucial in determining what works for whom and in which circumstances (Giroldi et al. 2014; Wong et al. 2012). This knowledge is the cornerstone of medical curricula to promote reflection and of teacher training to facilitate reflection. In our study, therefore, we explore participants' views on the value of an educational activity of which the aim is to collaboratively reflect on professional practice (van Braak et al. submitted). We focus particularly on their views about the *mechanisms* that explain why certain aspects of the activity do or do not create educational value.

Methods

Data collection

We conducted video-stimulated interviews with residents participating in 24 recorded collaborative reflection sessions from all eight general practitioner (GP) training institutions in The Netherlands. During weekly sessions scheduled throughout their three-year GP training program, small groups of 5–15 GP residents collaboratively discuss experiences from practice (Veen and De la Croix 2017). The sessions typically last 1–1.5 h and are facilitated by one or two teachers (an experienced GP and/or a behavioral scientist or psychologist), whose task is to facilitate reflection for professional learning and development. This type of collaborative reflection sessions originates from Balint group meetings, during which professionals "explore difficult interactions with patients through case presentations and discussions" which "broaden their perspective on the initial difficulty they experienced, and can influence their overall perception of their practice and interactions with patients" (Van Roy et al. 2015, p. 686; Balint 1955).

We selected sessions for recording using maximum variation sampling over the eight Dutch GP vocational training institutes and year of GP training program (see Table 1). All residents and teachers of the recorded groups gave written informed consent. On the informed consent form, residents could agree to do a video-stimulated interview and, eventually, 31 residents were interviewed within two weeks of the recording (see Table 1).

Interviews were conducted between May 2017 and January 2019 by two authors (EG and MB) who were not involved in the design or teaching of collaborative reflection sessions, giving them a relatively neutral stance to the educational activity. As anticipated, their 'outsider' role created a safe environment for residents to express their potentially critical opinions of the recorded sessions. Interviews followed a pilot-tested interview protocol (cf. van Braak et al. 2018). Participants gave written informed consent prior to the interview. During the 45–60 min. interview, residents were asked to select for reflection a part of the recorded session that was in any respect noteworthy for them. The interviewer instructed the resident to comment on any aspect of the viewed recording that they had experienced as positive or negative. Residents were encouraged to stop the recording and start talking whenever they wished; they were

prompted only minimally (van Braak et al. 2018) to minimize researcher influence on what was evaluated. Interviews were audio-recorded for transcription, during which recognizable personal and institutional information was anonymized. Ethical approval for this study was obtained from the Ethical Review Board of the Dutch Association of Medical Education (NVMO), dossier 829.

Table 1 Overview of recorded groups and interviews conducted per year/ institute. Each recording is denoted by an x, followed by the number of interviews about that recording.

	Year 1	Year 2	Year 3	**Total**
Institute A	x (1) x (1)	x (1) x (1) x (1)	x (1) x (1)	**7 (7)**
Institute B	x (2) x (1) x (2)	x (1) x (1)	x (2)	**6 (9)**
Institute C	x (2)	x (2)	x (1)	**3 (5)**
Institute D	x (1)	x (2)	x (1)	**3 (4)**
Institute E	x (1) x (1)			**2 (2)**
Institute F			x (2)	**1 (2)**
Institute G	x (1)			**1 (1)**
Institute H		x (1)		**1 (1)**
Total	**10 (13)**	**8 (10)**	**6 (8)**	**24 (31)**

Analysis

Residents' narratives (Gee 2014) elicited in the interviews were analyzed by MB, MV, and EG using Template Analysis (King 2012) in Atlas.ti. Template Analysis is a thematic coding approach that—other than, for example, grounded theory—allows researchers to take a "contextual constructivist stance that is sceptical of the existence of 'real' internal states to be discovered through empirical research" (King 2012, p. 418). This affordance, as well as its flexibility in developing a coding structure based on a priori and deductively established codes (i.e., the template), particularly suits our research aims.

EG and MB first pilot coded one interview to decide the unit of analysis and get a feel for a possibly useful coding template. They decided to proceed coding by identifying all interview fragments in which participants displayed a norm about an aspect of the reflective discussion interaction (i.e., reflected on the value or lack of value of that aspect). Each identified interview fragment would be coded using three coding categories established a priori: the object (what is seen as valuable or not valuable), its valence (whether it was seen as valuable, not valuable, or probably ambiguous), and the mechanism (why the object would contribute to educational value

or not). These categories constitute the basic structure of the coding template, which could then be flexibly applied to the remaining interviews. MB coded all remaining interviews. MV double coded every fifth interview, after which MB and MV conferred for consensus; codes in already coded interviews were adapted accordingly.

Following this initial coding round, MB merged the overlapping codes and organized the resulting codes into central themes (e.g. structure, safety) while preserving the connections interviewees had made between positively and negatively valued aspects and mechanisms perceived to account for this value or lack of value. Building on the central themes, MB and MH then identified the norms underlying the ascription of value or lack of value to particular aspects of discussion. The findings presented below are a synthesis of these shared normative orientations (Maynard and Heritage 2005)—"normative rules" that "both define what immediate ends should and should not be sought, and limit the choice of means to them in terms other than those of efficiency" (Parsons, as cited in Hamilton 1985, p. 62).

Results

In the interviews, residents discuss valuable collaborative reflection sessions in terms of providing *educational value for all*. In the residents' discourse, *inclusivity and diversity*, *safety*, and *efficiency* are key norms that are perceived to contribute to the sessions' main goal of educational value for all. In the following, we first elaborate on that goal, then discuss the normative orientations that supposedly contribute to it. Finally, we present the residents' views on the value of activities and contributions to ongoing reflective interaction in light of the normative orientations. See Table 2 for a summary of the findings.

Table 2 Summary of the main findings: participants' perspectives on collaborative reflection sessions

Main aim is to achieve educational value for all	
Norms that are perceived conditional to creating educational value for all	1. Inclusivity and diversity 2. Safety 3. Efficiency
Activities that contribute to these norms (per phase)	*Telling*: create telling space; share tellable and discussable stories *Exploration*: structuring to focus on main issue in telling; room to 'feel out'; diversity of questions *Discussion*: dive deeper into potential causes, explore possible directions, hint at solutions; leave room for group process; monitor and jump in as expert when needed *Conclusion*: summarize uptake/'learnable'

Collaborative reflection: aim

Residents consistently addressed a common benchmark for good collaborative reflection: "educational value for everyone" (interview F803). This value is represented as a 'layered' value, constructed throughout the reflective discussion in three concentric circles (Fig. 1).

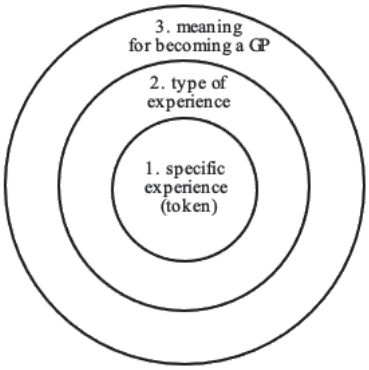

Figure 1. Graphic representation of the multiple layers of value derived from case discussions in the collaborative reflection setting.

Building on a *specific experience* shared by one individual (circle 1), the group should treat the experience as a token of a *type of experience* (circle 2) that is recognizable as a relevant and *meaningful* issue that carries a sense of urgency *in the process of becoming a GP* (circle 3). For example, a resident may share an experience of a difficult patient contact (circle 1), which is treated as a token of a broader interactional dilemma such as discussing a difficult matter with a patient while not damaging the relation of trust with the patient (circle 2). This is ultimately discussed in the context of being a GP, who has to be able to say things that either would not be said or would be very delicate to express in daily life (circle 3). This token-type relation allows for educational interaction that serves both the individual who experienced the situation as well as others who might have had or will experience similar situations. Talking about what happened may seem a tedious practice at first and a long shot toward professional development, but it is perceived as carrying a significance that highlights the unique quality of the participants' current situation in training: "a luxury position that you won't have once you've graduated, and […] this is the time to use it" (D700). Ideal collaborative reflection discussion, thus, is relevant for the practice of multiple participants beyond the here and now.

Though the importance of achieving educational value is widely shared, the interviews display residents' disagreement about the nature of this value. Some appreciate the value of obtaining new knowledge, a solution to a problem or advice about an issue. Given their comparable situations, residents can relate to each other's issues, which increases the perceived

value of their advice. Others, though, regard many discussions as "too solution-oriented" (C811). They value the significance of recognition by "peers who are in the same boat" (D753). Its relativizing and reassuring potential, in their view, might benefit long-term practice more than solutions or advice do. For some, sharing is already valuable enough as an activity in itself. It helps to organize one's thoughts or just "get things off your mind" (D753) with the group merely functioning as a sounding board. This is one of the main points in which residents' views diverge: should collaborative reflection discussion carry value beyond the sharing? Mostly, yes. As one resident put it:

> I don't really like it when it's just venting for the sake of venting. […] I really think it should produce, you know, a return on learning, that you get something out of it (D753).

Another view that residents consistently express is that it is not enough for the reflective discussion to *have educational value,* but that value should also apply to *everyone* present. Summarizing a session they attended, one resident commented on its value for the group members:

> Yes, for [name of one resident] personally, I think it had [value], but for the group, I thought, it wasn't the most clarifying of sessions. Last week's session was, I thought, far better because [then] many more people brought up their personal issues (E821).

The resident quoted here distinguishes personal benefit from group benefit, characterizing the limited value as a lack of clarification. In contrast to the session currently discussed, last week's session featured many more people's personal input—which supposedly contributed to its educational value.

Collaborative reflection: norms

To realize *educational value for all*, collaborative reflection interaction should, according to the residents, be *inclusive and diverse*, *safe*, and *efficient.*

Inclusivity and diversity. In residents' talk about the collaborative reflection sessions, the bottom line for creating educational value is for something *to be brought up* for discussion. If issues go unshared, stories remain untold, responses are withheld, turns are passed, what can be learned? Residents orient to a norm of inclusive participation: everyone should get the chance to bring something up for discussion and contribute to the discussion of what is brought up. Only in that way is value created for all, as one resident explained:

> Sometimes I'm rather passive, because then I think, well, I just can't do it. I won't yell over other people's voices. Um, yeah, it differs quite a lot, actually. Some days I'll do my

> [best]. Some days I'll find my story really important and then I'll stand up for [myself]. Then I'll always try to speak up. But, um, yeah, I think that […] sometimes I find it hard to find the space for that. Mostly it's the same people […] who probably benefit more from the exchange [of experiences] because they have more turns (C808).

Standing up for one's right to have a turn, as this resident puts it, may be one way of obtaining a turn, but residents also value the shared responsibility of all participants (including teachers) to distribute turns fairly. Both overtly active and apparently passive participants should learn to dose their participation in the group discussion. A variety of participants creates a diversity of perspectives, which the interviewees evaluated as beneficial to the learning process. Importantly, though, residents do not like being forced to participate, as compulsory contribution may reduce authenticity and compromise a safe learning environment, which in turn depreciates the educational value.

Safety. Related to the norm of inclusivity and diversity is residents' orientation to 'safety', that is "feeling safe [enough] to bring up something for discussion", "to not turn on each other", "to be able to say things to each other respectfully, even the less pleasant things" (B870). Participants regard a safe learning environment as one that allows non-judgmental interaction that encourages vulnerability and openness. In such an environment, everyone respects each other, including possibly opposing, idealized, unorthodox views and whatever situation they are in. Creating a safe learning environment, many residents comment, is a co-construction of teachers and residents. Residents see it as the task of the *teacher* to treat mistakes as learning opportunities, not as evidence for low assessment. *Residents* can contribute to a safe climate by welcoming others' viewpoints and opening up about personal issues relevant to becoming a GP. Teachers can validate such displays of vulnerability by complimenting residents who do so for the example they set for others in the group.

Efficiency. Inclusivity, diversity, and safety could be interpreted as a wildcard for long and deep reflection sessions. Residents, however, stress the importance of efficient discussion. Probably in parallel with their professional practice, they appreciate interactional behavior that promotes progression toward the educational end in terms of pace and 'depth' of discussion. Such progression requires structured yet dynamic interaction, which is mostly perceived as the teachers' responsibility. Teachers' contributions are weighed for their potential to spur discussion to higher levels and time-efficient processes. One resident, for example, rated a certain teacher's "intervention" (raising a new subtopic) as "a very good contribution" (A823) because it smoothed the interactional process and reopened the discussion about an issue that was relevant both to the case in question and everyone else's practice too. Doing this, the teacher created educational value for everyone.

Residents value various other ways to create efficient discussion. In their view, residents themselves can contribute to efficiency by posing leading questions or raising an issue for discussion. The group should help define the issue if it is still unclear for the resident speaking. These actions focus the discussion onto the main point of value for residents and allows an issue to be generalized from a specific situation to something recognizable to others. To enhance efficiency, teachers should make a list of cases to be discussed at the start of the session. This allows for proper time management and provides clear reasons for cutting short long stories. If the conversation trails off, teachers should turn the focus back on track to the main issue, thus serving the educational end of this particular discussion. The following comment from a residence underscores the importance of this tactic:

> Yes, here we're going back to […] the very practical, um, almost in the direction of giving tips. But just before this [happened], there was this nice interaction where [a resident] said, 'You know, I'm scared of what others think of me.' And then I think, yes, but that's where you [the teacher] can draw the line again. Then I think, ah if only you [the teacher] intervened at this point, we could keep it going and also, I think, go quite a bit deeper. But now a question pulls it from the deep back up to the superficial and then I think oh, what a pity. […] It was going so smoothly just now. […] It's a shame, that in the group or that a teacher, you know […] I think that if this point were taken up […] then you'd get there much faster, because it can take ages at times (C811).

Though structuring is generally valued for contributing to efficient interaction, it can backfire by cutting short extensive exploration and dynamic detours in unpacking complex cases. Fixed procedures "remove all spontaneity and the learning curve, too" (B859), much like teachers intentionally withholding guidance leaves residents "swimming" (A831) for unseen shores. According to the residents, dynamic structuring nudges interaction efficiently on course toward value for all.

Collaborative reflection: activities

Residents' normative orientation to *inclusivity and diversity*, *safety* and *efficiency* in accomplishing educational value for all is reflected in their perceptions of the value of activities that take place in the various phases of interaction: telling, exploration, discussion, and conclusion. Most attention (in terms of time spent in the recorded sessions and interview time devoted to it) is paid to the discussion phase. Telling and conclusion tend to be short phases, although the telling phase can be extensive if a resident's aim is to vent whatever is on their mind. The conclusive phase considers all phases relevant to educational uptake.

Telling. According to one resident, the potential of the telling phase is determined by the space it is allowed. Telling a story is an interactional accomplishment that requires a longer stretch

of talk—ideally uninterrupted. As residents point out, interjections may contribute to efficiency by shortening verbose tellings, but at the same time undermine the functional freedom to take and be given "the space to vent anything and everything you want to share" (B851). Everyone else "shuts up and listens" (G856), withholding questions, opinions, advice, and judgments for later phases, thus constituting inclusivity and safety as the teller proceeds.

For a telling to have educational value, residents point to the importance of the 'tellability' and 'discussability' of the story. Not all experiences provide 'tellable' stories—in the sense that they have a point—and not all tellable stories are 'discussable'—in the sense that they either open up the grayish floor between guideline-white and unethical-black or induce a stirring of emotion ("at some point, everyone gets triggered here", C806), betraying the participants' relation to the issue at hand. Against this norm, bringing up purely medical or procedural questions has limited value for some:

> I think we either get to the solution very fast, […] following the guideline, or people have their own opinion and, yeah, they don't change [that] easily. That sort of stays the way it is (G856).

Yet, stories on straightforward medical topics are sometimes considered tellable for their uniqueness ("most likely, others haven't come across this either", A715), which could make them perfect learnables to share with fellow residents. Whatever the topic, therefore, stories become *tellable* and *discussable* for residents whenever the stories address something that carries an urgency or relevance in terms of professional standards and competent practitioner behavior. Discussing that topic would contribute educational value for all the future doctors present.

Exploration. Following a resident's telling, participants usually ask for clarification, probing for additional information or to determine of which 'type' this experience is a 'token'. In residents' words, clarification helps to understand "how we can best help you" (G856) in the search for answers, recognition, or whatever is expected from this case discussion. In this phase, "directed, continuous attention to uncover the aim" of this telling is valued highly by several residents. As one resident observes, such attention directs the focus in complex stories and contributes to a useful learning uptake for the teller. Residents acknowledge the difficulty and importance of striking a balance between inclusivity/diversity and safety on the one hand, and efficiency on the other. One resident explains,

> The one says this, the other says that, and in a way that's very positive. It ensures safety, and it's natural conversation, but to be a bit more constructive and time-efficient, it'd be good if once in a while someone called out, what's your question? (B869).

Structure, thus, is considered essential in this phase.

According to several residents, a huge upshot of this phase is the information it gives about how far the teller wants to disclose themselves. Exploration allows the group to "feel out" the teller (G856), while the teller is allowed to set limits. Taking enough time for "edging" toward the possibly emotional core of the issue instead of "going smack bang" into it (G856) can be functional, even if less efficient:

> If you go in directly with 'what does it do to you?' then it's rather confrontational. You may need some kind of detour to get more comfortable in that setting" (C811).

Evidently, efficiency should sometimes be subordinate to safety in this phase.

Residents' evaluate the variety of exploratory questions that may be asked positively, turning to the importance of diversity for promoting understanding of the issue at hand:

> Just like [name of fellow resident], who asked, 'What [kind of] help does she [the patient] actually want?' Well, I wasn't thinking about that at that point. So that again is an eye opener. And now I realize that, yes, wait, in this case the problem is […] (A823).

The posed questions reflect the diversity of perspectives other residents may have: "very many different characters, people who react differently and have different ways of being a GP" (B859). Diverse contributions foster "good dynamics" and stops the group from "spinning its wheels [i.e. wasting time]" (B859), which again shows the residents' orientation to progress and efficiency.

Discussion. Usually, exploration naturally evolves into discussion, a much commented on phase in the interviews. According to the residents the discussion phase is where individual cases should be treated as tokens of a type by transforming the specific issue into a collectively relevant learning issue. One resident reported: "Here we're all thinking, oh this could happen to me too. What can we learn from this case to prevent it happening?" (A831). Highly valued contributions dive deeper into the issue to suggest potential causes, explore possible directions, and hint at solutions. Residents may share similar stories, which may function positively as a display of recognition and trigger a sense of 'we're all in this together', but can also divert the conversation onto a side-track with no added value. Still, those stories signal the relevance of the discussed issue to another resident, a factor valued as a marker of inclusivity and a clear benchmark of value *for all*.

Teacher participation is regarded as indispensable in the discussion phase. Although too much interference is unwanted, residents expect teachers to monitor the discussion for 'no go's' and to comment on unprofessional behavior. If they do not, one resident explained, "it would be like a GP who's been in the business for years is approving it [unprofessional behavior]" (A831). Also, residents expect teachers to lead the discussion to topics they know to be important from first-hand experience:

> Yes I do expect a teacher… what I really appreciate about these teachers is that they do lean back a lot and let things happen and also trust that we will be able to question each other and get somewhere. Um, but still, he [the teacher] is the hands-on expert. So, at some point I do want to know from him, yes, how does it work or how do you do that? […] Yes, that's what he's here for, isn't he? (C811).

This resident points out two teacher behaviors that enhance educational value in this phase: (1) leave room for the group's process (which may be less efficient than strictly structured discussion directed straight at the learning issue), and (2) monitor the conversation and jump in with expert knowledge (the voice of experience) when needed. Both behaviors are presented as contributing to the group's learning process.

Conclusion. In this final phase, residents value a teacher's summary that highlights the 'learnables' of the discussion. This builds educational value for all, as it creates an opportunity to "collectively draw a personal note, the lesson from it" and also emphasizes any message of importance for the teller (A845). These summaries may be provisional, not intended to strike the final blow on *the* solution or outcome, but rather to call everyone's attention to the seeds that have been sown in the attempt to grow toward professional standards. Ideally, *each* resident present—perhaps the teachers as well—would find something *valuable* in each discussion. It could be a concrete solution, but an abstract 'nudge' or 'setting in motion' with long-term effects is more likely, according to this resident:

> She's been asked so many questions that I assume she'll have to keep on processing [for a while]. The group doesn't have to give the answer. With all the questions she's been asked, she could come across someone, and then she might think, 'hey, that fits me precisely' or something. I think we can set things in motion right here, or get things going and let it go on outside [the group]. To put it bluntly, I think it seldom happens… you might be able to use a tip from the group, but things are so personal that to really make it fit, even more so when it concerns very personal things, that almost never happens (C811).

Whatever it may be, then, if you "get something out of it" (D700) either now or in the future, the discussion has proved its merit.

Discussion

Based on our qualitative analysis of residents' narratives in reflective video-stimulated interviews, we synthesized shared normative orientations on value in collaborative reflection

sessions. Residents describe the potential of collaborative reflection sessions as a concentric construction of educational value for future practice for all. In their views, *inclusivity and, diversity*, *safety* and *efficiency* are necessary for transforming unique experiences into tokens of recognizable issues that are meaningful to discuss in the face of future practice. These norms guide their assessments of specific teacher and resident behavior throughout the case discussion.

Our findings suggest three main features of the collaborative reflection interaction that contribute to educational value for all. First, the collaborative nature of the interaction. The value of *group* interaction resonates with extant reports of narratives of students and residents about the value of collaborative reflection on practice experiences (Chen and Hubinette 2017; Zou et al. 2019). The group setting allows residents to *collaboratively* construct individually relevant 'learnables' (Koschmann et al. 1997; Veen and de la Croix 2017) that integrate diverse views on professional practice. The educational potential of such dialogic environments of shared meaning making has been recognized in many educational contexts (see e.g., Mercer and Littleton 2007; Reznitskaya et al. 2009).

A second feature of the interaction that contributes value is *storytelling* as a 'tool' to collaboratively reflect during these sessions. Storytelling is the vehicle used to construct the reality of past experiences (Arminen 2004; Bruner 1991; Warmington and McColl 2017), which creates new ways to view the self, others, and the profession (Hardy 2017; Sandars and Murray 2009). The identity work that is done through storytelling makes relevant the discussion of others' relation to themselves, the situation, and the future profession. Such shared meaning-making promotes the formation of professional identities (Chen and Hubinette 2017; Wald et al. 2015). It forms the machinery, the mechanism, that creates educational value from a single experience. This finding thus reflects the possible effectiveness of narrative pedagogies described in the broader literature (e.g., Brady and Asselin 2016).

The third feature that contributes to value creation during this educational activity is the role of the teacher. As role models, teachers in our study were perceived as a valuable resource and tested benchmark for professional practice. Their expert position brings valued opportunities for pointing out inconsistencies, noticing and dealing with strong emotions, and probing for thought-provoking conversation (Sandars 2009). Also, as moderators, teachers facilitate structured spontaneity (van Braak et al. submitted). Far from creating a dictated environment (Zou et al. 2019), the teachers' responsibility is to facilitate an open, dialogic environment for learning. Though it may sound counterintuitive, residents in our study stated that clear boundaries and strict procedures create the space for vulnerability, confidentiality and trust (cf. Gallagher et al. 2017). Whatsoever fits these boundaries is likely to contribute to educational value for all.

The current synthesis of GP residents' normative orientations on value in collaborative reflection sessions develops our understanding of the educational aims of these professionals and their perceptions of ways to realize those aims using a new methodological approach. Two aspects of that approach strengthen the study's findings. First, during data collection, the

interviewers used limited prompting. In contrast to elicited responses, responses in our interviews indicate what the residents themselves consider relevant or noteworthy enough to report amid a sea of possible topics and observations that such one-hour recording could raise (van Braak et al. 2018). Also, as responses to recordings of actual interactions, the residents' comments on value or lack thereof were very specific (i.e., "this question is valuable at this moment, because it contributes to this aim"). Both features contribute to a detailed understanding of what is valued and why. Second, the value of our residents' perspectives on valuable features of collaborative reflection sessions is corroborated by the analytic move to synthesize individual residents' narratives in underlying shared normative orientations (Maynard and Heritage 2005). The resulting normative orientations on valuable collaborative reflection practices describe the general features of specific activities and behaviors that lend these their value. The general nature of these features makes the findings applicable beyond the specific evaluated situation. Also, their broad character allows teachers to engage with the findings considering their own practice—something a summary abounding in individual residents' ifs and buts would be unlikely to instigate.

Despite its affordances, however, the methodological approach also has two limitations. First, conducting video-stimulated interviews is time consuming. In addition, it is expensive to hire external interviewers who would be more likely to create a safe environment for criticism than teachers of these sessions would. Therefore, the details of our study's approach may not suit the limited time and resources available in educational practice. For application of this methodology to improve educational practice, we recommend a 'light' version of the approach. Even if just one or two participants would take 10–15 min to reflect on short recordings of education, their reflections would provide rich, empirically related 'snapshots' for teachers to respond to. Provided that the residents' reflections are interpreted for what they really are (subjective, situational interpretations of education), these reflections likely stimulate teachers to (re)think and (re)design educational practices, thus fostering professional teacher development. A second limitation is the impossibility of assessing whether residents' views on value and lack thereof are justified. Even highly valued teacher interventions may not have accomplished educational value for all. Therefore, we plan to use the findings of our study as the basis for an analysis of the moments in the video that residents evaluated. When we examine what happened in the sessions at those moments, do we find that the action that was evaluated in the interview had particularly negative or positive interactional consequences?

In conclusion, our synthesis of normative orientations displayed in residents' narratives about valuable features of collaborative reflection shows how participants' perspectives offer deep and detailed insight into their situational understanding of the local teaching context. Although residents are typically not experts in didactics (Stark and Freishtat 2014), their perceptions are an invaluable resource for understanding "how reflective learning within the curriculum can be better developed to increase engagement from learners" (Vivekananda-Schmidt et al. 2011, p. 1). As such, they form our key to unlock educational value for all.

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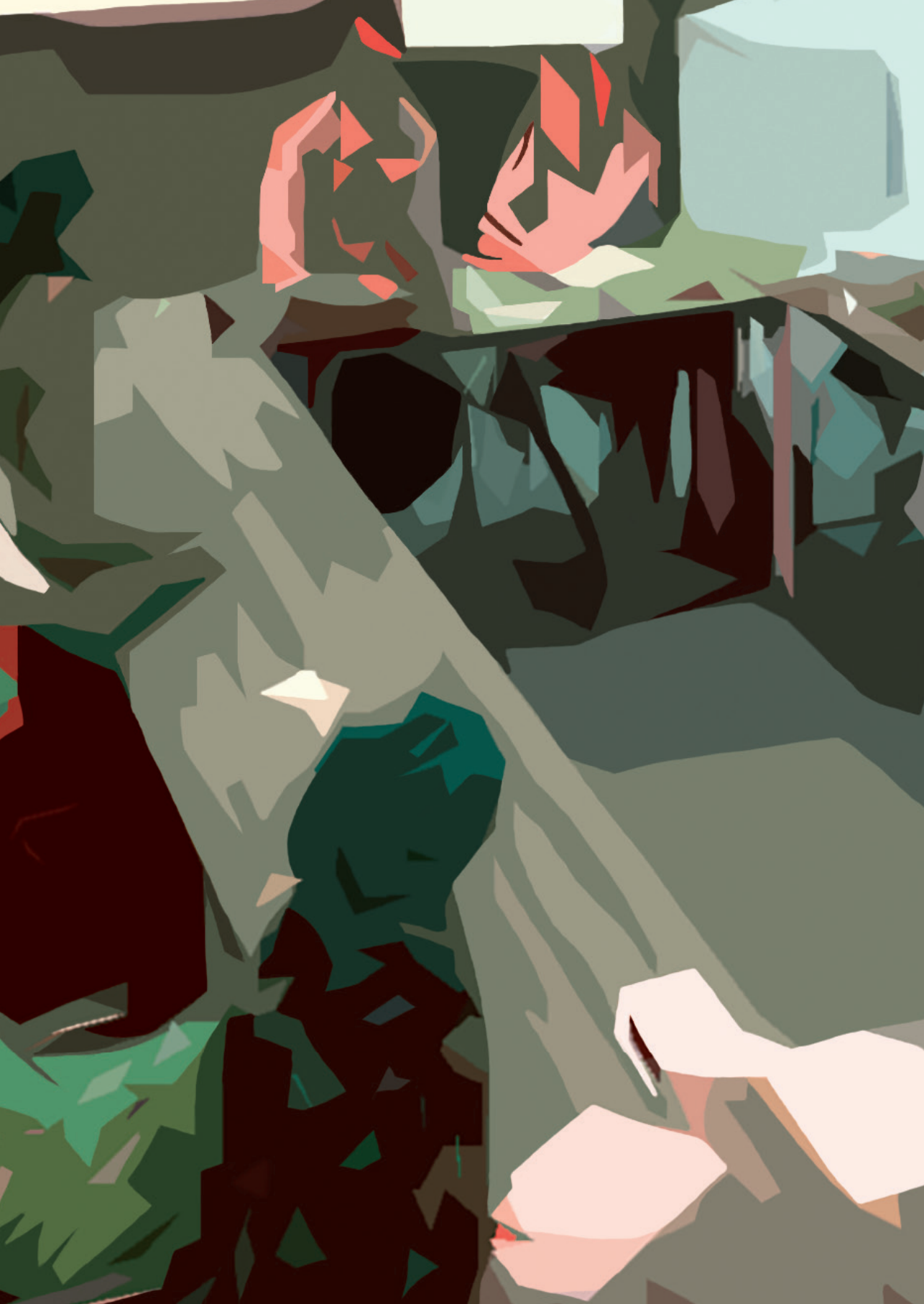

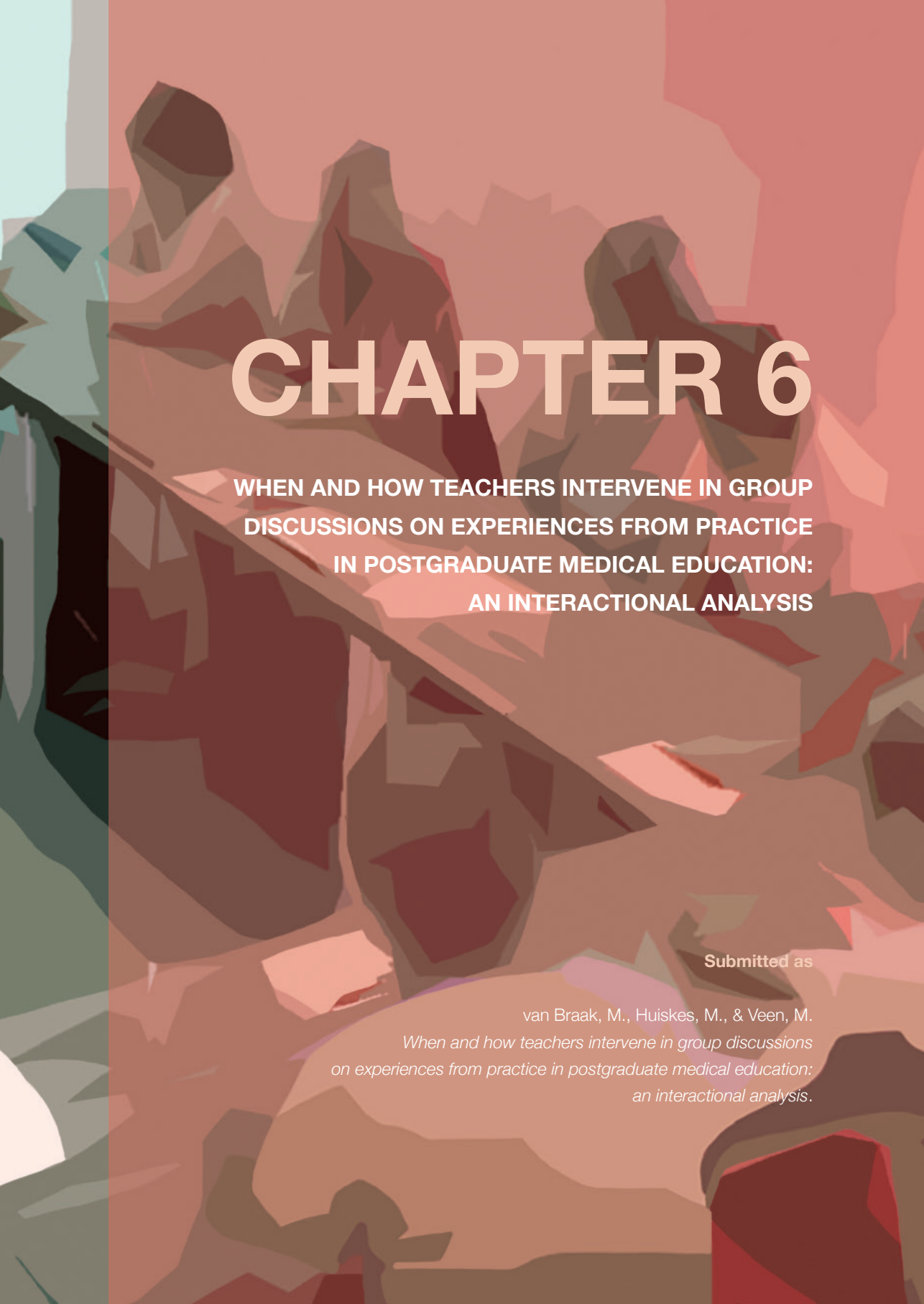

CHAPTER 6

WHEN AND HOW TEACHERS INTERVENE IN GROUP DISCUSSIONS ON EXPERIENCES FROM PRACTICE IN POSTGRADUATE MEDICAL EDUCATION: AN INTERACTIONAL ANALYSIS

Submitted as

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When and how teachers intervene in group discussions on experiences from practice in postgraduate medical education: an interactional analysis.

Abstract

Purpose

Medical educators constantly make decisions on when and how to intervene. Current literature provides general suggestions about types of teacher interventions, but does not address how and when they should be done. Our study aims to fill this gap by describing in detail the actions teachers do when intervening, interactional consequences of those actions, and how these are related to teacher roles in group discussions.

Materials and methods

From 41 video recordings of group discussions on experiences from practice at the Dutch postgraduate training for General Practice. These discussions start with the telling of an experience, continued by an exploration, discussion and conclusion. We collected all moments where teachers first entered the group discussion in this cycle of sharing experiences. We analyzed these 142 teacher interventions using Conversation Analysis. In a first step, we described the timing, manner, actions, and interactional consequences of each intervention. Next, we categorized these into teacher roles. Finally, we analyzed the enactment of these roles in the distribution of the related actions over the telling, exploration, discussion and conclusion phase of the group discussion.

Results

First teacher interventions were done at observably critical moments. The actions done by them could be categorized in moderating, expert, and evaluator actions. Moderating actions are least directive, evaluator actions most directive. Moderating actions were commonly done during the telling and exploration of an experience. Expert and evaluator actions were more common in ongoing discussion.

Conclusions

Teacher interventions are produced as occasioned by teachers by their indexical placement and explicit uptakes of prior turns, often showing an orientation on something being ‘amiss’. The placement and form of the actions done by these interventions may hint at an orientation of teachers to intervene as late as possible. Also, teachers often account for their intervention by explicitly addressing the rationale behind the intervention. The interventions have to be (and are) ratified by a specific uptake of residents in the next turn. Thus, teacher interventions are an interactional accomplishment of the group. This detailed description of how, when and with what effect teachers intervene provides authentic material for teacher training.

Introduction

Group discussion on experiences from practice (i.e., case discussion) is an ubiquitous educational activity in all types of medical education. One of the challenge for teachers in facilitating such discussions is how to ensure educational value for all participants (cf. van Braak et al., 2021). Each moment in the discussion potentially makes relevant a choice between alternatives: How much guidance do you provide? How do you monitor or adjust the process, without pre-empting valuable contributions by students in the group? For teachers, two considerations are at play here: *whether* the teacher needs to do something at a certain point in the interaction and, if so, *what kind* of intervention is called for.

Advice from research on teacher interventions in one specific educational setting, Problem-Based Learning, mostly points at cognitive orientations that teachers should adopt: "think empower, not control" (Azer, 2005, p. 678), create environments that invite students to intervene (Kindler, Grant, Kulla, Poole, & Godolphin, 2009), take verbal and non-verbal expressions from students as "useful indices of learning" (Gukas, Leinster, & Walker, 2010, p. e10), intervene less as the interactional competence of participants grows (Haith-Cooper, 2000; Lekalakala-Mokgele, 2010). More concrete but still heuristic suggestions for facilitating group discussion in medical education are to first leave room for participants to answer a question (to stimulate active participation; Aarnio, Lindblom-Ylänne, Nieminen, & Pyörälä, 2013), withhold evaluation of student responses (it takes back the interactional initiative, hindering collaborative elaboration of knowledge; Hmelo-Silver, 2002), ask open-ended questions (Azer, 2005), give specific process-related feedback (Kindler et al., 2009), and push for explanations, revoicing students' turns, summarizing, and generating hypotheses (Hmelo-Silver & Barrows, 2006). Eventually, the teacher needs to translate these suggestions in *actions*. Those actions have rarely been described so far.

In addition to rarely being reported, the crux of those actions with which teachers intervene in group discussion is that they are always occasioned by the *particulars* of the ongoing discussion. That means that the same intervention in a different interactional context can do very different things and have various effects. It also means that teacher interventions are not the sole responsibility of the teacher: they are actions that contribute to the collaborative achievement of constructing the educational setting at hand. Finally, the fact that interventions are occasioned by prior turns means that generalized advice on the type of interventions that teachers could or ought to do falls short, as it does not recognize the local contingencies of teaching situations. In this study, therefore, rather than looking for generalizable heuristics about 'good' intervention, we systematically analyze teacher interventions in their educational ecology. In other words: Why *that* (this intervention) *now* (at this point in the discussion) (Schegloff & Sacks, 1973)? We describe the actions that teachers do when intervening, the practices they use, the timing of those actions, and their interactional consequences in the ongoing interaction. In doing so, we address the hiatus in our knowledge about actual intervention practices. The resulting description

of intervening actions in their contexts provides teachers with a variety of concrete options for tailored application in unique educational situations.

Materials and methods

Setting

We focused our analysis on group discussions about experiences from practice (which is commonly part of 'reflection education'; Uygur et al., 2019) in postgraduate education of Dutch General Practitioners in training. During weekly sessions lasting 60–90 minutes, GP residents reflect on experiences encountered in their residency (van Braak et al., 2021; Veen & de la Croix, 2016). An experienced GP and/or a behavioral scientist/psychologist facilitates the sessions through four phases (Veen & de la Croix, 2017):

(1) one resident *presents* an experience in the form of telling about the situation;
(2) residents and teachers collaboratively *explore* the experience to clarify the situation and define a focus for discussion;
(3) residents and teachers *discuss* the experience focusing on the issue defined in (2);
(4) the group, teacher or 'teller' resident formulates the *uptake:* lessons learned or advice.

In the following, we refer to each full cycle of (1)-(4) as a cycle of experience discussion.

Data

The data derives from 41 sessions, recorded with two or three video cameras in order to capture all participants on at least one camera. Researchers were not present during the recording. Participants were offered the option to stop the recording temporarily, but no one used this in any session. Also, up to one week after the recording, participants could ask the first author to delete parts of their recording without having to provide a reason. This option was used twice; both requests were from residents who on second thoughts did not want to have the experience they shared and subsequently discussed recorded. To capture the verbal and non-verbal details of the interaction, recordings were transcribed using the Jeffersonian transcription conventions (see Appendix A; Hepburn & Bolden, 2013). Recognizable personal and institutional information was anonymized; participant names were pseudonymized.

Participants

On average, nine residents attended per recorded session (five minimum, fifteen maximum). Participants were in their first year (14 groups), second year (12 groups) or third year (15 groups) of training. The majority of group discussions (25 of 41) were facilitated by two teachers. Teachers were GPs (35), specialist physician (1) or behavioral scientists/psychologists (30) with 0.5–18 years of teaching experience. All participants consented to the recording prior to the session. Approval for this study was obtained from the Ethical Review Board of the Dutch Association of Medical Education (NVMO), dossier 829.

Analytic procedure

We analyzed the function and timing of teachers' interventions using the data-driven, iterative process of Conversation Analysis (CA) (Sidnell, 2013). As an interactional, qualitative methodology, CA allows us to investigate the systematic organization of talk during the group discussions (Mazeland, 2006; Schegloff, 1968). It is particularly suited for analyzing group discussions because here, talk is the very gist of education (Stokoe, 2000; Watson, 1992).

In the first stage of analysis, we collected teacher interventions in all phases of the cycle of experience discussion. Discussing instances of this collection in data sessions (Sidnell, 2013) with the author group and external CA researchers, we chose to focus on the *first* intervention in each cycle of experience discussion. More than subsequent interventions, teachers' *first* interventions display an urgency for intervention. Note, though, that those first interventions also occur later in the cycle, sometimes even in phase (3) or even (4). We did not look at situations where teachers did consider intervening, but did not do so – simply because we cannot retrace when those occurred.

In the second stage of analysis, we collected the first teacher intervention in each of the 142 cycles of experience discussion in our data. We then analyzed each intervention for

- the *actions* done with that intervention (e.g., correct, corroborate);
- how these actions are occasioned at that point in the interaction (i.e., their *timing* in relation to the four phases, and in relation to the directly preceding interaction)
- *how* these actions are done (e.g., corroborating a conclusion by illustrating it with an own experience);
- and the *effect* of those actions on the subsequent interaction.

This level of detail helps us to understand "the resources, practices, procedures and reasoning on which the participants themselves rely in accomplishing particular actions in and in making sense of the contributions of others" (Heath, Luff, & Sanchez Svensson, 2007). We will first present a few overarching observations regarding these foci and next illustrate those with examples of interventions per phase of the experience discussion cycle.

Results

Overarching observations on the *timing* of interventions

In principle, teachers can intervene at any point in the cycle of experience discussion. Yet, our analysis revealed that teacher interventions tend to occur in the exploration (2) and –mainly— discussion (3) phases. Interventions frequently function as pivots between two phases, for example between telling (1) and exploration (2) by providing a summary formulation of the telling in the form of a proposed focus for discussion. Within each phase, teacher interventions tend to be positioned near the end, at a 'point of no return': the last possible opportunity to contribute to an otherwise completed unit of interaction (Schegloff & Sacks, 1973). This increased teacher involvement at the end of interactional projects corroborates earlier findings that teachers tend to postpone their interventions to the last possible moments (van Braak, Veen, Muris, van den Berg, & Giroldi, accepted).

Overarching observations on the *actions* done with the interventions

We first identified the actions done by first teacher interventions. Some actions intervened in the interactional process itself, such as *focusing the discussion* and *inviting people to participate*. These we glossed as moderator actions, since they mediate in the interactional process to refocus it topically or in terms of participation. Moderator actions are frequently done during phase (1), the experience telling, and phase (2), the exploration.

Some actions contribute to the collaborative achievement of educational value by providing input from an epistemically higher position, such as *giving advice* and *reassuring*. These we glossed as expert actions, since the teacher with those actions can be seen as constructing their position as having increased access to the ways of being and doing in the GP profession. Expert actions typically occur in the discussion phase (3).

Finally, we found a variety of *assessments*. These we glossed as evaluating actions, because they normatively judged conduct shared in the interaction. Such actions are done at rather specific moments, usually directly after the experience presentation (1) or at a potential closing point in the discussion phase (3).

Overall, moderating actions are the 'lightest' version of intervention, in the sense that they may *direct* the interaction but do not explicitly and normatively *address* the topic at hand. Expert actions have a normative dimension in the sense that they orient to the hierarchical relationship between 'beginner' and 'advanced' ways of dealing with a situation. Evaluating actions are most directive given their normative nature and the limited options for subsequent actions.

An overview of the actions and some examples are presented in Table 1.

Table 1 Examples of teachers' moderating, expert, and evaluating actions

Specific actions	Examples
MODERATOR: Is the interaction progressing, is everyone still on board? (n = 97)	
request missing information (n = 25)	"You've got two [supervisors], haven't you? (…) Maybe you should share a bit more about your situation." (A715)
request elaboration (n = 23)	"But- bec- because you then feel like 'hey I'm running out of time' or 'it's spilling over' and is that then- what erm- how- how you experience it then?" (B815)
focus discussion (n = 19)	"Would you mind zooming in on that?" (C811)
request clarification (n = 9)	"What do you mean by that?" (E915)
manage participation frame (n = 9)	"Shall we keep the focus central for a while, guys?" (B869) "You can tell the group." (H825) "I erm- [name resident], what do you want to say, what's your view on this?"(B859)
share meta perspective on discussion (n = 5)	"But what was happening here?" (A715)
follow up on other resident's contribution (n = 4)	"And what should be the goal of that?" (H825)
summarize interaction so far (n = 3)	"So, here, giving information is key" (D887)
EXPERT: Can information from professional experience contribute to the discussion? (n = 21)	
present a hypothesis (n = 9)	"Could the mourning process still be at play here?" (B859)
advise/suggest (n = 6)	"Do you know the KNMG's standard note? On giving medical certificates?" (D887)
refer to professional rules/ regulations (n = 5)	"And if you're [doing] the initial screening, at [point] A and B, if someone at that point- like 'hey, there's no breathing, and I can't feel a pulse' well, then there's no need for doubt. Then you just jump onto them." (G824)
reassure (n = 1)	"But I think- I just wanted to say- do you think it's weird? T that happens to me too, even after twenty years." (A823)
EVALUATOR: Does the discussed conduct meet professional standards? (n = 11)	
evaluate professional conduct (n = 6)	"yes, listening to your story, it sounds utterly adequate for this [case]. It was good that you instantly saw like well, I'll follow ABCD (…)." (G824)
evaluate case presentation (n = 5)	"I think that it's a very good topic, worth discussing for a while here." (A852)

N.B. Since interventions sometimes featured more than one action and some actions were ambiguous in terms of the three glosses, the total number of instances does not equal the total number of analyzed first teacher contributions.

The action categories presented here are analytic categories inductively derived from the data. They do however reflect the professional roles that teachers in this setting are believed to have (van Braak et al., accepted). In the following, we describe the placement of the actions and their interactional consequences throughout the phases of the experience discussion cycle (except the conclusion phase, where first interventions did not occur). Our aim here is not to be exhaustive, but to illustrate how the different actions in their interactional context contribute to the collaborative construction of the educational setting. In the analyses, we show how, overall, first teacher interventions treat the preceding interaction as something that needs correction or direction to add educational value.

Intervention during experience presentation: Do we have a complete, clear, and focused story?

Teacher interventions in the experience presentation phase are relatively rare. When they do occur, they tend to orient on a lack of *completeness*, *clarity*, and *focus* of the information shared so far. This orientation is displayed in moderator actions like requesting elaboration, focusing, or summarizing (see Table 1). These have in common that they direct the topic or participation frame of the interaction.

Extract 1 illustrates a teacher (T) treating a resident's (R1) experience presentation as incomplete. The resident has told about her frustration about assistants scheduling extra consultations on days that are already busy. So far, the experience presentation has been a factual description of the situation, summarized by the resident in lines 1-12. Her summary projects a next item in a list ("that is one") (Selting, 2007), but in overlap with that, the teacher redirects the telling topically: he both pre-empts the residents' continued telling and invites further telling on the proposed issue.

For other participants, the projected closing of the first part of this telling (line 12) provides a last opportunity to say anything in relation to the first part of the telling. Responding to the transition relevance (Sacks, Schegloff, & Jefferson, 1974) of the moment, T invites the teller to elaborate on her emotions ("feel", line 15, and "experience", line 18). He thus treats the telling so far as incomplete in that respect. Stress on "feels" (line 15) and "experience" (line 18) underscores the contrast between already shared facts and thus far unshared feelings. While the format of T's request for elaboration on feelings connects to the prior turn (e.g., "I'm getting behind", line 15, "and" prefaced format of the turn), it simultaneously makes talk about other matters relevant (Walker, 2007; Jefferson, 1984). This *topical shift* displays moderating work.

Extract 1: what was that like for you then?

```
1       R1      dus duss (0.3) dingen waar het hier mis is ge↓gaa:n,
                so soo (0.3) things that went wrong ↓here,
2               dat dat er gewoon mensen bij op gepland worden,
                that that people are just added to the schedule,
3               (0.5)
4               terwijl ik ook al een beetje uitloop,
                when I'm already slightly behind,
5               e:hm: (0.4) en dat gaat dan >regelmatig zonder over↑leg<,
                u:m: (0.4) and that frequently happens >without consul↑tation<
6               (ga) ik ook wel wat (op) aangeven dat ik dat toch graag
                I (will) let them know that I really do want that
7               >ook in over<↑leg wil van nou of het überhaupt me gaat
                >also in consul↑tation< like well whether I'll manage all that
8               lukken of niet,
                yes or no,
9               (0.7)
10              e:::hm
                u:::m
11              (0.7)
12              pt da-  [dat is één,  ]
                pt tha- [that is one, ]
13      T               [maar (      )] [(wa- )] want je
                        [but (       )] [(wha-)] because you
14      R1                              [ ja,  ]
                                        [ yes, ]
15      T       voelt dan van ↓hé ik ben aan het eh uitlop[en],=
                then feel like ↓hey I am getting behind sche[dule],=
16      R1                                                 [•h]
                                                           [•h ]
17      T       =of het loopt over,=
                =or it's spilling over,=
18              =en: is dat dan- wat eh   [(        ) hoe]: er↑vaar je dat dan?
                =and: is that then- what um [(   ) what]: was that ↑like for you then?
19      R1                                [pt         nou]
                                          [pt    well]
20              (.)
21              e::hm hangt >dr een beetje van af< hoe ↑lang het is,
                u::m it depends >a bit on< how ↑long it takes,
```

Moderating actions can also pre-empt further telling by pivoting to the subsequent exploration phase. Such pivots bridge the telling and exploration by connecting to the telling while having independent topical potential to create room for others' contributions (Holt & Drew, 2005). Extract 2 shows an example: teacher T transforms a 'pit stop' in the experience presentation into an opening for further exploration of the experience by the group. With that, he treats the experience presentation so far as complete, clear and focused enough to move on to the exploration phase. Resident R1 so far has presented an experience where she wanted to see two nursing home patients who were being prepared for dinner. She presents this situation as a first example of a bigger issue (line 1): standing up for her own agenda despite the risk of being unfriendly to others (lines 3–5). Again, this "first" projects a "second" (Jefferson, 1990;

Selting, 2007) - and thus continuation of the telling. At the same time, her summary assessment of this first example is recognizably closure-implicative in that it (Hoey, 2018). In second position (Arminen, 2005), T transforms the telling into an opportunity for exploration of the shared situation (lines 12–29):

Extract 2: would you mind zooming in on that?

1	R1	en (.) >naja< (.) dat is één voorbeeld waarvan ik denk;
		and (.) >okay< (.) it is one example that makes me think;
2		(1.2)
3		misschien moet ik soms gewoon;
		maybe sometimes I should just;
4		(0.3)
5		dan maar even geen vriendjes willen zijn,=
		not want to be friends for the moment,=
6		=maar gewoon;
		=but just;
7		(.)
8		zeggen van Qja (.) ik snap dat >het vervelend is<,
		say like Qyeah (.) I understand that >it is annoying<,
9		maar >we doen het gewoon even op deze manier<.
		but >we'll do it this way for now<.
10		punt.Q
		period.Q
11		(0.2)
12	**T**	**vind je (dat) goed om daar in te zoomen?**
		would you mind zooming in on that?
13		**(0.3)**
14		**(want) je hebt een mooie casus,=**
		(because) you have a nice case,=
15	R1	=j[a.]
		=y[es.]
16	**T**	**[je] schetst de casus- gisteren het is vijf uur,**
		[you] sketch the case- yesterday it's five o'clock,
17	R1	ja.
		yes.
18	**T**	**ik wil twee casus zien,**
		I'd like to see two case,
19	R1	ja.
		yes.
20		°([ ) zien°]
		°([ ) see°]
21	**T**	**[ehm ma]ar ze geven mij de ↑wind van voren,**
		[um bu]t they gave me an ↑earful,
22		**en op dat moment (.) gaat er iets in mijn ge↑dachten,**
		and at that moment (.) I change my ↑mind,
23		**en besluit ik één (.) casus te zien.**
		and I decide to see one (.) case.
24	R1	ja.
		yes.
25	**T**	**°en eentje niet.°**
		°and not the other.°
26	R1	ja.

```
                yes.
27      T       [((                    looks     ][   around))              ]
28              [>zullen we daarop< eh inzoomen?][((handgebaar groep     ))]
                [>shall we zoom in< uh on that?][((hand gesture to group ))]
29              ((looks [at R))]=
30      R1              [prima.]=
                        [ok.   ]=
31      T       =((looks [around the group))]
32      R2              [maakte het nog    ] uit hoe: be↑langrijk je het vond?=
                        [did it matter     ] how: im↑portant you thought it was?=
33              =die tweede?=
                =the second one?=
34              =want (waarom maakte je die-)
                =because (why did you decide tha-)
35              (0.2)
36      R1      ((clears throat, starts responding))
```

As in Extract 1, the timing of the teacher intervention in line 12 is salient. It is done at a pivotal point in the telling, when R1 pauses but signals that there is more to come in the presentation (lines 1–10). At that point, T produces a summarizing formulation (Solem & Skovholt, 2019) of key points (lines 16–25). His formulation builds toward redoing R1's proposal for discussion (not shown) to the group (see "we" in line 28 and T's "lighthouse gaze" ranging over the group (Bjork-Willen & Cekaite, 2017; Willemsen, Gosen, van Braak, Koole, & de Glopper, 2018). With that, the teacher proposes a focus for discussion for ratification by the teller (line 29) and group. R1 accepts the proposal, with which she opens the floor for discussion. T then looks around, indeed inviting the group to react to the proposal. By starting to ask a question (lines 32–34), one resident accepts the invitation.

This sequence of actions achieves collaborative closing of the telling phase and opening of the exploration phase. The teacher (1) treats the telling as sufficient (complete, clear) for discussion even if R1 would have continued, (2) directs the interaction topically by highlighting particular elements for discussion, and (3) changes the participation frame from individual to group. In collaboration with the teller's and groups' validation and acceptance, these actions moderate the interaction by progressing it forward in terms of phase, topic, and participation frame.

Intervention during exploration: Do we have all and only all relevant information to discuss the issue?

Teacher interventions in the exploration phase orient to the *relevance* of questions *to the issue at hand*. This orientation is again mainly visible in moderating actions, such as refocusing, summarizing, and inviting elaboration on earlier turns at talk. These again have in common that they direct the ongoing interaction topically and in terms of participation.

Extract 3 shows a very prompt moderating action at the start of the exploration phase. The resident presenting his experience (R1) formulates his focus for discussion in terms of a dilemma to share or to not share suspicion of a serious medical issue with a patient. Following R1's

concluding statement (lines 1–2; “so”, downward intonation) and the teachers’ “okay”, which “displays preparedness to move onto some next-positioned matter” (Hoey, 2018, p. 332; Beach, 1993), fellow resident R2 poses an exploratory question (line 7). This initiates the exploration phase, but its unfolding is pre-empted by the teacher (lines 8-11):

Extract 3: wait a minute

1	R1	dus daar zit ik een beetje over: in van ( ) (.) ↑hoe: (.) had
		so that bothers me a bit like ( ) (.) ↑how: (.) could
2		ik dit het beste kunnen brengen.
		I have brought this across the best.
3		(0.5)
4		°dat.°
		°*that.*°
5	T	°↑o↓ke.°
		°↑o↓*kay.*°
6		(3.0) ((T is writing))
7	R2	hoe heb je t ge↑bracht?
		how did you ↑bring it across?
8	R1	ik heb gebracht van e[eh
		I brought it like u[uh
9	**T**	**[na: wacht effe. ((kijkt op))**
		[we:- wait a bit. ((looks up))
10		**die wil ik eve- want dat is een beetje de kers op de taart,**
		I’d like to jus- because it’s more like the cherry on top,
11		**die wil ik heel eventjes eh achterhouden.**
		I’d like to uh wait a bit with that one.
12		**kun je dat eh-**
		can you eh-
13	R3	°kun je daarmee [leven?°]
		°*can you live [with that?°]*
14	R2	[°is goed] is goed.°
		[°kay] it’s okay.°
15	T	[ja?]
		[yes?]
16	R4	[wa-] wat speelt er eh voor jou ↑mee.
		[wha-] what’s in ↑play here uh for you.
17		wat eh qua tijd (van het) onderzoek en eh-
		what uh in terms of the time (of the) examination and uh-
18	R1	nee want >ik had verder gewoon< (.) wat be↑doel je?
		no because >for the rest I just< (.) what do you ↑mean?

The first exploratory question invited the teller (R1) to share their solution to the issue (line 7). T, however, self-selects in the middle of R1's turn-constructional unit (Clayman, 2013; line 9), halting the narrative before the report reaches its conclusion. This displays a sense of urgency. She then provides an account for halting the narrative (lines 10-11), in which she treats R1's question as not timely: it presents the culmination of the shared experience, something that is best left for later in the discussion as it gives away the crux of it. This account shows the teacher's orientation on topic management in the unfolding of the exploration and discussion of the experience shared. The teacher's action is pre-emptive, but unlike the interventions in Extract 1 and 2, does not direct the interaction towards a specific topic. In that sense, the intervention redirects the exploration without determining its course – indeed. With R4's subsequent question (line 16), which accepts the topical redirection, the exploration phase is reopened on a different track. The moderating work is now complete.

Intervention during discussion: Is the discussion so far sufficient to answer the issue?

Once discussion is underway, intervention becomes more complex in terms of room for participation and in terms of the type of action such intervention could do. In this phase, teachers orient to the importance of a diversity of perspectives and solutions that address the issue under discussion. This orientation is displayed in moderator actions like inviting residents to participate, in expert actions like giving advice, and evaluating actions like assessing potential solutions. More than just directing the topic or participation frame, the latter actions have in common that they also normatively address what is been talked about.

In Extract 4, we show a teacher intervention that includes all three action categories as an example of the multifunctional nature of many interventions in this phase. The Extract shows a relatively late intervention, timed after considerable discussion. We join the discussion on a hectic CPR situation in an interaction between the teller of the experience R and fellow resident R2. At a transition relevant place in that interaction, T for the first time in this cycle of experience discussion takes a turn (line 10). With his intervention, he offers a compliment, a heuristic, and a new subtopic.

Extract 4: it sounds utterly adequate

1	R2	nee maar ik bedoel meer voor jou gevoel van wat jij net zei van
		no but I mean more like in the way you felt, what you just said
2		dat dat je geen goede overdacht kon geven,=
		that that you couldn't do a good handover,=
3	R1	=[ja.
		=[yes.
4	R2	=[of dat je het gewoon allemaal zelf nog niet op een rijtje had,
		=[or just that you yourself didn't have an overview of it all,
5	R1	nee [echt to↑taal niet.]
		no [not at ↑all.]

6 R2 [dat komt juist door de] snel[heid] waarmee je zoiets dan
[that's precisely because of the] spe[ed] at which that
7 R1 [ja]
[yes]
8 R2 [(hebt)].
[(happens)].
9 R1 [ja]
[yes]
10 T ja als ik jouw verhaal hoor dan klinkt dat uiterst ade↑quaat.
yes if I listen to your story it sounds utterly ↑adequate.
11 bij deze (.) het was goed dat jij me↑teen zag van nou (.) ik ga
for this one (.) it was good that you saw right away that well
12 uh (.) ABCD* aanpakken,=
(.) I'm going to uh (.) follow ABCD*,=
...
31 maar op zich (.) klinkt het [heel] adequaat.
but all in all (.) it sounds [very] adequate.
32 R1 [ja]
[yes]
33 ja=
yes=
34 T =en bij twijfel gewoon erop duiken.=
=and when in doubt just jump in.=
35 =daar komt het in ↑feite op ↑neer.=
=that's what it boils ↑down to in ↑fact.=
36 R1 =ja=
=yes=
37 T =en uh (.) wat mij wel ↑opviel is dat jij op dat moment wel
=and uh (.) what ↑struck me is that at that moment you
38 twijfelde en dat die ↑echtgenoot eigenlijk (.) uh [de] knoop
were in doubt and that the husband actually (.) uh cut [the]
39 R1 [ja]
[yes]
40 T doorhakte van moet ik reani↑meren.
through the knot, like [now] I must re↑suscitate.
41 R1 naja ik zat dus te du- te dubben van oké.
well yes but no so I was in doub- in doubt like okay.
42 ((explains her doubts in the situation))

* A systematic approach to deal with acute care situations.

R1 and R2 are discussing a factor that may have contributed to R1's feeling of inadequacy and incompetency in this situation (lines 1–8). At a possible point of completion, when both residents in form agree on what they are discussing, T takes a turn (line 10). He produces an extremely positive assessment of R1's conduct (an evaluating action), which contrasts with the discourse of *inadequacy* preceding it and nips any search for potential causes of the doubt in the bud. The combination of reaffirming (lines 11–20) and repeating (line 31) the evaluation, as well as presenting an expert professional norm (lines 34–35; an expert action) settles the issue of doubt about R1's conduct – at least, it is not contested after this intervention and thus collaboratively established as concluded.

With these evaluating and expert actions, the teacher reframes the *prior* discussion. T's next action (lines 37–40) is formatted as an additional comment, which functions as a pivot (Holt & Drew, 2005) to further discussion on an as yet undiscussed aspect of the experience. Like the topical shifts proposed by the teachers in Extracts 1 and 2, this proposal does moderating work. In a sense, even this 'light' moderating action limits the type of actions that can be done by the others in subsequent interaction: coming back to the prior issues would likely require interactional work (Sirois & Dorval, 1988). The observation that this intervention was done only after considerable group discussion shows a teacher orientation on the primacy of the group in participating in the interaction. Even then, the few seconds this interventions took can leave ample interactional room for the group's perspectives yet leave a mark on large parts of *preceding* and *subsequent* interaction.

Discussion

In this study we described the actions teachers do when intervening in group discussion in postgraduate medical education. A first main finding is that if teachers intervene, their moderating, expert and evaluating actions show evidence of responding to something 'amiss' in the ongoing interaction: the experience presentation is not complete, clear or focused, the exploration is not relevant, the discussion does not include different perspectives or does not help find ways to deal with the issue. That is, interventions are embedded in ongoing interaction and as such produced as occasioned by the specifics of the preceding interaction. With indexical placement and explicit references to prior turns, teachers produce the interventions as occasioned by prior turns. Residents' uptake in the form of ratifying the moderating, expert and evaluating actions done with the interventions constructs the interventions as a collaborative interactional accomplishment.

The observation that teachers orient to something being 'amiss' when they intervene has implications for 'doing teaching' in this context. First, if teachers *do not* intervene, this could be interpreted as an implicit ratification of the activity at hand (Nieboer et al., 2020) – although it could also be treating the context as one where residents and teachers have particular interactional rights. Second, if teachers *do* intervene, the interactional meaning of their actions that is constructed with those interventions is that the teacher deems intervention necessary. In combination, these interpretations imply that each teacher intervention displays an *interpretation of the preceding interaction*. What the teacher does could be seen as more than 'just listening' like any other participant (described as the participant role of teachers; Veen & de la Croix, 2016): whatever the teacher does or does not do constitutes a normative response to and in the ongoing interaction.

A second main finding relates to the timing of teacher interventions. First teacher interventions are done at critical moments in all phases but the concluding one. Only rarely are

they done when a resident presents their experience and even then mostly towards the end of the phase. Expert and evaluating actions, which are relatively limiting compared to moderating actions in terms of the type of actions that can be done in subsequent interaction, have a close temporal link to the later phases of the reflection discussion cycle. We could interpret these findings as hinting at an orientation of teachers to intervene as little and late as possible. Such interpretation would be in line with a guideline reported in early literature on teacher roles in group discussion (Gall & Gall, 1993, p. 11): "do not intervene in the groups any more than is absolutely necessary". More generally, the proposed connection between the timing and type of teacher interventions adds a new dimension to general role descriptions of medical teachers (Harden & Crosby, 2000; Meeuwissen, Stalmeijer, & Govaerts, 2019; Stoddard & Borges, 2016).

Based on our analysis, we have two practical suggestions for teachers. First, teachers could use the pivotal function of interventions strategically. If the interaction is valuable in terms of established educational aims, teachers do not need to intervene – even if the discussion takes an unexpected turn. They could avoid pivoting in some situations – given that later interventions can equally well leave a mark on the interaction so far while leaving plenty of room for the participants to explore and discuss (see Extract 4). Research in another educational setting has shown that such transitions work well when the teacher bridges the current and new topic (Creider, 2020). Second, teachers could approach the question of intervention from a role or identity perspective. In situations where teachers do intervene, they could consider how a moderating, expert or evaluating action would contribute to the interaction: is pivoting the ongoing interaction necessary? Would that require mere moderation, expert input, or evaluator feedback? Would that require instant involvement, or could it also be done later?

Reformulating the considerations of intervention in interactional terms refocuses our attention on behaviors that constitute the course of actual interaction. Focusing on the 'why that now' (Schegloff & Sacks, 1973) of actual teacher behaviors in ongoing interaction, enabled us to provide detailed descriptions of the interventions in terms of timing and actions enacted by teachers at various phases in interaction. These descriptions can serve as a basis for teacher training. Showing teachers exemplary situations for collaborative discussion of what happens in these situations can help teachers understand how possible action trajectories could lead to different interactional outcomes (Stokoe & Sikveland, 2017).

Our study is limited in two respects. First, we could not analyze situations where teachers decided *not* to intervene. Such considerations are not observable and are not likely to be reliably remembered after the fact. Future research could analyze situations where teachers' embodied behavior shows evidence of possible doubts to jump in. Second, moderating, expert and evaluating actions may not be equally relevant in educational contexts where socialization into a *profession* is not the main aim. The principle behind these action categories, however, would likely be similar: teachers in other contexts may also do particular actions that construct their various roles or identities at specific moments in that interaction and make their interventions analyzable in terms of the timing, form, and effect of these actions.

Despite these critical notes, the study provides authentic material for teacher training, and offers generalizable insights into a variety of useful intervention strategies. With that, we contribute to addressing the challenge of facilitating group discussions in the context of medical education and beyond.

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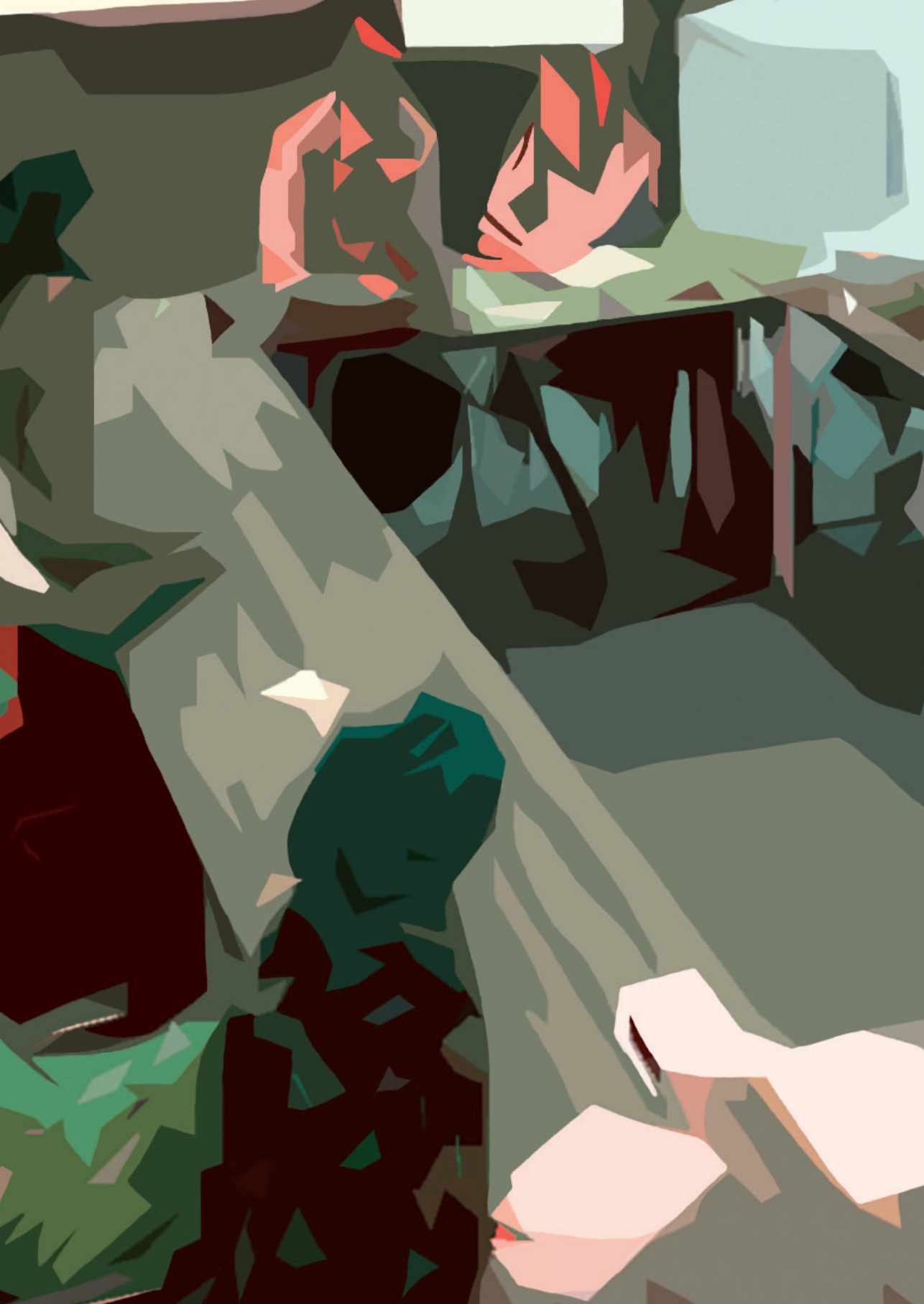
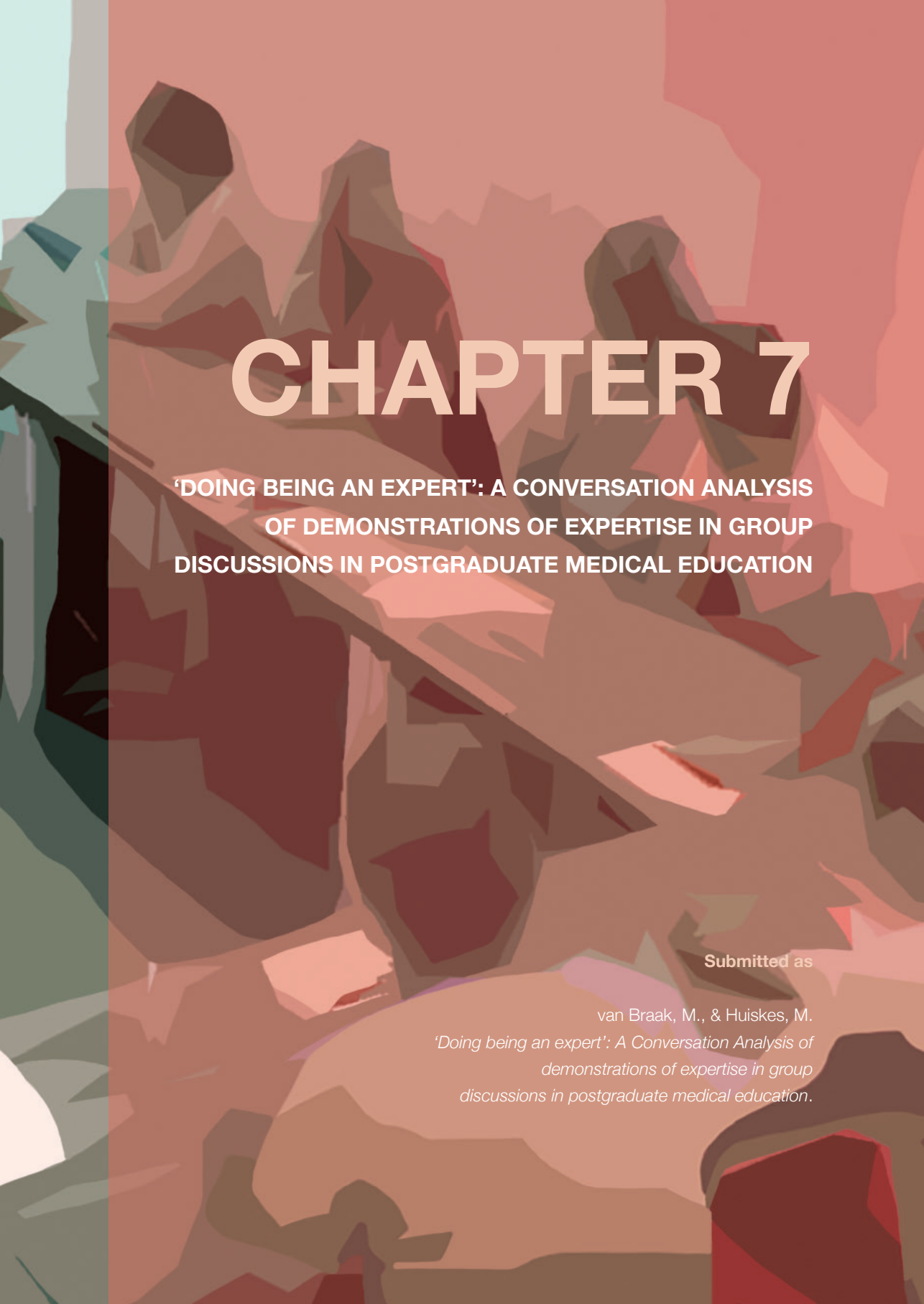
Appendix A

Transcription conventions (based on Hepburn & Bolden, 2013)

Symbol	Meaning
[word [word	overlapping talk
word= =word	'latching': no gap between two turns
(1.0)	pause of 1.0 seconds
(.)	micro pause, shorter than 0.2 seconds
?	turn is produced with sharp rising intonation
,	turn is produced with slightly rising intonation
—	turn is produced with flat intonation
.	turn is produced with falling intonation
□ □	marked rising or falling shift in syllable intonation
WORD	louder than surrounding talk
'word°	softer than surrounding talk
w<u>o</u>rd	stressed syllable
wo:rd	lengthening of the preceding sound
wo-	abrupt cut-off
>phrase<	faster than surrounding talk
<phrase>	slower than surrounding talk
hh	audible aspiration
.hh	audible inhalation
(word)	unclear talk
( )	inaudible talk
((points))	verbal description of (non-verbal) actions





CHAPTER 7

‘DOING BEING AN EXPERT’: A CONVERSATION ANALYSIS OF DEMONSTRATIONS OF EXPERTISE IN GROUP DISCUSSIONS IN POSTGRADUATE MEDICAL EDUCATION

Submitted as

van Braak, M., & Huiskes, M.
‘Doing being an expert’: A Conversation Analysis of demonstrations of expertise in group discussions in postgraduate medical education.

Abstract

Professional socialization (i.e., getting acquainted with the ways of doing and being in the profession) is key to medical training. Traditionally, experts in the community who embody the standards of the profession play an important role in this process. In this paper, we provide an account of how expertise is co-constructed within medical education sessions, and how that contributes to the socialization of 'learners' into the profession. We do so by analyzing a collection of instances where teachers 'do being an expert' in group discussions about experiences from practice in the context of Dutch postgraduate training of General Practitioners.

Using Conversation Analysis, we analyzed the sequential context of displays of expertise, their function, the sources of expertise referred to, and their interactional consequences. We describe the different ways participants make their expertise relevant in the group discussions. This is done in three sequential positions: elicited, licensed, and volunteered. These sequential contexts are consequential for the interactional function of these displays of expertise (e.g., correcting, corroborating). These displays contribute to the socialization of the 'learners' in three ways: By positioning themselves and being positioned as expert representatives of the profession, teachers (1) provide access to the culture, tradition, and practices that are lodged within the specific professional community, (2) create opportunities to attend to the tension between textbook guidelines and messy practice, and (3) contribute to the construction of 'socialized' understandings of situations, or "professional vision".

Theoretically, the current description of displays of expertise contributes to our understanding of the practices and functions of 'doing being an expert' in educational context. Practically, the description of expertise enactment helps us understand how, interactionally, accomplishing expertise can support the socialization of medical professionals in training. The practical suggestions derived from the analyses can contribute to the training of future medical professionals in a variety of educational contexts.

Introduction

Professional socialization (Brown & Finn, 2021; Biesta & van Braak, 2020) is key to the educational journey in medical contexts. From students to specialists, doctors in training engage in activities that establish their membership of the profession (Goodwin, 1994; Goodwin, 2017; Lave & Wenger, 1991; Ochs, 1991). Experienced members of the profession play a key role in this process by modeling professional ways of being and doing, and enacting the community's shared norms and values in encounters between 'becoming' and 'experienced' professionals. The modeling role, however, is a sweet-sour one: while it is indispensable in the process of professional socialization, it also endangers just that which it seems to promote. Contributions from experienced professionals in educational contexts can set the tone, direct the discussion, rule out options, open up venues, and redirect professional conduct (van Braak, Huiskes, & Veen, submitted). Thus, the role of experienced professional, often institutionally assigned to teachers in medical education, poses a didactic dilemma (Maudsley, 1999): do I proffer my expertise, or not? If others elicit my expertise, do I go along with their invitation or are there reasons to withhold it? If I do bring in my expertise, what does it do in the ongoing interaction? In this paper, we provide an account of how expertise is co-constructed within medical education sessions, and how that contributes to the socialization of 'learners' into the profession, by analyzing a collection of instances where teachers 'do being an expert' in group discussions on experiences from practice in postgraduate medical education. The resulting description of teachers' practices fosters our understanding of how, interactionally, learning from experienced professionals contributes to the socialization of professionals in training and provides practical suggestions for teachers in the context of socializing 'new' members into the medical profession.

'Doing being an expert' is an interactional accomplishment (Arminen, Koole, & Simonen, 2021). While someone may be assigned an expert role institutionally, this role needs to be established and ratified in the local, situational context of ongoing interaction. Like any identity, expert identities in conversation are provisional (they can but need not be established in a particular interaction) and multiple (people take on different identities over the course of interaction; cf. Goffman's notion of 'footing', Goffman, 1979; Myers, 2004). Someone's position as an expert is always subject to negotiation (Heritage & Raymond, 2005; Mondada, 2012; O'Connor, 2015; Nissi & Lehtinen, 2016): it can be claimed, induced, projected, invited, taken up, ratified and resisted discursively (Jacoby & Gonzales, 1991; Antaki & Widdicombe, 1998; Mesinioti, Angouri, O'Brien, Bristowe, & Siassakos, 2020). Indeed, typical features of expert identities in conversation, such as authority (role asymmetry; Heritage & Clayman, 2010) and high epistemic access (epistemic asymmetry; Heritage & Clayman, 2010; Stivers, Mondada, & Steensig, 2011) are achieved interactionally (Matoesian, 1999; Pomerantz & Rintel, 2004). For example, displays of expertise can be made relevant by others by positioning themselves as a novice or as having low epistemic access (Sarangi & Clarke, 2002; Carr, 2010) or by treating the

other as possessing privileged access to some knowledge or experience (Heritage & Raymond, 2005; Nguyen, 2006; Carr, 2010; Stivers et al., 2011; Saito, 2012; Morek, 2015).

So how do people accomplish 'doing being an expert' (Sacks, 1995)? People do so using a variety of discursive practices (Goodwin, 1994; Reichert & Liebscher, 2012). These practices constitute actions that can be interpreted as and are treated as expert activities, e.g., explaining, giving advice, and instructing (Herijgers & van Charldorp, 2020). People use explication of knowledge as a vehicle for "the display of expertise and epistemic superiority" (Morek, 2015, p. 240; Heritage & Raymond, 2005). Expressions of moral stances of certainty, evidence for claims, modality markers and reported speech can be used to signal one's direct access to knowledge and experience (Kiesling, 2009; Storey, 2012; Chovanec, 2016; Gordon & Luke, 2016). Authorized voice (Mondada, 2012), such as "the use of declarative mood, linguistic means that convey generalized assertions or abstractions, as well as the use of standard language and a certain prosody (e.g., a schoolmasterly tone, Keppler, 1989)" (Morek, 2015, p. 241), further constructs the speaker's expert identity. Also, by showing an entitlement to engage in interaction (Myers, 2004; Nissi & Lehtinen, 2016) (which is linked to epistemic responsibility; Stivers et al., 2011), people constitute their obligation to know and contribute something (Nissi & Lehtinen, 2016), thus constructing themselves as 'owners' of that knowledge domain.

Various institutional settings have their own specialized practices for construing expertness. In educational context, teachers can construe doing 'being an expert' in various ways. Role performance in medical educational setting is one example (Storey, 2012). The instructional Initiation-Response-Feedback sequence (Hall & Looney, 2019; Sinclair & Coulthard, 1975) used in primary and secondary education is another. In these sequences, teachers pose Known Information Question (Mehan, 1979), which posits them in a position of being knowledgeable and having prime epistemic access to the topic of the question. The third turn subsequently provides opportunities for the teacher to enact a higher epistemic and/or interactional position relative to the students: it is used to accomplish a variety of pedagogical actions such as assessment and explanation (e.g., Lee, 2007; Richards, 2006).

In this paper, we take an interactional approach to expertise in the context of medical education. We report a Conversation Analysis of a collection of instances where teachers do 'being an expert' in group discussions on experiences from practice in the postgraduate training of General Practitioners, focusing on the moments when the do 'being an expert', what elicits these displays of expertise, what practices are used, the functions it serves, and how it is responded to. We will show how the three sequential positions in which instances of 'doing being an expert' occur (elicited, licensed, and volunteered) are related to the function of those displays of expertise. In each of these situations, the display of expertise is a collaborative construction between teachers and residents. Following the analysis, we discuss three ways in which such displays contribute to the socialization of postgraduate residents.

Methods

Data and participants

This study is part of a larger project on collaborative reflection in eight Dutch institutes that train general practitioners (van Braak, Veen, Muris, van den Berg, & Giroldi, accepted). The training for GPs, for which graduates of basic medical training can apply, comprises three years of internships in GP practices and related care contexts; educational days are scheduled each week. These days usually begin with a group discussion of experiences from practice (45-90 minutes). During the group discussion, residents (GPs in training) and teacher(s) collaboratively discuss experiences from practice (e.g., difficult patients, personal dilemmas, successes and failures) with the aim of generating educational value for all present (van Braak et al., 2021). Participants are usually seated at tables in horseshoe formation, sometimes in a circle with no tables in front of them. We video-recorded 41 of these group discussions, distributed over the eight institutes, with three camera's. The first author installed the camera's prior to the session start and collected them afterwards, she was not present during the recording. Participants could stop the recording mid-session when they felt it hampered the discussion in any way; this option was not used. Participants could also request deletion of a part of the recording up to one week after the recording if they felt uncomfortable about it being included in the study; this option was used twice.

Group discussions in this setting are attended by on average 10 residents and one or two teachers (GP and/or behavioral scientist/psychologist). Residents in our data set were in their first year (14 groups), second year (12 groups) or third year (15 groups) of GP training. Teacher experience ranged from 0.5 to 18 years. The groups differed in the number of times they had met as a group (seldom to weekly for almost a year). All participants gave written informed consent to record, analyze and report on the session they were attending. Ethical approval for this study was obtained from the Ethical Review Board of the Dutch Association of Medical Education (NVMO), dossier 829.

Analytic procedure

We used Conversation Analysis (CA) to describe interactional situations that showed explicit instances of teachers 'doing being an expert'. CA is an ethnomethodological, inductive approach to social interaction (ten Have, 2007; Sidnell, 2013). Rooted in sociology, CA aims to describe how people in interaction perform social actions that construct the world around them on a moment-to-moment basis. In analyzing the multimodal unfolding of that interaction, the conversation analyst tries to describe *why* and *how* a certain action (*that*) is done at this point (*now*) in the local context of this interaction (Schegloff & Sacks, 1973). Applying this approach to instances of expertise construction in our data means describing how this instance of doing expertise has come about, what it does, and how it is responded to.

We began our study with a detailed analysis of a collection (Sidnell, 2013) of all instances of teachers 'doing being an expert' in recordings from randomly chosen two of the eight institutes (n = 12). We initially collected instances based on (1) descriptions of demonstrations of expertise in the broader CA literature (e.g., explanation, cf. Heritage & Raymond, 2005; Morek, 2015; Chovanec, 2016; Herijgers & van Charldorp, 2020), (2) displayed member orientations in the interactions, e.g. orientations to higher epistemic access, and (3) our lay intuition on interactional constructions of expertise, e.g. references to track record of being a doctor, mentions of established habits or 'best practices'. Analyzing several instances closely in data sessions (Sidnell, 2013), we worked to identify what characterized these instances as explicit forms of 'doing being an expert'. Going back and forth between specific instances and the growing collection, we categorized the instances into three sequential contexts (Schegloff, 2007): contexts where expertise was explicitly requested, or licensed, or volunteered. We excluded ambiguous expert contributions, such as stand-alone compliments, which signal a hierarchical position but may also have another function, such as closing an activity. Once we had a definitive description of the phenomenon, we turned to recordings from the other six institutes to complement our collection. We analyzed the new instances globally to see if our close analysis of the instances in the first two institutes' recordings would apply beyond the initial collection.

Results

In this section, we present examples of (1) explicitly recruited expertise, (2) expertise licensed by prior talk but not explicitly recruited, and (3) volunteered expertise by describing how it comes about (sequential position), its function, the source of expertise referred to, and how it is received (interactional consequences). Overall, the examples show how participants collaboratively construct the relevance of expertise in this professional socialization context.

Recruited expertise

When residents recruit expertise, expertise is made conditionally relevant. Explicit solicits demonstrate a clear orientation on the need for expertise, e.g., as *ratification* (Extracts 1–2) or *information* (Extract 3). This need can be addressed (Extracts 1–2) or resisted (Extract 3) by the teacher in second position. Whether it has indeed been addressed becomes clear in third position, when the teacher is treated as (not) having adequately attended to the displayed need.

Extract 1 shows a simplest example of a request for ratification. In a discussion about residents' performance, one resident asks the teacher to confirm ("well I think so?") how many residents per group eventually do not meet the performance standards (line 6). Both teachers readily provide confirmation by nodding and muttering "yes" (lines 8–10). The resident who posed the request then moves the discussion forward by building onto the information just confirmed (lines 11–12).

Extract 1: request for confirmation

1	R1	(ja tis best wel u↑niek) dat het al zo (.) redelijk goed gaat.
		(yes it's really u↑nique) that it's going so (.) well already.
2		((several residents make sounds of agreement))
3	R2	(>maar dat is ↑ook een dingetje hè want<) per groep valt er
		(>but that's the thing ↑too because<) per group on average
4		gemiddeld al (.) ↑één iemand [ui:t,
		one person drops [ou:t,
5	R3	[ja ja.
		[yes yes.
6	R2	volge[ns mij toch?
		well [I think so?
7		[((looks at T1, then T2))
8	T1	[((nods))
9	T2	[([[nods))
10		[ja::.
		[yes::.
11	R2	en dat (.) ergens is het ook wel fijn dat (.) het misschien nu
		and that (.) in a way it's also nice that (.) it might be
12		gebeurt,
		happening now,

The requested confirmation is provided in second position, without reference to the teacher's experience. Yet, by virtue of asking the teacher for confirmation, the teacher giving that confirmation, and the participants accepting it, the participants collaboratively establish the teacher's identity as someone who has access to repeated instances of residents not meeting performance standards (cf. Antaki & Widdicombe, 1998; Myers, 2004). In this situation, requested and given expertise seem aligned in the provision and acceptance of minimal ratification. Yet, the extent of expertise requested is subject to negotiation. When expertise is recruited, the teacher makes an assumption of the scope of expertise needed to address the request. In Extract 2, we see how the extent of the requested expertise is accomplished interactionally over a series of turns.

As in Extract 1, the resident in Extract 2 asks for confirmation. This time, the item for confirmation is an insight (line 4–8) gained from an external source: an absent supervisor (line 3). The teacher's subsequent ratification of this insight (lines 11–12) could have closed the sequence, as we saw happening in the previous Extract, but it does not. Although the resident treats the ratification as adequate (lines 13–14, 20–21), the teacher continues to build his ratification using increasingly more explicit references to access to experiences like the one discussed (14, 16, 22–23).

Extract 2: request for confirmation followed by negotiation about extent of expertise requested

```
1       R1      maar dat zei iemand- wie ↑zei dat nou.
                but someone said that- now who ↑said that.
2               (.)
3               >volgens mij< een opleider vorige ↑week ofzo.=
                >I think it was< a supervisor last ↑week or sometime.=
4               =die zei van Qja jullie in je eerste jaar ben je altijd heel
                =he said like Qoh yes in your first year you're always very
5               erg (.) bezig met ↑echt een diag↑nose (.) eh eh erop plakken,=
                very (.) busy ↑really um um coming up with (.) a diag↑nosis,=
6               =terwijl dat soms ook helemaal niet eh (.) ↑hoeft.Q
                =when sometimes that isn't necessary um (.) ↑at all.Q
7               [>k weet niet< of je het daarmee ↑eens bent?
                [>I don't know< if you a↑gree with that?
8               [((looks at T))-----------------------------
9               [maar,]
                [but, ]
10              [------]--[----
11      T               [((nods [ ))
12                      [ja daar [ben ik het [heel erg heel erg mee eens.
                        [yes I agree with that very very much so.
13      R1                      [ja         [ja
                                [yes        [yes
14              en dat ↑dacht [ik-
                and that I ↑thought-
15      T                   [(dan heb je) duizeligheid,
                            [(there is this) dizziness,
16              ja en dat eh (.) dat is een symp↑toom.
                yes and that um (.) that's a ↑symptom.
17      R1      [ja.
                [yes.
18      T       [en dan (.) ja bij negentig procent ↑heb je daar niet echt een
                [but then (.) yeah for ninety percent you don't really ↑have
19              [een een onderliggende ziekte bij. ]
                [an underlying disease.           ]
20      R1      [nee en dat- (0.4) dat dacht      ] ik van ↑oh ja.=
                [no and that- (0.4) that I thought] like ↑oh yeah.=
21              =dat is eigenlijk ook wel voor ons [alle↑maal om te beseffen,]
                =that's actually relevant for us   [↑all to realize as well, ]
22      T                                          [ en  en  je  kunt  ook  ]
                                                   [ and  and  you  can also ]
23              tegen een patiënt ↑zeggen uiteindelijk,=
                ↑tell a patient ultimately,=
24              =maar dat moet je inderdaad nog leren,
                =but you still have to learn that,
25              (0.8)
26              dat het dat het een klacht is,
                that it it is a complaint,
27              en geen ↑ziekte,
                and not a ↑disease,
28              en dat het niks ernstigs is,
                and that it's nothing serious,
29      R1      [nee
                [no
```

```
30      T       [en dat het vanzelf weer over gaat,=
                [and that it'll get better by itself,=
31      R1      =ja.=
                =yes.=
32      T       =maar dat is het-
                =but that's the-
33              dat is uiteindelijk het het ↑huisartsen[spel.]
                but that's ultimately the the G↑P [game.]
34      R1                                         [ja. ]
                                                   [yes.]
35      R2      net als die huidproblemen.
                just like those skin problems.
36              daar is het ↑ook zo.
                it's the ↑same thing.
37              eh ik heb het heel vaak dat ik een plekje zie en denk van (…)
                um it often happens to me that I see a spot and think (…)
```

In singling out one teacher (line 9), the resident in this Extract orients to the relevance of this teacher's identity for ratification of the gist of the conclusion so far. Though only minimally recruited in a yes/no-formatted request for confirmation, the teacher resists the formal constraints set by this type of question (Raymond, 2003) to expand his initial strong agreement with the proposed insight (line 15–19). The resident's "and that I thought" (line 14) could be read as treating the teacher's agreement as sufficient. Alternatively, it could just signal that the resident has more to say – which appears so in the indexically related upshot of the discussion later on (lines 20–21). Here, the resident treats the teacher's turn, in which he refers to repeated encounters with similar situations (i.e., own experience), as further corroboration of the provisional conclusion of the discussion so far, and also as a learnable for all (line 21) (Zemel & Koschmann, 2014). What is going on here may be an attempt by the resident to claim vicarious expertise by having knowledge of a worthy lesson to share with everyone.

The following interaction could be interpreted in light of this interpretation as a negotiation of expertise between resident and teacher. The explication of a learnable, as we see R doing in line 20-21, is usually interpreted as closure-implicative in this setting (Veen & de la Croix, 2017). But again, the teacher continues his account by pointing to yet another reference to expertise (lines 22–30): an option for future conduct presented as part of a repertoire of options in situations like these ("you can also"). This suggestion moves the upshot of the discussion beyond the abstract "realization" proposed by the resident (line 21). Formatted as an end point of a learning process ("ultimately", "you still have to learn that", lines 23–24), the suggestion reinforces the asymmetry in professional competence between teacher and learners (line 24) while establishing his expert status in relation to the initial reference to the external source of expertise mentioned by the resident. With that, he reclaims his position as an expert on the matter. Throughout this extensive sequence the role of soliciting resident has changed into active recipient.

In this Extract, then, we see how a resident presents herself as a developing professional who has gained an insight outside of the group that may be worth sharing with her peers but licenses confirmation by the experienced professional in the room. In response, the teacher

modifies and expands this 'learnable', presenting himself as someone with access to this type of situation independently of the external source, while at the same time delivering the upshot of the discussion as shared by all members of the profession ("that's ultimately the GP game", line 33). This, in turn, is ratified by the recruiting resident (line 34) and also initiates a demonstration of understanding by another resident (lines 35–37) (Koole, 2010). Collaboratively, then, the participants have now interactionally constructed an expert understanding to which the teacher and residents relate from various positions along the trajectory of socialization into the profession.

Teachers may also resist 'doing being an expert', for example, when the information requested should already be known or when the preferred didactic option might be to build collaboratively toward an understanding of the matter (see Zemel & Koschmann, 2011, on teachers avoiding explicit third-position evaluations in favor of a questioning sequence to facilitate convergence in thinking). Extract 3 is an example of negotiating a need for sharing expertise as the interaction unfolds. In this case, the requested expertise is not ratification, but *information.* This request, directed at one teacher by direct eye gaze, makes doing being knowledgeable relevant. Indeed, teacher's ready "no" (line 3) can be interpreted as establishing an expert identity. Yet, he positions himself in a relative K^- stance by mitigating the information provided (lines 3–6: hesitations, "kind of threshold", "I guess", "possibly"). K^- stance generally signals relatively low epistemic access or rights to know (Drew, 2018), but note here the declarative mood. This can be heard as authorized voice (Morek, 2015; Mondada, 2012), which constructs K^+ status. In this case, the teacher's conveyed compromised access to the information requested initiates *collaborative* knowledge construction (line 9 and onwards):

Extract 3: request for information initiates collaborative knowledge construction

1	R1	wordt dit ver↑goed eigenlijk door de zorgverzekering.=	
		is it actually being reim↑bursed by the health insurance.=	
2		=die taxi?	
		=that taxi?	
3	T	nee alleen als je e::hm heb je een soort ↑drempel van volgens	
		no only if you u::m you have a kind of ↑threshold I guess	
4		mij ehm eh eh	
		um um um	
5		het verandert wel per jaar hoor,	
		it does change per year,	
6		>en misschien per zorgverzekering<=	
		>and possibly per health insurance<=	
7		maar >volgens mij heb je< een drempel van de eerste honderd	
		but >I think you have< a threshold you have to pay the first	
8		euro moet je zelf betalen,=	
		hundred euros yourself,=	
9	R2	=ja.=	
		=yes.=	
10	T	=en als je dus dan- taxi voor chemo of voor	[voor bestraling
		=and so if you- a taxi cab for chemo or for	*[for radiation*
11	R2		[ja.
			[yes.

```
12      T       [dan dan zit op een gegeven moment] dan eh ben je heel snel
                [then then at a certain moment    ] then um you'll very quickly
13      R2      [        (ja die dialyse )         ]
                [       (yes that dialysis)        ]
14      T       door die drempel heen,
                pass that threshold,
15              [(           )]
16      R3      [ maar je kan ] toch ook lid ervan zijn (.) of?
                [but you could] well be a member (.) or?
17              ((several people agree simultaneously))
18      R4      deel[taxi.
                sha[red cab.
19      R3          [gedeeld.
                    [shared.
20      T       ja dat is dan ehm
                yes that is then um
21      R3      zorgtaxi of regiotaxi.
                care taxi or regional taxi
22      T       ja dat zijn van die taxi's.
                yes there are those taxis.
```

The direct elicitation (request, eye gaze) of information from the teacher establishes his primacy to know (Myers, 2004; Stivers et al., 2011). The subsequent hedges and signs of doubt (lines 3–14) might be indications of the ways in which the teacher is attempting to retain the institutionally assigned role of expert in situation in which he is unsure about something someone else expects him to know. Ratification of the provisionally provided information would be relevant in this context and, indeed, that is what a resident provides in lines 9, 11 and 13. The following joint construction of knowledge on the finances involved in taxi transport for medical purposes creates a sense of a shared search for the way things are; belonging to the process of professional socialization.

As these three Extracts demonstrate, recruitment of expertise shows an orientation to the need for expertise and creates the opportunity for participants to collaboratively and progressively constitute a teacher's expert identity in that educational moment. In all three situations, residents appealed to expert access to knowledge (either experiential, as we saw in Extracts 1 and 2, or factual, as in Extract 3) in the form of ratification and information provision. The presented situations show that recruitment and provision of expertise is an interactional accomplishment: the extent and sufficiency of the recruited provision of expertise is under negotiation as the interaction unfolds.

Licensed expertise

Expertise may also be licensed by prior talk instead of being explicitly recruited. In this case, the expertise is offered in first position. Though not conditionally relevant, licensed expert contributions are formatted as made relevant by and building on something in the prior talk. As such, they show the teacher's orientation to a need for expertise. The following section presents two examples. In Extract 4, the teacher's 'doing being an expert' *settles an issue* of 'what is

allowed' related to the formal rules of supervision. In Extract 5, it *normalizes* disputed behavior. In both situations, the teacher conveys (higher) epistemic access to the norms of the profession.

The licensing context in Extract 4 (below) is a discussion about the formal rules applicable to a situation in this specific educational context: is a GP-in-training allowed to do home visits with someone other than their supervisor? One of the teachers raised the issue of doing co-visits with "you went alone" (not shown). Though formatted as a check, it is treated by the telling resident as an invitation to account for the supervision situation: she strongly disputes the suggestion that she did the visit on her own and follows this with an account of why she went with another supervisor. She concludes by suggesting that the other supervisor may have been a factor at play in the situation (lines 1–4). This could have rounded off the issue, but it did not. In addition to accounting for her supposedly not-quite-textbook situation, she now claims access to the formal rules *and* the messy mores of the profession by projecting yet another account ("but", line 6). The reference to formal guidelines seems to stir a reaction in the group (lines 7–10). Faced with this indistinct collective response, the teacher responds first non-verbally (line 9) and then verbally (lines 11, 13–15) by showing expert access to professional resources. This response is treated as 'settling the issue' (lines 16–20).

Extract 4: expertise settles an issue of interpretation of formal rules

1	R1	ehm (.) dus ik was ook met een andere opleider.=
		um (.) so I was with another supervisor.=
2		=dus misschien eh dat dat ook wel [eh-
		=so probably um that that might well [eh=
3	T1	[ja [ja.
		[yes [yes.
4	R1	[wat eh (>heeft
		[have eh (>made
5		uitgemaakt<).
		a difference<).
6		>maar het< mag officieel ↑niet >weet ik< maar,
		>but< officially it's ↑not allowed >I know< but,
7		((several people talking [indistinctly))
8	R2	[jawel [met een opleider dat mag wel
		[okay [with a supervisor it is allowed
9	T2	[((nods))
10	R3	(mits ze zoveel) jaar er↑varing hebben mag het.
		(at least if they) have so many years of ex↑perience it's allowed.
11	T2	ja.=
		yes.=
12	R1	=oh maar hij is ook al [jaren opleider.]
		=oh but he's been a supervisor for [years and years]
13	T2	[(het hoeft ook niet eens een opleider)]
		[(it doesn't even need to be a]
14		te zijn,
		supervisor),
15		maar als het maar een ervaren huisarts is.
		so long as it's an experienced GP at least.
16	R1	↑oh.

```
                ↑oh.
17              [nou,
                [well,
18              [((several [people talking simultaneously))
19                         [(ik vond-) op ↑zich vond ik het heel leuk
                           [in it↑self (I found-) I liked it a lot
20              om ook eens met een andere opleider mee te gaan,
                going with another supervisor for a change,
```

The way the residents discuss the issue of taking another supervisor along on home visits calls on a semantic field of rules of conduct in the profession ("allowed" "officially"). Residents offer their convergent interpretations of these rules (lines 8–12). In overlap, the teacher takes a turn to formulate an even stronger heuristic ("it doesn't even need to be"), which makes the prior argumentation irrelevant (lines 13–15). His display of access (Stivers et al., 2011) to the formalities of the profession in this situation initiates the closing of the issue: it is acknowledged with a change-of-state token (Heritage, 1984), which does understanding of something that had been problematic (line 16) (Seuren, Huiskes, & Koole, 2016), and in turn is followed by a *well*-prefaced turn that treats the former as an interjection and returns to the main topic of the discussion (Mazeland, 2016) (lines 15–18).

In this Extract, then, we see how ambiguity about the interpretation of formal guidelines induces a teacher display of access to the rules of the profession. The residents implicitly position themselves as 'not-yet-full-members of the profession', which licenses a display of expertise, which in turn is treated as settling the issue. Together, participants thus construct the teacher's identity as an expert who is granted the final say in issues that concern professional standards. Gaining access to these standards can be seen as part of the process of socializing into the profession.

A similar indefiniteness about professional conduct is visible in Extract 5. Here, however, we see that residents explicitly do 'being an apprentice'. In exploring the desirability of searching the internet for information during consultations, one resident claims a feeling of incompetence ("clumsy", "very strange", "I've just got to look it up"; not shown). Others respond that internet use can be okay if framed in a particular way and that patients do not necessarily mind. Still, the suggested wording of this framing (not shown) and the reaction of one patient to one resident's internet use (lines 1–3) are treated as laughables (Glenn, 2003; Ford & Fox, 2010), indicating a nonseriousness that further contributes to the ambiguity of the informal norms at play here. Such ambiguity in combination with the discourse of perceived inadequacy makes relevant a reassuring normalizing action of the experienced professional in the room (lines 7–15). Indeed, the teacher self-selects following the closing-implicative formulation (Heritage & Watson, 1979) of one of the residents in line 6. By referring to repeated occurrences of the type of situation under discussion (line 8), as well as by referring to himself as "even I" who, just like the residents, "still" has to look something up, he constructs his opinion as coming from a professional at the established end of the socialization spectrum.

Extract 5: expertise normalizes an issue of ambiguity

1	R1	maar een patiënt zei ↑gister tegen mij
		but ↑yesterday a patient said to me
2		Qhé ken jij dokters versus >internet<.=
		Qhey do you know doctors versus >internet<.=
3		=maar jij bent alle↑bei.
		=but you're ↑both.
4		((laughing and [indistinct mumbling [by several people))
5	R1	[dus-
		[so
6	R2	[('tis een combinatie ja.)
		[(it's a combination yes.)
7	T	>maar toch< is het niet ↑gek.=
		>but still< it isn't ↑weird.=
8		=ik zeg ook nog wel eens [tegen een patiënt
		=sometimes even I still say [to a patient
9	R3	[ja.
		[yes.
10	T	dat ik iets [moet opzoeken,
		I have to look [something up,
11	R2	[ja.
		[yes.
12	T	of dat ik het ↑ook niet precies uit mijn hoofd weet,
		or that I don't know it off by heart ↑either,
13	R2	[ja even in de protocollen (of zo)]
		[yes just the protocols (or something)]
14	T	[en van mij mag je- dat is helemaal-]
		[and I don't mind that- that's completely-]
15		dat is echt niet zo ↑gek ↓hoor.
		that's really not that ↑weird ↓hey.
16	R4	nee=
		no=
17	R5	('k heb ook wel een paar keer gehoord) Qja het is ↑logisch dat
		(I've heard that a few times) Qoh yes it's ↑logical that
18		je [niet al die namen [kent ofzo.=
		you [don't know all those [names or something.=
19	T	[ja. [ja.
		[yes. [yes.
20	R5	='tis (ook niet zo dat- [ )
		=it's (not as if- [ )
21	R3	[ik vind het juist (vaak) zorg↑vuldig.
		[I think (often) it's being me↑ticulous.

At play here is professional expertise and ways to deal with the lack of it in front of a patient who may assume that you have expert access to that knowledge. The discourse of incompetence in the face of the perceived informal norms of the profession creates a relevance for reassurance. By marking a contrast with the previous ("but still", line 7), doing a sharedness in experience ("even I", line 8), and endorsing the problem as a recurrent issue ("still", line 8), the teacher normalizes the problem. In addition to that, his 'doing allowing' ("I don't mind that") and his presentation of the case as nothing extreme ("completely", line 14, and "really not that weird", line 15) further normalize the behavior. In combination with the conclusive "really not" and "hey", this normalization provides the reassurance that touches off from the prior discourse of incompetence and ambiguity.

The reassurance is received with tokens of acknowledgment (lines 9, 11, 13, 16) and an upgraded positive assessment of the discussed way of doing: it is not merely "not that weird" (line 15), but "often it's being meticulous" (line 21). With that, the residents treat the teacher contribution as a timely, fitted, and 'potentially to be agreed with' action. In this interaction, thus, we see participants working together to establish standards of conduct, orienting along the way to the exemplary function of the teacher as an experienced member of the profession. The teacher's 'dissolving' function, as shown in this and the preceding Extract, is exemplary for contexts that license expertise.

Volunteered expertise

When expertise is volunteered, the teacher assumes a need for expertise without the expertise being explicitly asked for or being licensed by prior talk. These offerings, done in first position, show an orientation to something amiss, missing, or otherwise in need of 'repair' (van Braak, Huiskes, & Veen, submitted). These things need to be ratified in second position, for example by a claim or demonstration of understanding, in order to establish the teacher's expert identity. The teacher can endorse such ratification in third position, which completes the interactional accomplishment of 'doing being an expert'. Alternatively, the teacher's offered expertise may also be resisted in second position, initiating a pursuit or topic change, or the need for expertise may be subjected to negotiation. The following shows four examples of proffered expertise that accomplish different things compared to their elicited counterparts: advice (Extract 6) and correction-like monitoring of the professional norms at stake (Extracts 7–9).

In Extract 6, the teacher demonstrates access to the type of situation that resident 1 has been sharing by offering a possible strategy for dealing with a recurrent problem. This proffer of *advice* is formatted as a contrast ("can", line 14) to the "difficulty" (line 3) of the as-yet only partially solved situation (a conflict with a patient; lines 4–13). The form ("I" "sometimes" "that") highlights the sharedness of the feeling, 'does' experience, and also allows room for alternatives. While there is no go-ahead for the offer (line 16), the teacher goes on to produce it anyway (lines 17–18).

Extract 6: offering a possible way to deal with a recurrent problem

1	T	maar toch had je de hele middag nog dat rotgevoel.
		but still you had that bad feeling the whole afternoon.
2	R1	ja.
		yes.
3	T	ja (0.5) ja ↑das lastig.
		yes (0.5) yes ↑that's difficult.
4	R1	het was ze was uitgeraasd en ze sna-
		it was that she'd finished raging and she did un-
5		ze ze zei ook dat ze mijn punt snapte hè dat het .h eeh
		she she also said that she understood my point you know that it .h um
6		ik ↑had ook gezegd dat die ↑vrijdag wat onhandig van mij was,=
		I'd ↑said that that ↑Friday I'd been a bit clumsy,=
7		=hè?
		=you know?
8		de rest heb ik niet gezeg- (dat zeg ik) Qdat daar kan ik
		I didn't say the rest- (I mean to say) Qthat I can't say
9		helemaal niks over zeggen,=
		anything about that,=
10		=dat moet u ↑niet met mij bespreken,
		=you ↑can't discuss that with me,
11		(0.4)
12		eeh (0.8) ja.
		um (0.8) yes.
13		nee dus het was wel- het was wel deels uitgesproken.
		no so indeed it was well- it was partially set straight.
14	T	ik kan je wel vertellen hoe ↑ik dan soms van dat rotgevoel een
		then I can tell you how ↑I sometimes try to ↑sort of get rid of
15		↑beetje af probeer te komen?
		that rotten feeling?
16		((blank [stares))
17		[en dat is even bij mijn c(h)oll(h)ega
		[and that is by dr(h)opp(h)ing in on my
18		b(h)innenlop(h)en (.) hahaha van me af.
		c(h)oll(h)eague (.) hahaha getting it off me.
19	R1	ja maar ↑die is dan al bezig met ↑spreekuur zeg maar.
		yes but then ↑they'd be busy doing consul↑tations- just saying.
20		haha[haha
21	R2	[ja (.) ↑ik dacht altijd dat je ging ↑skiën.
		[yeah (.) ↑I always thought you went ↑skiing.
22	T	[(nou) ((head shake))
		[(well)
23		[((group laughs))
24	R1	nou ik ben wel even- volgens mij ben ik nog vijf minuten bij de
		well I think I popped in for just five minutes
25		assistente even wezen e:h-
		to see the assistant u:m-
26	R3	ja das wel [goed even bakkie thee halen ja.]
		yes that's [good just grabbing a cup of tea yeah.]
27	R1	[thee drinken zeg maar ja] ik (dacht)
		[a tea break you know yes] I (thought)
28		Qloop [toch al een half uur uit dus eeh]Q
		Qoh I'm [half an hour behind schedule already so eh]Q

29	T	[even ja even] *[just a moment yes just a moment]*
30	R1	haha[ha
31	T	[even van je af e:h *[just putting it away from yourself e:h*
32	R1	precies.= *exactly.=*
33		=even- maar toch blij- ja het ↑blijft gewoon hangen ↓ofzo. *=just- but then still- yes it's ↑still in the air ↓or something.*
34	T	ja (.) nu ook nog? *yes (.) even now?*
35	R1	nee nu niet meer.= *no not anymore.=*
36		=want ik had dat was vrijdag, *=because I had that on Friday,*
37		toen had ik zaterdag alweer dienst, *then I had rotations again on Saturday,*
38		heb ik met mijn opleider alweer nagesproken, *I've already discussed it with my supervisor,*

By proffering her advice in the form of a personal coping strategy that closely resembles the organizational structure of a second telling in response to a first telling (Arminen, 2004), the teacher orients to the need for a solution to the problematic situation. Her advice – an action typically perceived as expert conduct (Herijgers & van Charldorp, 2020) – is not accepted at first but rejected as unworkable ("yes but", line 19) and treated flippantly (lines 20–23). By showing a vulnerable and more nuanced professional persona, the teacher sets themselves up as something else than a flawless role model with all the answers, which might be the reason for the jokes: showing the residents a future where they will sometimes still be clueless might not be the most attractive prospect for professionals in training.

At this point (line 22/23), the teacher could have worked to account for or elaborate on her advice, by referring further to her experience and the benefits outcomes of the strategy, for example. None of this happens. Instead, the resident experiencing the problem shares how she did something similar to what the teacher 'advertises' (lines 17–18). This initiates a sequence in which several residents and the teacher collaboratively establish the value of the coping strategy. Midway this collaborative construction, the teacher repeats the ultimate goal of the strategy, this time from the perspective of the other ("just putting it away from yourself", line 31, see line 18). The general consensus now seems to be that the proposed strategy can be helpful in dealing with situations like these. Once again, however, the tide is turned, when the resident seems to diminish the value of the strategy by noting that talking did not take away her bad feeling (line 33), but that a similar strategy (to talk it over with her supervisor) did (lines 35–38).

Extract 6 thus shows an instance of proffered expertise that was not readily accepted, but triggered a negotiation about its usefulness in the type of situation discussed. In this negotiation, the teacher did not hold her stand *because of* her expert status, nor did she explicitly *refer to* her expert status to establish the value of her contribution as an expert professional (although giving

advice in the context of a troubles telling conveys K+ stance and establishes her institutionally assigned K+ status; cf. Drew, 2018). The troubles telling context (Jefferson & Lee, 1981), may explain its hesitantly construed acceptance.

The trickiness of proffering expertise without being asked for it is also evident in the next example. Offering unsolicited expertise might go against norms of engagement in everyday interaction (cf. Jefferson & Lee, 1981), but in the current educational context it appears acceptable (at least to some extent). In extract 7, the proffer is done in post-position (Schegloff, 1996), bearing a hint of *correction*. Situated toward the end of a discussion, one resident invites the teller of the experience to share her feelings (line 1). In her reflection (lines 2–9, partly shown), the teller mentions her supervisor's positive evaluation of her conduct in practice (not shown). The evaluation is placed in a closing-implicative report of positive feelings, setting the scene for a change of topic. The teacher, however, brings up "just one more thing" (line 12), showing an orientation to something in need of being set straight. He displays some reservations about the resident's conduct ("I think that is quite a thing") with reference to his own practice ("I wouldn't do that so fast so easily") and accounts for that opinion ("I think") in terms of generalities (lines 19–26) that constitute his expert status as an experienced professional (Morek, 2015). This contribution accomplishes a disagreement between the external source and the teacher himself, setting the tone for further discussion (lines 27–46).

Extract 7: disputing an expert's positive evaluation of resident conduct

1	R1	heb je 't uiteindelijk wel met een goed gevoel ehm-
		did you end up with a good feeling um-
2	R2	'k heb met een goed gevoel- ja ook uh >toen ik wel hoorde dat
		I did with a good feeling- yes also um >when I heard that
3		ie was overleden< dacht ik Q↓ja ↓jaQ.
		he had passed away< I thought Q↓oh yes ↓oh yesQ.
((5 lines omitted, further description of situation and feelings))		
9		en dan slaap je toch wat rustiger,=
		and so you're sleeping a bit better,=
10		=en dan zit je niet °ergens meer mee°.
		=and then you aren't left °with anything anymore°.
11	?	°ja goed°.
		°yes right°.
12	T	nog even uh uhm bij een niet bekende patiënt terwijl d'r met de
		just one more thing um um starting palliative se↑dation
13		eigen huisarts niet over gesproken is palliatieve se↑datie
		for an unknown patient without discussing it
14		starten,
		with their own GP,
15		dat vind ik wel een dingetje zeg maar.
		I think that is quite a thing just saying.
16		[((several residents produce soft yesses, nodding))
17	T	[zou ik zelf niet zo makkelijk zo snel doen.
		[I wouldn't do that so fast so easily.

18	R2	˚nee˚.=
		˚no˚.=
19	T	=he want anders- je kent al die omstandigheden niet,
		=you know because otherwise- you don’t know the circumstances,
20		ja als je dat start dan is dus die persoon ook inderdaad in
		yes if you start it then that person is indeed
21		slaap.=
		asleep.=
22		=en die wordt niet meer wakker [in principe.
		=and he won’t wake up again [in theory.
23	R2	[˚ja˚.
		[˚yes˚.
24	T	dus die ja die heeft ook- kan dan niet meer met z’n huisarts
		so yes he also- in this case he can’t communicate with his own GP
25		˚of naja˚.
		˚or yes˚.
26		communi↑catie is ↑ook gestopt.
		communi↑cation has been stopped ↑too.
27		((R3 and R4 talk simultaneously))
28	T	hè?
		what?
29	R3	dan kan je dat intermitterende doen toch?
		then you could do that intermittent thing couldn’t you?
30		((several people talking indiscernibly))
31	T	ja maar dat [zou]
		yes but that [would]
32	R3	[want] zo’n pomp kan je weer stopzetten hè?
		[because] a pump like that can be stopped again
		can’t it?
33	T	nee ↑dat klopt <u>oo</u>k,
		yes ↑that’s right t<u>oo</u>,
34	R3	([↑afspreken.)
		([↑arrange it.)
35	T	[˚>dat klopt ook<˚.
		[˚>that’s right too<˚.
36		maar je je neemt wel een enorm <↑v<u>oo</u>rschot> [op op het beleid
		but you you’re really getting <a↑h<u>ea</u>d> [of of the policy
37		[((several people
38		say yesses))]
39	*T*	*van de eigen] huis[arts.*
		of the own] G[P
40	R5	[ja (.) tenzij het beleid al ↑vast ligt.
		[yes (.) except when the policy has been ↑set.
41	T	naja dat (.) goed dat kan [kan.
		well then (.) okay that’s [possible indeed.
42	R5	[([ )
43	T	[zorgplan (.) gaan we weer.
		[care plan (.) here we go again.
44		nee dat klopt.
		no that’s right.
45	R6	maar je zou dan dus wel doen wat ((R2)) gedaan heeft?
		but in this case you would do what ((R2)) did?
46		((T explains that he indeed would do so))

By presenting his doubts as necessary to be mentioned despite the topic nearing its closing, the teacher treats both the other expert's evaluation of the resident's conduct and the residents' conduct itself as problematic. This could have instigated a defense by the resident (R2), but it does not (see also lines 18, 22). Rather, it initiates a negotiation about the topic in which the teacher presents himself as knowledgeable (lines 27–44). This negotiation ends with a reference to the "care plan", which is treated as an already-closed topic (line 43). The next move is again a teacher-addressed solicitation of expertise in the form of a request for confirmation of his use of the particular approach mentioned earlier (line 45).

Noteworthy in in this Extract 7 is the post-formatting of the teachers' doubt. It signals the constant monitoring work that the teacher seems to be doing: whatever creates a wrongful idea about the professional norms or rules of conduct in certain situations must be corrected before it is ratified by the closure of the topic to which it relates. We see similar actions when teachers make explicit their assessment of the discussion as 'lacking' something, e.g., "what I still miss in the story / because I have worked with asylum seekers a lot in past times and this sort of made me think about that". In one rather atypical example, the teacher places himself in lower epistemic position ("I don't know for sure") while showing an orientation on their monitoring task:

Extract 8: doubting suggested long-term effectiveness of a drug

1	R1	hè want dat is eigenlijk de de standaard hoe je alles ↑afbouwt.
		PART because actually that is the the standard for coming ↑off everything.
2		dat doe je met benza's [(dat doe je met])=
		that's what you do with benzos [(that's what you do with])=
3	R2	[( )]
4	R1	=je zet om tot iets langwerkends >zodat mensen beetje de<
		=you switch to something with long-term effects >so that people
5		gewoonte ook uh (.) ↑afleren,
		sort of< ↑lose uh (.) the habit too,
6		maar dat je- de ↑stof afbouwen- dat je dat eh langzaam zo
		but that you- reduce the ↑substance- that you do it slowly like
7		((downward hand move))
8	T	is dat- wat- van die ↑benzo's weet ik niet helemaal zeker.=
		is that- what- about those ↑benzos I don't know for sure.=
8		=volgens mij is dat juist een kwestie van omzetten naar
		=I think that's actually a question of switching to
9		diaze[↑pam.
		diaze[↑pam.
10	R2	[diaze↑pam.
		[diaze↑pam.
11	R3	[dat is ook de langwerkende.]
		[that's the long-working one.]
12	R1	[dat is ook de langwerkende.]
		[that's the long-working one.]
13		daarom doe je dat.
		that's why you do it.
14		(.)
15	T	.h ˚ok˚

```
                .h °okay°
16      R1      langwerkende- langwerkendste benzo.
                long term- longest term effect benzo.
17              dat kun je dan rustig afbouwen.
                then you can slowly scale it back.
18      R2      °ik vind die ( ) wel een goeie inderdaad°.
                °I think those ( ) is really a good one°.
19              want ik heb nu gezegd ((vervolgt))
                because I've now said ((continues))
```

With the indexical "is that" and "that's", here the teacher hooks onto the information shared about the long-term effectiveness of an opioid (lines 2–6). Without backing up his doubts about this information, he offers the name of an opioid as an alternative to use to get people off the meds. Though not making an explicit reference to experience, he proffers the suggestion as coming from his own understanding of how things are ("I think", line 8). It turns out that this offered drug is exactly what the resident was talking about (lines 11–12). The resident's explanation ("that's why you do it", line 13) and the teacher's acceptance of it ("okay", line 15) move the interaction out of what has now become a clarification sequence. In this case, then, the teacher's monitoring action eventually resulted in sharing knowledge about the workings and function of a drug, which is part of the knowledge base of the profession and thus contributes to the socialization of its members.

Teachers' orientation to monitoring an interaction for something 'missing, 'wrong', or otherwise in need of 'repair' highlights their heightened epistemic access to professional ways of doing and being. Sometimes, however, their proffered expertise goes against a general understanding of the formal rules of the profession (e.g. treatment protocols). We see a clear orientation to this tension in Extract 9 (below), when participants collaboratively construct a best practice for dealing with communication with the GP's weekend service. GP visits outside office hours are organized in regional centra manned by GPs who work in a GP practice in the region. That means that consultations outside office hours usually are with a GP who is not the patient's own GP. To communicate the results of the consultation, GPs make notes in the patient dossier or send results by uploading documents in the digital patient system.

In this Extract, the teacher initiates the sequence by connecting an ambiguously critical question to prior talk ("because I was wondering about that you know", line 4). In this situation "I was wondering" seems to mark a contrast, introducing a doubt about what has been established as common practice or 'just the way things are' (lines 1–3 and before, not shown). Although the question seems to prefer a no-response in this contrastive context, resident 2 builds a case that notifying a patient's GP by mail should indeed be enough (11–13, 18). She contrasts 'feelgood' behavior with lawful behavior (lines 15, 18). This contrast is further unpacked by the teacher in a contribution that settles the issue based on her own experience (lines 19–26).

Extract 9: collaborative exploration of a heuristic for practice

1	R1	en en tussendoor is er nog weinig
		and and in the meantime the GP
2		door de huisarts gebeur-
		hasn't done mu-
3		in ieder geval (.) bij ( )=
		in any case (.) with ( )=
4	T2	=want dat vroeg k me af hè,
		=because I was wondering about that you know,
5		want want als je het no↑teert,
		because because if you take ↑note of it,
6		hè (.) als je ↑echt wil dat de huisarts iets doet,
		you know (.) if you ↑really want the GP to do something,
7		(1.0)
8		is no↑titie dan (1.1) [(˚voldoende˚.)]
		is a ↑note then (1.1) [(˚sufficient˚.)]
9	R2	[er is] laatst iemand
		[recently] someone
10		aangeklaagd omdat-ie de ↑post niet op tijd had gelezen.=
		got sued because he didn't read his ↑mail in time.=
11		=dus ik denk dat dat wel redelijk (leidend) is.
		=so I think that that is relatively (leading).
12		als in (0.6) je bent als huisarts verplicht om (.)
		as in (0.6) as a GP you are obliged to (.)
13		je:: (.) schriftelijke:: brieven van de HAP te ↑lezen.=
		↑read you::r (.) letters:: written by the GP post.=
14		=dus ik denk dat ja ik kan me voorstellen dat je-
		=so I think that yes I can imagine that you
15		gevoelsmatig=
		feeling-wise=
16	T1	=ja=
		=yes=
17	R2	=e:h wel een belletje doet,
		=u:m you would give them a call,
18		maar (0.4) ju↑ridisch >is dat ↑denk ik< ˚voldoende˚.
		but (0.4) ↑legally >it is ˚enough˚< I ↑think.
19	T2	ja precies want zo gaat het (.) v:aker met de post.
		yes exactly because that's how it (.) o:ften goes with the post.
20		dus je bent er niet,
		so you're not there,
21		of je bent net twee dagen weg,
		or you're away just for a couple of days,
22		assistente (.) voert alvast de post in,
		assistant (.) is already registering the mail,
23		(1.6)
24		ik denk als je echt wil dat de huisarts eh
		I think that if you really want the GP eh
25		op de hoogte is en eh (.) ( ) (.)
		to be informed and eh (.) ( ) (.)
26		dat dat je niet op de: (0.4) ↑post (0.3) moet vertrouwen.
		then then you shouldn't (0.3) trust the: (0.4) ↑mail.
27		(1.4) ((soft agreeing sounds))
28	T1	en als het er zo (.) staat zoals jij voorlas hè
		and if it is written (.) like you read it PART

Here we see a collaborative exploration of how to deal with a situation: communicating (as an out-of-office hours GP) something very important to a patient's own GP. The teacher's contribution to this sequence of searching for good practice is, first, initiating it in a way that may raise doubts about the proposed approach, and second, its closing. In this closing, she demonstrates access to the way things are (lines 19–22: "that's how it often goes", generic 'you', declarative mood; Morek, 2015). This exposition is received in silence; its commonness unacknowledged. Nonetheless, it functions as a powerful buildup to the practice-based heuristic of dealing with the situation. Its if-then format in combination with the stressed "really" (line 24) and downward intonation contour present the heuristic as a final say, as it indeed is treated by the residents' minimal agreement (line 27).

In this example, then, the teacher proffers a heuristic based on experience with messy practice instead of the formal rules presented in textbooks. She does so in a way that aligns her contribution with the ongoing discussion, though her exposition of hands-on lived experience in fact positions her subsequently presented heuristic as a lived one that may be based on a reality that the others do not have access to yet. The other participants orient to the power of experience to seal the discussion by not contesting the proposed heuristic, going along with its closing-implicative nature. In doing and being granted the final say, the teacher thus provides strong guidance in the process of socializing into the profession.

Discussion

In this study, we describe practices of expertise and their function in different sequential contexts. Expertise needs to be made relevant by participants. That presents participants with the question when expertise could or should be made relevant and for what purpose. From our Conversation Analytic study in the context of group discussions on experiences from practice in GP training, we draw two main conclusions about participants 'doing being an expert'.

The first main finding is that 'doing being an expert' is made interactionally relevant in three sequential positions (similar to types described in mundane conversation, see Schegloff, 2007) that have implications for its interactional function, that is, the interactional ratification of the need for expertise. When residents *recruit* expertise, they explicitly position themselves as not-yet-full-members of the profession, making a display of expertise by an experienced professional *conditionally relevant*. In our recordings, these displays served ratifying and informing functions (see Extracts 1–3) that build on high access to formal as well as informal and practice-based knowledge and experience. An interesting side point here is the difference between access to knowledge and access to experience (Heritage, 2011; Sacks, 1995). Whereas knowledge (or, more precisely, information) can be shared and become equally accessible by the one who shares the information and those receiving it, experiences merely become second-hand experiences for those with whom they are shared. Until residents themselves have had an experience that a

teacher claims recurrent access to, the experience can never be 'owned' and thus never be understood as lived experience. In that sense, sharing experiences only foreshadows the path to socialization in that type of situation; it does not work toward it as sharing of information does.

When residents' prior talk *licenses* 'doing being an expert', as is the case when residents implicitly position themselves as 'on the way to' membership of the GP profession, teachers treat expertise as *called for* (van Braak, Huiskes, & Veen, submitted). These sequential contexts typically accomplish clarity about what is normal or allowed in the profession (see Extracts 4–5). More than recruited expertise, 'doing being an expert' as touching off from prior talk needs to be ratified in second position for the teacher's expert identity to be accomplished. Here, as well as in the third sequential context, we see how casting an institutional identity is indeed "indexical and occasioned" (Antaki & Widdicombe, 1998, p. 3).

When teachers *proffer* expertise, the need for expertise is *assumed* and established in first position. Teachers in these contexts clearly show an orientation to something in need of attention for some reason (cf. van Braak, Huiskes, & Veen, submitted). Displays of proffered expertise typically give advice or iron out misunderstandings. As well as actions that settle an issue when ambiguity about the norms licenses such decisive action, proffered expertise actions closely link to the normative nature of socialization. The existence of formal rules and informal ways of being and doing implies rights and wrongs (and possibly gray areas, too) and makes relevant interventions directed toward good, professional behavior. As we have seen, however, the relevance of the shared expert information must be ratified in the next turn.

Summarizing these findings, then, our first main conclusion means that epistemic/experiential positioning is essential to the construction and interpretation of action. It is a sequential matter for the participants to negotiate; this negotiation is part of how participants constitute their locally relevant identities. A great deal of that negotiation is about epistemic rights and responsibilities. Like teachers, residents also convey or claim an extent of epistemic access (sometimes even primary epistemic access) to aspects of the topic at hand (see e.g., Extract 5, 8). Such displays can result in sequences of collaborative knowledge construction (see e.g., Extract 3). That this is the case, however, is not a novel finding: it is largely in line with prior work on identities en epistemics in other institutional contexts (e.g. Antaki & Widdicombe, 1998). What this study adds, is the connection between the construction of expert actions and identities with the specific medical educational context in which professional socialization (Biesta & van Braak, 2020) is key.

The second main finding, then, is that 'doing being an expert' contributes to residents' ongoing socialization process in three ways. First, by positioning themselves and being positioned as expert representatives of the profession, teachers provide access to the culture, tradition, and practices that are lodged within the specific professional community (Goodwin, 1994; Biesta, 2020). The interaction in which this takes place is a "meeting point of discourses and practices" (Widdicombe, 1998, p. 200), in which the resident is invited to 'locate' or 'position' themselves in some way in the professional ways of doing and being (Widdicombe, 1998; Carr,

2010; Biesta, 2020). This process of locating oneself is what we see playing out in negotiations of expertise (e.g., Extract 6), ratification of expertise (e.g., Extract 5), and transfer of expertise to other situations (e.g., Extract 2). This is the identity work that socialization entails (Biesta, 2020). Second, teachers 'doing being an expert' contribute to socialization by attending to the tension between textbook guidelines and messy practice (see especially Extract 9). Access to the messiness of practice is treated as a resource that creates room for dialogue between the formal guidelines and actual practice; what may be referred to as the hidden curriculum (Biesta, 2020).

Third, 'doing being an expert' contributes to the construction of 'socialized' understandings of situations, or "professional vision" (Goodwin, 1994, 2017). What is professional about this way of seeing the world is that it is oriented to, presented as, and recognizable as ways of seeing that "shape events in the domains subject to their professional scrutiny" as "objects of knowledge that become the insignia of a profession's craft", objects that "animate the discourse of a profession" (Goodwin, 1994, p. 606). By constructing situations as instances of a type of recurrent situation, teachers thus transform the situation discussed into something relevant and recognizable as part of the profession. This is the very act of socialization.

Our study has provided a detailed description of one of the most steering interventions that teachers can do: 'doing being an expert'. This description is valuable as a representation of practices for discussion in teacher professionalization training. The extracts could be used in a CARM-like training (Stokoe, 2014), where actual educational situations are played, stopped, and discussed as the interaction unfolds. Apart from that, our analyses provide a number of suggestions for educational practitioners. The different ways of bringing in expertise show the plethora of options that teachers have to represent the culture, tradition, and practices of the profession (Biesta, 2020). These could serve as examples to enrich the teachers' palette of options to do so. Interestingly, some of these representations are done on teachers own behalf, with reference to probably unique individual experiences. These can be effective, too – contrary to what teachers may believe about withholding individual experiences for the detrimental effect it is sometimes perceived to have on the interactional process. Further research could investigate situations where the individual expertise of a teacher is oriented to as individual-in-contrast-to-collective expertise, to describe how these situations get treated and probably work toward socialization in different ways. Another suggestion is to exploit the provisional status (Myers, 2004) of expert identities – a finding resulting from the study's situational, interactional approach to expertise. Teachers could deliberately adopt an epistemic higher or lower stance to elicit different types of responses and thus steer the ongoing discussion. We have not systematically researched how lower epistemic stances adopted by teachers are responded to and how they could contribute to socialization – this is an area for future investigation.

Our analyses show when and how participants invoke, manifest, or otherwise make 'doing being an expert' live (Widdicombe, 1998) in the context of socializing into the profession of general practice. Although we acknowledge that our definition of displays of expertise has

been quite broad, our approach has allowed us to formulation suggestions about what may create an environment for ratification versus resistance to the expertise and, following that, how we value these reactions in such didactical terms as socialization. Such description helps us understand how teachers as established members of the profession can create opportunities for the formation of professional identities of residents (Cruess, Cruess, Boudreau, Snell, & Steinert, 2014) – which is at the heart of professional socialization.

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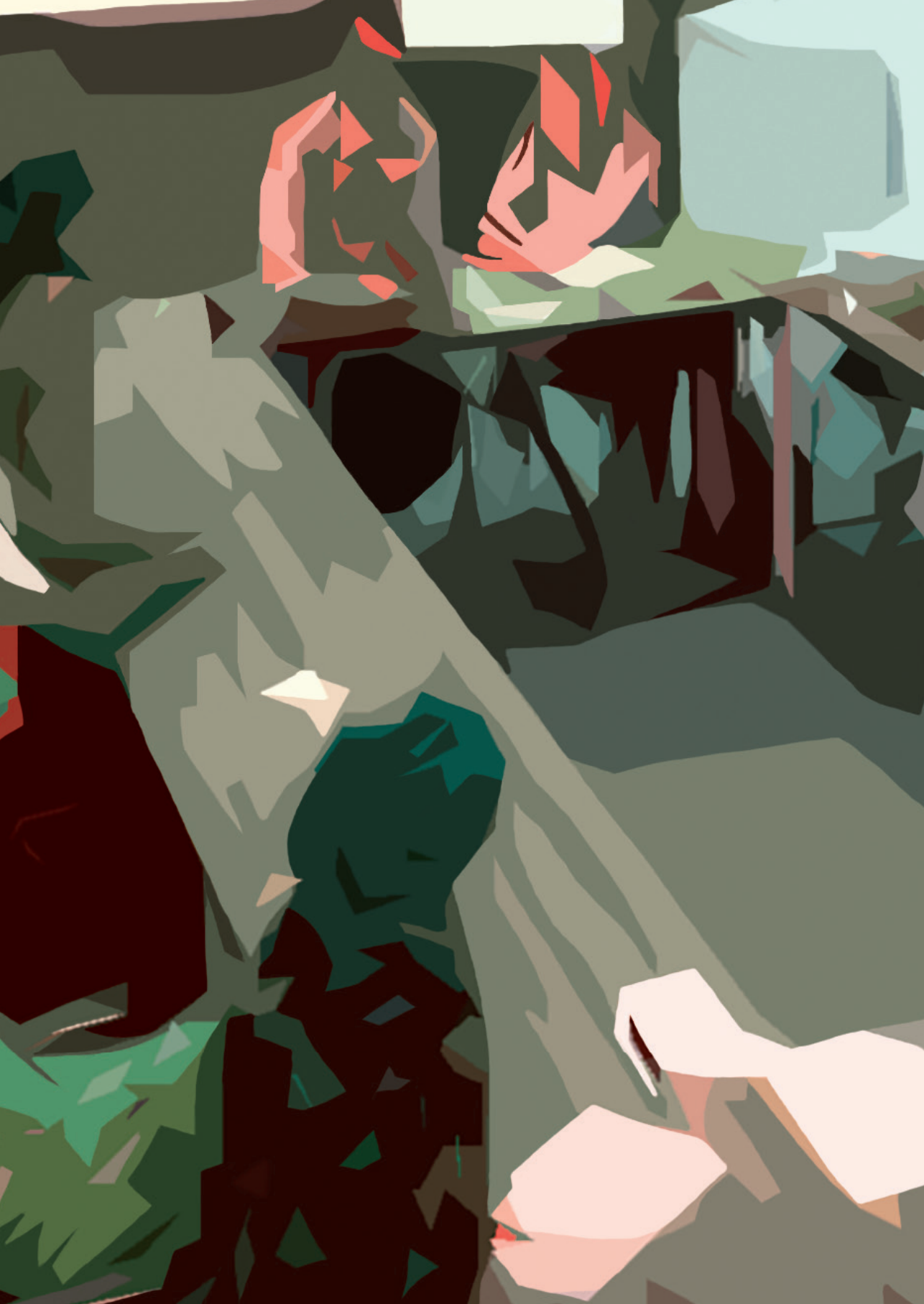
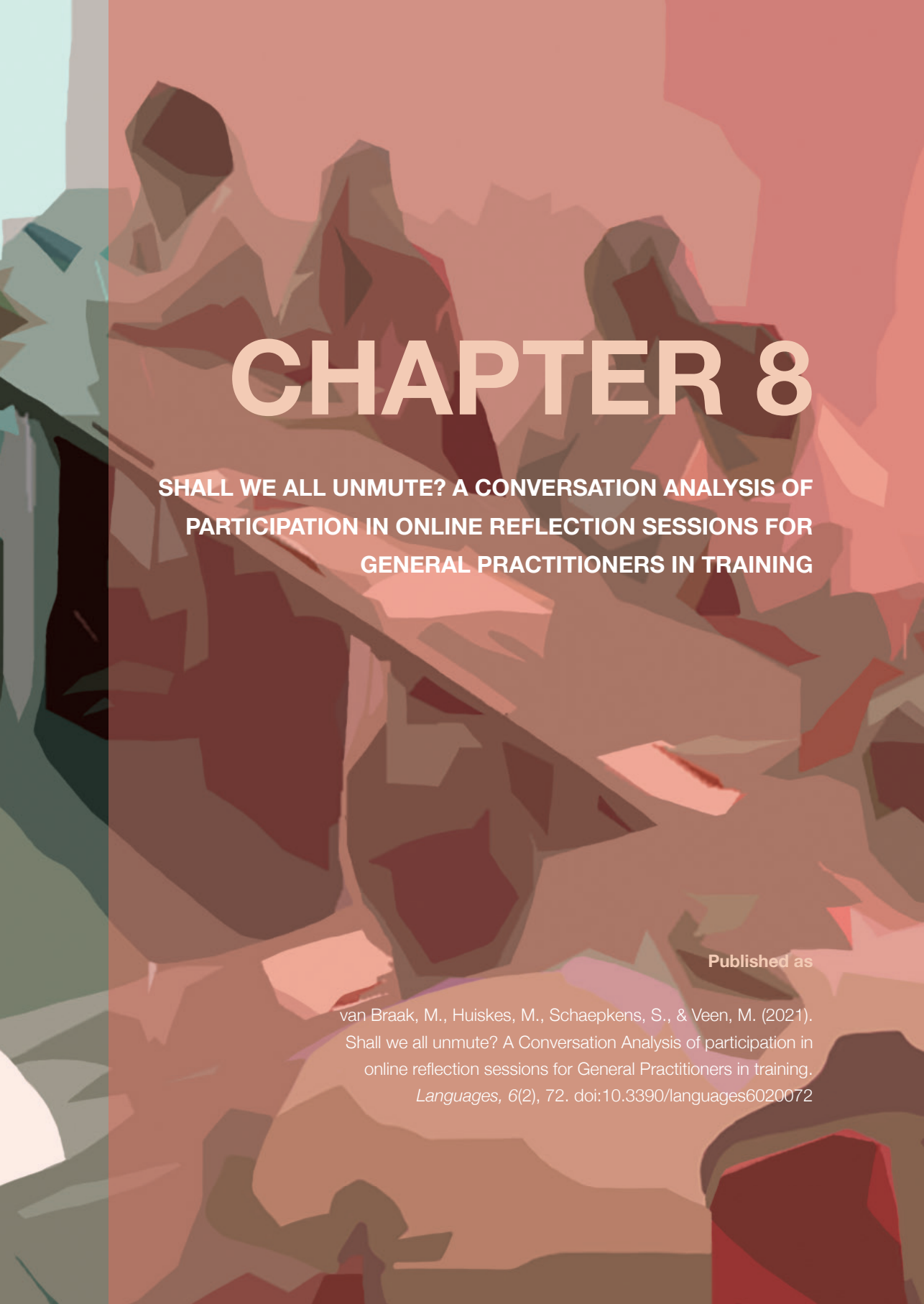
7





CHAPTER 8

SHALL WE ALL UNMUTE? A CONVERSATION ANALYSIS OF PARTICIPATION IN ONLINE REFLECTION SESSIONS FOR GENERAL PRACTITIONERS IN TRAINING

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Abstract

The COVID-19 pandemic has induced many changes to education in many contexts. In this study, we describe how general practitioners in training (residents) accomplish participation in collaborative reflection sessions conducted on Zoom. In this online setting, taking part in interactions is understood to be crucial to the creation of educational value. To study forms of participation used on Zoom, we recorded three group reflection sessions and examined them with Conversation Analysis. We focused on how participation is shaped by and is contingent upon the affordances of the online environment. Our analyses show that participants explicitly orient to the interactional accomplishment of participation in frameworks that change in the various phases of case discussion. Participants establish new procedures to deal with both familiar and sometimes new problems of participation introduced by the online environment. We describe these procedures in detail to contribute to the understanding of the accomplishment of participation through situated practices such as embodied talk-in-interaction. The findings can serve training purposes in online education across both medical and non-medical curricula.

Introduction

Online education has become a reality due to the COVID-19 pandemic. The shift from co-present to online education has consequences for the types of interaction that can take place. Researchers have reported on the challenges of distanced, lagged, internet-dependent communication (e.g., Seuren et al. 2020) while others have described the affordances of video-mediated settings (e.g., Oittinen 2020). In this paper, we focus on an aspect of the new environment that is key to engagement in education: participation. We examine how Dutch general practitioners in training (residents) manage their own and others' participation in online education by analyzing their collaborative reflection sessions. Constituting an important part of medical training, these sessions are usually highly appreciated in terms of educational value (van Braak et al. 2021). In online form, however, teachers are finding them challenging to facilitate. Teachers report having to work very hard to get and keep a discussion going. Residents report having to struggle to take or hold turns in the discussion. Apart from anecdotal accounts, however, we do not know how teachers and residents manage online participation. A description of participants' interactional practices and the resources they draw on to participate could be helpful in addressing these challenges.

From previous research on co-present collaborative reflection sessions in GP training, we know that participation is seen as a key component to creating educational value for all residents in attendance (van Braak et al. 2021). We also know that teachers see it as their task to encourage residents to participate in ongoing discussions by bringing in their own experiences or responding to others' (van Braak et al. n.d.a). At the same time, recent descriptions of online participation in a variety of institutional settings have shown that the features of online environments have an impact on the ease and manner of participation in ongoing interaction (for an overview, see Mlynář et al. 2018).

There are many issues with participation, that is, "actions demonstrating forms of engagement performed by parties within evolving structures of talk" (Goodwin and Goodwin 2004, p. 222), in online environments. First, accessibility to the interaction is compromised in the case of muted microphones, or, more generally, due to technological or internet limits. Second, "the sequential organization of actions is often disrupted by technology-related troubles, such as delays and orientation disparities" (Oittinen 2020, p. 5). Lags in the interaction signal can hinder smooth turn-taking (Seuren et al. 2020), which has to be coordinated in the absence of some useful resources, such as gaze direction (Halvorsen 2013; Hjulstad 2016). The use of various modes (e.g., video and chat) also poses challenges in establishing sequential order across the modalities (Gibson 2014). Third, the lack of immediacy in space and timing presents issues of reference (see "fractured indexicality", Due and Licoppe 2021, p. 9). Although each person can see everyone else if their camera is turned on, no one can determine exactly at what or whom others are looking at any point in time (Hjulstad 2016). This situation weakens the "performative significance" of non-verbal behavior (Melander Bowden and Svahn 2020). Indeed, multimodal

actions have been found to be minimized and in need of upgrading for them to be received (Heath and Luff 1993). Yet, the visual affordances of the online environment also allow for multiple and simultaneous ways of participation. As such, the technology is a resource that participants can use to construct an interactional space that provides for the activities at hand (Hansen 2020; Mondada 2007; Oittinen 2020).

In sum, research so far shows how video-mediated ways of interaction may compromise participation. Participants, however, may find ways to address these issues. For example, Seuren et al. (2020) describe doctors and patients working collaboratively to find ways to deal with the challenges and use the affordances of the environment to solve problems that arise. Focusing on educational interaction in our study, we analyze how participation in online education is shaped by and contingent upon the affordances of the online environment. Studying these online interactions contributes to our theoretical understanding of how, in detail and locally, participation is "accomplished through the participants' situated practices, which are produced in and through embodied talk-ininteraction" (Due and Licoppe 2021, p. 4). Concretely, describing the specific practices that participants use could prove useful for online education in current GP training as well as other types of online educational interaction, because these practices can be employed to accomplish the main institutional goal of creating educational value for everyone (cf. Tůma 2018).

Methods

Setting

Our study on online participation in Dutch GP training builds on earlier research into this setting in co-present form (van Braak et al. n.d.a; van Braak et al. 2021; Veen and de la Croix 2016; Veen and de la Croix 2017). In this medical educational setting, residents collaboratively reflect on practice experiences under the supervision of two teachers. The teachers are experienced GPs, either behavioral scientists or sometimes specialist doctors. The weekly sessions take place throughout the three-year course and are attended by the same group of about 10 residents for several months at a time. Currently, all collaborative reflection sessions taking place at the recording site are done on Zoom.

Data and Participants

We analyze three online collaborative reflection sessions, recorded between November 2020 and January 2021. These sessions were recorded as a pilot data set for analysis of online education in this setting. Each recording involves a different group of residents and teachers. Table 1 presents an overview of the participants and recorded groups.

Table 1 Characteristics of the recording, participants, and group history per recorded session.

Recording	Length of Recording (h:m)	Residents Attending	Year of Residency	Teachers Attending	Meeting History of Group
1	01:46	11	first	1 GP, 1 behavioral scientist	together for 3 months, 2 co-present sessions
2	01:34	11	first	1 GP, 1 behavioral scientist	together for 11 months, had 3.5 months of co-present sessions
3	01:30	11	second	1 GP, 1 geriatrician	together for 2 months, no co-present sessions

All participants provided written or video-recorded informed consent for recording and analysis of their collaborative reflection session. The Medical Ethics Review of Erasmus Medical Centre, Rotterdam, the Netherlands confirmed that the Medical Research Involving Human Subjects Act did not apply and therefore official approval of the study by the committee was not required (reference number MEC-2020-0898).

Analytic Procedure

We used Conversation Analysis (CA) (Ten Have 2007), an ethnomethodological approach to study recordings that originated in sociology. The analytic focus of CA is on the social actions that are accomplished with and in talk-in-interaction (Sidnell 2013), including embodied, multimodal conduct such as gaze behavior (Hazel et al. 2014; Mondada 2014). First, we transcribed the recordings using Jeffersonian transcription conventions (Hepburn and Bolden 2013; Jefferson 2004) and adding multimodal features of the interaction where relevant. Following the common methodological procedure of CA investigations of interaction (Sidnell 2013), we first watched the recordings closely to observe any noticeable aspects of social interaction. One phenomenon that stood out, also in relation to our earlier research into this form of education (van Braak et al. n.d.a), was the participants' ways of engaging in the online environment.

Moving back and forth between noteworthy instances of participation and the full recordings, we identified several distinct practices that participants used to accomplish participation and engagement throughout the sessions. We noticed that these procedures change as the session moves through its four phases: 1. case presentation, 2. exploration, 3. discussion, and 4. closing (van Braak et al. n.d.b; Veen and de la Croix 2017). In the following, we present the practices that

participants used to take part in the unfolding online interaction (cf. Koschmann et al. 2011). Our focus is on the situated nature of these moments of participation (when), the actions that they accomplish (what), and how participation is accomplished.

Analysis

In the following section, we provide an analysis of how participants display an orientation to participation as a collaborative interactional achievement in an online setting.

First, we will show that participants at times explicitly orient to the particular features of the digital environment with respect to participation at the beginning of the session. This allows them to avoid the pitfalls, but also to exploit the specific affordances of the medium in creating optimal circumstances to facilitate participation. This shows that participation is one of the main considerations for the participants in the overarching project. It also shows that participants modify their use of the online setting in light of this consideration. Second, we will show that participants use specific practices of participation in doing story recipiency during the case presentation to adjust to the characteristics of the online setting. Both analyses, as well as the subsequent analyses of the transition from case presentation to discussion and the discussion itself, show that participants use the specific features and the affordances of the online setting to participate in the activity of collaborative reflection.

However, the online environment also introduces some specific interactional problems for the collaborative calibration of participation in the various phases of collaborative reflection. Each of the distinct phases poses distinct challenges in the sense that for each of the phases the participation framework needs to be modified or recreated to foster optimal participation. In the last part of this section, we will analyze some of the practices that participants use to deal with these challenges in an online environment.

Before we start: Establishing audio norms

Participants themselves orient to the issue of participation in the local context of the online environment. At the start of one session (recording 1), we saw participants collaboratively establishing a norm for audio resource use in that session (lines 14–22). In doing so, they show an orientation to optimal participation as the possibility of a direct response to ongoing interactions. In the following fragment, the recording has just begun and one of the two teachers (T2) first welcomes everyone and then addresses one of the residents (R1, line 2).

Excerpt 1: Shall we all agree not to use the mute function (recording 1, preliminary to case discussions)

1 ((start recording))
2 T2 zo goeie↑morgen allemaal heheheh
well good morning everyone ((smiles))
3 (naam R1) jij staat ↑dubbel ingelogd volgens mij,
(name R1) you've logged in twice I think

((lines omitted))

12 R1 ja °('k weet ook niet)°
yes °(I don't know either)°
13 (1.5)
14 T1 zullen we vandaag weer afspreken om allemaal van de mute
shall we all agree again not to use the mute function
15 af te gaan?
today
16 T2 [((nodding))]
17 T1 [tenzij je echt] denkt k heb heel veel achtergrondgeluid,
[unless you really] think I've got lot of background noise
18 T2 [ja (.) denk dat] dat [wel het fijnst is.]
[yes (.) think that] would [be best]
19 R2 [((nodding))]
20 T1 [om de drempel] iets te verlagen om
[to lower the threshold] somewhat
21 te reageren op elkaar,
to responding to each other
22 (2.5)((several participants nod in agreement))
23 zijn er nog zaken die eh voorrang hebben=
are there any other issues that should have priority=
24 =even iemand die iets kwijt wil,
=anyone want to briefly share something um
25 e::hm,
u::m
26 (0.8)
27 een alge↑mene vraag,
a general question
28 (.)
29 [opmerking.
[comment
30 R2 [((shakes [head))
31 R3 [oh ik heb wel een ↑vraagje.
[oh I have a brief question
32 ehm aan iedereen eigenlijk,
um for everyone actually
33 (.)
34 wij hadden gister eh
yesterday we had um
35 ((provides background information, then poses question))

Teacher 1 initiates the group's agreement to the audio resource rules (line 14). Her proposal for all to "not use the mute function" is formatted as a suggestion for a shared decision about audio resource use for the current session: "shall we all agree to". In doing so, the teacher addresses the use of the mute function as the default mode of the medium and suggests an alternative that allows for direct and audible reactions to each other's contributions as the preferred mode of participation. Implicit in the teacher's additional explanation of the proposal (lines 20–21) is the idea that muted microphones hinder smooth back-and-forth conversation because of the hurdles they create for taking turns. She suggests modifying a default characteristic of the medium, in light of specific requirements of the overarching activity that the participants are engaged in. With their visual (lines 16, 19, 22) and verbal acceptance of the proposal (line 18), the participants have now collaboratively agreed and have set a strategy to deal with this particular feature of the online environment. Although participants in recording 2 and 3 did not explicitly construct a rule like the open mic one, this excerpt shows how participants may overtly orient to the importance of participation in this type of session.

The case presentation: Doing story recipiency

After a resident has been selected to share their case, the participation framework shifts from the any and many to just the one person. One participant embarks on a larger project: the case presentation (phase 1). For the duration of that project, that resident becomes the primary speaker. In the CA literature, a larger project is called a discourse unit (DU) (Houtkoop and Mazeland 1985). The other participants take on the role of DU recipients and produce "transient reactive turns" (Houtkoop and Mazeland 1985) displaying their recipiency and understanding of the DU underway.

For other participants, taking part in the unfolding narrative thus involves displaying adequate and accountable DU recipiency, for example, producing recipient tokens, doing news receipts, and aligning and affiliating with the primary speaker. In the preceding section, we showed that participants in recording 1 show an explicit orientation to the desirability—or at the least the possibility—of displays of verbal participation. However, because of timing issues resulting from lags in the internet connection, verbal displays of recipiency can be quite obtrusive. In the following, we focus on non-verbal, embodied displays of recipiency of a story underway in recording 3, as the digital environment seems to provide particular affordances and resources for this type of recipiency. We will highlight two practices in this extract: producing exaggerated facial expressions and maintaining facial expressions for an extended period of time. These practices show a participant's awareness of the constant monitorability of their embodied recipiency and an awareness of the ephemeral quality of their expressions such that these practices ensure increased salience and visibility.

Excerpt 2 shows an example where both practices are combined. Prior to this excerpt, R1, the primary speaker of the DU, has assessed her week as "quite frustrating", thus projecting

a DU elaborating the cause of her distress. She categorizes the DU as troubles talk (Jefferson 1988) and also hints at the type of responses she would like from the recipients. She then continues introducing the setting and illustrates her "issue" with a concrete example: "It had already started on the Wednesday before" (not shown). Both the build-up to this report, which introduces it as an example of her disagreement with the procedures, and the production of the report with marked prosody that can be seen as communicating an indignant state of disbelief index a clear stance of aversion and disbelief. This is elaborated on in the account that follows, presented in Excerpt 2. During this part of the telling, the facial expression of another participant (R2) explicitly shows extended affiliation with this stance of disbelief (line 3).

Excerpt 2: use your charm (recording 3, case presentation phase)

1	R1	en toen was het verzoek,
		and then they asked me
2		ja of ik even mijn chA:rmes in de strijd wilde gooien,
		whether I could use my charms
3		[om dan die mensen$_{Fig1}$ te overtuil]gen
		[to persuade these peo]ple
4	R2	[*raise - hold*$_{Fig1}$ *- release*]
5	R1	dat ze dan [toch gevaccineerd wilden worden,]
		to be [vaccinated anyway]
6		[scans screen]
7		(0.4)
8	R1	ja toen heb ik tegen die locatiemanager gezegd van nou (.)
		at that point I told my location manager well
9		charmes in de strijd gooien?
		use my charms
10		ik wil bij deze mensen langs
		I want to talk to these people
11		om te informeren over het vaccin
		to inform them about the vaccine
12		om te kijken (.) wat hun (.) redenen zijn
		to find out (.) about their (.) motives
13		om niet gevaccineerd te worden.=
		not to allow vaccination
14		=maar ik ga niemand over↑tuigen.
		but I will not persuade them
15		ik zeg dat is niet mijn ↑taak.
		that is not part of my job

In lines 1–3, R2 reports the request that the location manager directs at her in the form of an indirect quote: "Of ik even mijn charmes in de strijd wilde gooien". She uses prosody to mark the cause of her discontent. There is a strong emphasis on the word "charmes" (charms), which is produced with increased loudness and elongation. At the boundary of the turn-construction unit, R2 first raises her eyebrows and then widens her eyes producing a prototypical expression

of surprise (Figure 1, also see Darwin 1859; Duchenne 1862). She holds this expression for a moment and then gradually releases it while scanning the other participants on her screen with visible eye movement in line 6. Displaying her affiliation by assuming and holding this prototypical facial expression for an extended period, R2 sidesteps a possibly disruptive feature of this social setting, since verbal displays of recipiency can be very disruptive due to timing issues resulting from possible lag in internet connections. In addition, her display of affiliation also shows how she creatively uses the specific affordances of this particular medium: the ability to monitor all participants en face and inspect their facial expressions for signs of displayed recipiency. Displaying her affiliation by assuming and holding this prototypical facial expression for an extended period, R2 sidesteps a possibly disruptive feature of this social setting, since verbal displays of recipiency can be very disruptive due to timing issues resulting from possible lag in internet connections. In addition, her display of affiliation also shows how she creatively uses the specific affordances of this particular medium: the ability to monitor all participants en face and inspect their facial expressions for signs of displayed recipiency.

Figure 1. Resident 2's embodied response.

From case presentation to discussion: Modifying the participation framework

In the transition from case presentation to group discussion of the case (phase 1 to phase 2), the participation framework has to be recreated yet again: from the case presenter to the "reflective" group activity of collaborative discussion in which at least some other group members participate. The transition is marked by ambiguity: Although the previous activity (case presentation) is noticeably closed, who will take the floor to start the next activity (case discussion) is not clear. Non-verbal resources to select next speakers, such as directed gaze, are limited in the online setting, so joining the participation framework is restricted to verbal bids for turns. The teacher's role in recreating the participation framework is ambiguous as well: Is there or is there not a need for moderation?

In the following excerpt from recording 1, we observe participants dealing with the ambiguity of participation. At the possible completion of resident R1's case presentation, T2 does a number of "formulations" (Heritage and Watson 1979), interventions that summarize what

the case presenter has been saying and what her position was in the situation (lines 1–2). In line 3, R1 produces a minimal response aligning with the formulation ("ja"), after which T2 produces another minimal turn in third position ("okay"). This sequence is closure implicative and brings the project underway to a possible closure.

Excerpt 3: problematic/who would like to respond? (recording 1, transition from case presentation to discussion)

1	T2	dus het is eigenlijk het lijkt eigenlijk het initiatief
		so actually so it seems that actually the family is taking
2		vanuit de familie en het ziekenhuis.
		the initiative and the hospital
3	R1	ja.
		yes
4	T2	°oke.°
		okay
5		(4.0)
6	R2	ja.
		yes
7	T2	ja heheheh
		yes heheheh
8	R2	lastig. ((lachend))
		problematic ((laughing))
9	T2	wie wil dr rea↑geren. ((lachend))
		who would like to respond ((laughing))
10		wel een heftige casus eeh-
		what a heavy case aye ah
11	R2	ja.
		yes.
12	R3	nou ik (.) wil er wel op reageren,=
		well I (.) would like to respond
13		↑ziekenhuis hadden wij natuurlijk ook wel
		because in the hospital of course we also have people
14		mensen die je dan ↑niet kent,
		whom you don't know

The "okay" (line 4) in third position (Schegloff 1996) closes the sequence but is also closure implicative for the overarching activity (case presentation). This provides the other participants with an opportunity to self-select as the next speaker and modify the participation framework. However, no other participant takes the floor, and the current speaker does not continue, resulting in a pause of four seconds. After this pause, R2 selfselects as the next speaker by producing a minimal response ("ja"), followed by a minimal response by T2. This response is produced with laughter, which might be addressing the lack of progressivity in the talk. R2 then continues with an assessment—also produced with laughter—of the case presented by R1 ("problematic"), potentially moving into the next phase (collaborative case discussion).

Right after, the teacher explicitly opens the floor with an open invitation to react ("who would like to respond"), treating R2's utterance as a response to the case presentation and not as the start of a case discussion. This constitutes an explicit moderator action proposing a modification of the participation framework (van Braak et al. n.d.b). In reaction to the open invitation by T2, R2 produces another minimal response after which R3 self-selects and produces a lengthy response (line 12 and further).

One can wonder whether this explicit invitation was required or whether it was a barrier to participation. Before T2's invitation, R2 was already participating nonverbally and verbally (lines 6 and 8). However, R2's turn in line 8 ("problematic") is ambiguous between "doing recipiency" as part of the case presentation or moving the interaction into the discussion phase, where group members are expected to initiate contributions beyond doing recipiency. This may explain T2's seemingly redundant invitation (line 9). Ironically, the teacher's open invitation to "respond" can also be seen as sequentially deleting R2's "problematic", by not considering it as a (valid) response. However, the fact that resident R2 does provide a second story (Arminen 2004) right after R3's reaction (not shown), does seem to confirm that this utterance was already the start of a reaction rather than just recipiency. Again, the irony is that the unmute rule, established at the start of this session, allows for exactly this kind of direct response.

Strikingly, the modification of the participation framework in the transition from presentation to discussion is in many cases established via an explicit moderation action by the teacher. This could be a case of "over-moderating": Doing explicit moderation on the assumption that it is necessary in the online environment, while the environment itself provides opportunities to structure the transition in ways other than strict moderation. We see examples of unmoderated transitions in the recordings, too, where residents collaboratively recreate the participation framework without teacher intervention. In one instance, this transition is initiated "off the radar": Residents use the chat function to do discussion-like actions while the case presenter has not yet recognizably signaled the end of the telling. In that specific instance, the case presenter actually incorporates a response to that reaction in her case presentation. This is how recipiency can be done in a way that makes the response available while the person doing recipiency does not enter or disturb the conversational floor. This is a qualitative affordance of the online environment that shows an orientation to direct but non-disturbing participation.

Discussion of the case: Extending an existing participation framework

Once the participants have moved into the new activity of discussing the presented case (phase 3), participation becomes a matter of modifying the participation framework to include all the other participants—changing the rights and responsibilities of the participants in the activity. Interactional instruments such as the "open mic" rule proposed in session 1 may be intended to foster participation but joining an existing participation framework remains challenging regardless. In the following excerpt from the same recording, we show a continued attempt by one resident to participate in the ongoing discussion. The interaction takes place toward

the end of a case discussion by resident R1 and both teachers, who share the initial, tripartite participation framework (R1-T1-T2).

Excerpt 4a: tripartite participation framework (recording 1, discussion phase)

1	R1	ja
		yes
2		maar terwijl je dan eerst eigenlijk helemaal aan de andere
		but first you were really completely on the other
3		[kant,]=
		side
4	T1	[ja.]=
		yes
5	R1	=ik zat- helemaal ergens [anders,]
		I was completely somewhere [else]
6	T2	[ja.]
		[yes.]
7	R1	uiteindelijk kom je toch wel weer op het pad terecht,
		in the end though you get back to the same point again
8	T1	ja.
		yes
9	R1	maar dat vond ik wel een bijzonder gesprek.=
		but I thought it was a remarkable conversation
10		=dat het dan wel allemaal omhoog komt uiteindelijk.
		how everything does come up eventually
11	T1	hoe was dat voor jou?=
		how was that for you
12		hoe heb jij dat beleefd?
		how did you experience that
13	R1	nou ik vond het echt een leuk [gesprek]=
		well I thought it was really a fun [conversation]
14	T1	[ja.]
		[yes.]
15	R1	=en ik vond het jammer dat ik het niet had opgenomen
		and I thought it was a pity I did not record it
16		want ik dacht van [wow dit is echt een leuk gesprek.]
		because I thought [wow this is such a fun conversation.]
17	R2	[((smiles and nods along$_{FIG2}$))]

8

Figure 2. Resident 2's embodied response.

During R1's storytelling, both teachers frequently express non-verbal recipiency and verbal recipient tokens (e.g., lines 4, 8, and 14), making use of the established open mic rule. Moreover, both teachers ask follow-up questions directed at the current speaker providing her take on the presented case (R1). This pattern of frequently showing recipiency and asking questions constitutes a narrow, tripartite participation framework and validates resident R1 as the primary speaker. During this episode, other residents show persistent readiness to participate in these interactions, yet they fail to effectively join the initial participation framework. Resident R2 in particular produces multiple signs of recipiency and readiness to participate throughout R1, T1, and T2's exchanges. During the whole episode (that is approximately 3.5 min long, of which excerpt 4a shows a section), R2 verbalized four "recipient yeses" alongside those of the teachers' (not shown in 4a). Additionally, R2 produces multiple and strong signs of non-verbal forms of recipiency. For instance, while R1 declares gleefully that "it is such a fun conversation" in line 16, R2 shows increased non-verbal engagement by also enthusiastically smiling and nodding along (Figure 2). However, only after T1's explicit invitation for others to respond and join the tripartite participation framework R2 takes the floor (78–81, see Excerpt 4b).

Excerpt 4b: joining the tripartite participation framework (recording 1, discussion phase)

64	T1	(naam R1) herken je-
		(name R1) do you recognize
65		of of anderen
		or or you others
66		herken je dat het ook een leerproces is?
		do you also see that it's a learning process
67	R2	[ja
		yes
68		[((nod[ding))
69	RR	[((six [other residents are nodding))
70	T1	[dat je eigenlijk wat meer die context erbij betrekt,
		[*that you actually integrate the context a bit more*
71		wie zei ja?

```
                 who said yes
72               (naam R3)
                 (name R3)
73       R2      ja=
                 yes
74       R3      =nee volgens mij was het (naam [R4) of-
                 no I think it was (name R4) or-
75       T2                                    [((laughing))
76       T1                                    [ohh [(naam R4) [ j]a hehe ]
                                               [ohh [ (name R4)[yes heheh
77       R4                                                    [((headshake))]
78       R2                                                    [ja]>ik ik<]
                                                               [yes] I I  ]
79               zei ook ja,=
                 said yes too
80               =maar ik- in- inderdaad
                 but I- in- indeed
81               ik (merk) ook gewoon eh dat hele leerproces,
                 I'm also (aware of) that it's just a total learning process
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In line 64, T1 initially directs her question at the prior speaker (R1) using an explicit address term. However, before finishing her utterance, she cuts her question short and explicitly includes all the other participants as addressees of her question in line 65. This initial focus on R1 and T1's shift away from R1 show how the tripartite participation initially captivates T1's focus within that activity. Only after the self-correction is the participation framework modified to include all participants. In response to T1, R2 accepts the invitation in lines 67–68 with "yes" and nods distinctly, with six other residents nodding simultaneously in agreement (line 69). This creates an information overload and confusion about "who said yes" in lines 71–77. Many heads bobbing at once make it challenging to align the "correct bobbing head" with the audible "yes". In overlap with the nodding and right after the R2s "yes", T1 produces an increment to her question in line 70, explicating what she means by "the learning process". Upon completion of her utterance, she immediately initiates repair in line 71 to identify the participant who self-selected to join in on the discussion. It takes the participants a few turns (72–77) to identify the speaker, after which R2 successfully reinforces his bid for a turn in lines 78–79 with "I also said yes" and produces a longer contribution to the discussion.

In sum, this excerpt suggests that forms of verbal recipiency outside the initial, tripartite participation framework go mostly unnoticed by those who are already alternating turns in the set frame as a result of the spatial configuration and the organization of the audio stream of the online environment. Breaking out of the tripartite frame needs marked action, such as an explicit invitation to join, which can be troubling due to informational overload. The narrow participation framework captures the focus of those directly involved in the frame, drawing them further in; while the recipiency and readiness to participate of outsiders remains mostly unnoticed. One practice that circumvents this issue of being noticed, which we observe in two of the recordings,

is that residents use the chat function of the online environment to comment on aspects of the ongoing discussion, which can then be picked up by those part of the current participation framework. In that case, the chat responders are acknowledged as ratified listeners and active responders without them having to compete for a turn to participate in the interaction.

Case conclusion: Narrowing the participation framework

Moving into the concluding phase of a case discussion (phase 4), participants narrow the participation framework again. This concluding activity has a dual focus: 1. To give everyone the opportunity for final "mentionables" (Schegloff and Sacks 1973), and 2. To determine the value or uptake of the case discussion for the case presenter and possibly for others (Veen and de la Croix 2017). In our recordings, we see a typical participation pattern that addresses both. This pattern is related to the rights and responsibilities of different participants in this type of activity in this institutional context. As the formal chairs of the sessions, teachers take and are granted the responsibility to initiate and advance closings. Similarly, as the primary speaker, the case presenter is entitled to signal whether closing the ongoing activity is appropriate in light of what they wanted to get from the discussion. The other participants are mostly ratified listeners, unless they take up the invitation to share final thoughts. These rights and responsibilities are visible in the following participation pattern in the last phase of case discussions. Interactionally, this is achieved in two steps. First, one teacher opens up the closure of the prior section to move into the conclusion, leaving room for any participant to take a turn. Second, after this one or both teachers and the case presenter collaboratively close the case by establishing the value of the discussion. The following excerpt from recording 1 is an example in point (R1 = case presenter, T1 and T2 = teachers, R2 and R3 = other residents).

Excerpt 5: would someone else like to respond (recording 1, end of discussion phase)

1	R1	ja >ik weet dus niet hoe-<
		yes so I don't know how-
2		ja dat kindje is dus wel uit de reanimatiesetting gekomen,
		yes that little kid did come out of the reanimation setting
3		is vervolgens naar het (naam ziekenhuis) vervoerd,
		afterwards they moved it to the (name hospital)
4		maar (.) hoe- (wat) 't nu met- eh daarmee gaat weet ik
		but (.) how- (what) it's doing now ah obviously I don't
5		natuurlijk niet.
		know that
6	T2	nee.
		no
7		(2.0)
8	R1	ja.
		yes
9	T2	heftig hoor.
		that's heavy

10		(1.5)
11	R2	ja.
		yes
12	T1	is er nog iemand die nog wilt reageren of is het (2.2)
		would someone else like to respond or is this
13		voldoende zo?
		enough as is
14	R3	nou ook heel herkenbaar inderdaad je eh wisseling van
		well very familiar indeed your ah switch from
15		enerzijds van je emotie van
		your feelings about
16		hé wat fijn dat zondagsarmpje
		yay how nice that pulled elbow
17		[dan] zon heftige casus
		[and then] to such an intense case
18	T2	[ja]
		[yes]
19	R3	en waarschijnlijk moet je daarna weer door en dan komt er
		and probably you need to go on afterwards and then someone
20		weer iemand met een beetje eczeem die ook prima tot maandag
		comes in with a spot of eczema that could've easily waited
21		had kunnen [wachten],
		till [Monday]
22	T2	[ja: ((lachend))]
		[ye:s ((laughing))]
23	R3	(maar bij de eigen huisarts),
		but for their own GP
24		he eeh ( ) ook heel herkenbaar.
		aye aah ( ) also very recognizable
25		dus eh dat is ook wel eh
		so aah that is also rather um
26	T2	ja.
		yes
27		(4.0)
28		ja.
		yes
29	T1	nou goed dat je het gedeeld hebt (naam R1)
		well it's good that you shared this (name R1)
30	R1	yes
		yes
31	T1	ja (2.0) eeh (naam R4)
		yes (2.) aah (name R4)

Situated in a context of final generalities and assessments, which typically introduce topic closings (Schegloff and Sacks 1973), T1 does a pre-closing move of inviting final responses (lines 12–13). Her invitation shows an orientation to the opportunity to share "unmentioned mentionables" (Schegloff and Sacks 1973), the first focus of concluding activities. The yes-

preferred, second part of her invitation, “or is this enough (2.2) as is”, however, shows a clear orientation to the completion of the case discussion and also seems to narrow the opportunity to add anything at all. Yet, in lines 14–25, R3 takes up this invitation by adding to the case discussion. R30s contribution comes to a close in line 25 with a conclusion (“so”) that remains incomplete. In response, T2 produces a minimal recipient token that she repeats after a 4.0 s pause in which nobody else self-selects as the next speaker. Rather than repeating her invitation for further contribution, T1 then moves into closing the current case by thanking the case presenter (R1) and they jointly close the discussion by establishing the usefulness of the presentation (lines 26–31)—showing an orientation to their rights and responsibilities to advance the closing activity. With the case presenter “owning” the case and being entitled to affirm the usefulness of the discussion or lack thereof so far, this narrow participation pattern is contingent on the session’s goal of producing educational value—especially for the case presenter.

In an online environment, these modifications in the participation framework and the specific responsibilities of the specific participants (most notably the case presenter and the teachers) can yield interactional problems. Whereas in face-to-face settings participants are co-present in a physical space, in online settings participants convene in a digital space while also occupying another physical space that may call on their attention. The following excerpt from recording 3 provides a case in point. While the case presenter is formulating her uptake, her attention is drawn to something outside her screen (line 3). She explains her distraction by mentioning the package delivery (line 5) and mutes her microphone before walking out of frame. While she is away the participants discuss the uptake of her case (lines 17–21). When she comes back, the teacher explicitly reports on what they have been talking about in her absence (25–29) treating her access to what has been discussed as crucial to the activity (in line with her rights and responsibilities as the case presenter).

Excerpt 6: and now apparently there’s a parcel arriving (recording 3, end of discussion phase)

1	R1	naja goed.=
		oh well
2		=ik ↑moest t gewoon ef[fe: ja ik moest t gewoon even ↑kwijt.
		=I just had to quickly yes I just had to say it
3		[((kijkt naar iets buiten scherm
		[((looks at something outside screen
4		oh.=
		oh
5		=en d’r komt ook echt <u>nu</u> een pakketje binnen schijnbaar.
		=and now apparently there’s a parcel arriving
6		[starts getting up from the chair
7		[((slight laughter from various other participants))
8	T2	saved [by the bell.]
9	R1	[((laughing))] (saved by the bell).
10		pre↑chie-↑hi-↑hies hihihi
		ex-aaah-ct-ly hahahaha

11	T1	wordt vervolgd [denk ik ( )
		to be continued [I think ( )
12	R1	[((mutes microphone and walks out of frame))
13	T1	ja is een beetje afgekapte discussie zo.=
		yes it's a bit of an abrupt discussion ending this way.=
14		=maar zullen we maar wel eventjes verder?=
		=but shall we move on none the less?=
15		=want ik denk dat we het hier heel lang over kunnen hebben,
		=because I think we could talk about this for very long
16		(˚en dat we d'r op terug gaan komen,˚)
		(and that we'll come back to this)
17	T2	maar- misschien wel even nog één zinnetje-
		but- maybe briefly one more sentence-
18		e- i- ik denk dat wij als (.) of ↓wij (.) jullie als aios,
		ah- I- I think that we as (.) or we (.) you as residents
19		.h duidelijk je grenzen moeten aangeven.
		.h clearly need to set your boundaries
20		en misschien is dat ook de frustratie van (naam R1),
		and perhaps that's also (name R1)'s frustration
21		van- ja weet je ze is over haar grenzen gegaan,
		that- yes you know she went too far

((lines omitted; the teacher elaborates on this point, meanwhile R1 returns with the package in sight))

22	T2	kijk.
		look
23		het cadeautje is binnen,
		the present has arrived
24	R1	((gestures at the package))
25	T2	nou ik zei net (naam R1),
		well I was just saying (name R1)
26		een deel van je frustratie is natuurlijk ook dat jij voelt
		part of your frustration is of course also due to your
27		dat jij over je grens moest gegaan qua verantwoording,
		feeling that you had to overstep your responsibility
28		maar dat het niet werd opgepakt door je opleider,
		boundaries but that your tutor did not acknowledge that
29		dus dat jij d'r ingesprongen bent.
		so that you stepped in.
30		(2.7)
31	R1	ehm-
		um-
32		(.)
33		ja.
		yes

((further discussion between T1, T2 and R1 about what the main issue was and what feedback R1 can give to the supervisor in practice))

While the group could have moved on to the next case following line 12 (where the case presenter leaves the group to fetch the parcel), the teacher shows a dual orientation in her following talk (lines 13–16). First, she proposes to continue the discussion (line 14). In doing so, she shows an orientation to the relevance of this case for all present. That is, she treats the case as a token of a type of situation and derives a "learnable" for all present (lines 18–19) (Zemel and Koschmann 2014). Second, she shows an orientation to the "ownership" of the case presenter to the discussion underway. This is visible in her use of the particle "wel" (nonetheless) in her proposal to continue despite the absence of the case presenter. It is also in her uptake after the return of the case presenter. Once she is back with her package, she reformulates the upshot of the prior discussion for the case presenter—thus dealing with the interactional problems caused by features of the digital setting and again showing an orientation to the centrality of the case presenter in this activity: The one who presented the case is entitled to acknowledge or accept what is to be taken from the preceding discussion. Indeed, R1 partly acknowledges the teacher's interpretation of the main point (line 31 and further). This triggers T2 to make another suggestion for future steps to take. So, also in this closing activity, we see participants working toward the narrow tripartite participation framework that we observed earlier. In doing so, they are restricted by the affordances of the online environment, where video frames display the physical space that is part of someone's reality. This context provides for overriding responsibilities that influence the ongoing educational activity.

Discussion

In this study, we focused on residents' participation in collaborative reflection sessions held online. Participation is key to successful collaborative reflection (van Braak et al. 2021). As a result of the COVID-19 pandemic, institutions have been forced to shift to online education. This raises the question of how teachers and residents achieve participation as a dynamic, complex, and temporally unfolding interactional achievement that addresses the challenges and uses of the affordances of this new online environment.

In our analyses, we showed that participants display an explicit orientation to participation in an online setting as a collaborative interactional achievement. Participants orient to participation as a direct reaction in ongoing interactions throughout the session. For example, they explicitly addressed a specific feature of the online environment by establishing a norm for audio use at the start of one session. During the case presentation (phase 1), participants creatively orient to the specific affordances of the online setting: Discourse unit recipients use the inherent possibility to monitor and inspect the facial expressions of all participants to display embodied recipiency. In doing so, they use upgraded and extended non-verbal behavior—an online conversation strategy that has been reported in other contexts (Heath and Luff 1993) but was not found in recent online educational interaction (Melander Bowden and Svahn 2020).

The transition from case presentation to discussion (phase 1 to 2) poses difficulties in online settings because of the inherent ambiguity of these transitions (Veen and de la Croix 2016). We found three distinct practices that participants used to recreate the participation framework: self-selection using open mic policy, using the chat function, and via the teacher's explicit moderation. Our analyses reveal that this last strategy puts additional strain on the teacher, whose role might then become limiting rather than facilitating. During the case discussion, the participation framework should ideally give everybody a chance to speak, transforming the discussion of an individual case into a collaborative learning experience (Veen and de la Croix 2016). This typically involves extending the participation framework. Here we saw that one of the affordances of the online environment can also constitute a drawback. On the one hand, all participants are—in principle—available en face for others to monitor: They are continuously inspectable for meanings that can be gleaned from their facial expressions. This provides resources that are not available in face-to-face settings, where participants are often seated in a horseshoe formation, but also makes them accountable for adequate recipiency at all times. On the other hand, it is impossible to tell whether participants are actually monitoring others at any moment: During digital meetings, we cannot determine who is looking at whom—a situation very rare in face-to-face encounters even in groups (Stivers 2021). Thus, the particularities of the social situation (Goffman 1972) may result in non-verbal contributions going unnoticed by other participants. Also, in this phase, a strategy that was meant to facilitate participation, that is, the open mic rule, might actually have detrimental effects in making it harder to enter the conversation for participants outside the initial tripartite participation framework of the case presenter and the two supervisors.

In the conclusion phase, the participants need to manage two distinct orientations to the participation framework. First, participants need to establish that everybody has had a chance to speak their mind and that the group has reached some sort of collective understanding or agreement. Second, the case presenter should confirm that this understanding is an adequate discussion of the considerations of their particular case. Both goals portray an orientation to creating educational value for all (who want to raise additional questions or issues) and specifically for the case presenter. Here again, the specific characteristics of the online setting make it hard to move beyond the tripartite participation framework of supervisors and case presenters, which is illustrated by participants' focus on maintaining this frame even upon the case presenter's return after a short absence to open the door for a delivery. Each phase of a collaborative reflection session thus imposes a new participation framework that needs to be accomplished through participants' situated practices in and through embodied talk-in-interaction. In this sense, case discussions like these can be described as situated activity systems (Goffman 1961; Goodwin 1996; Levinson 1979), "repetitive social encounters in which individuals are brought into face-to-face interaction with others to perform a single joint activity of somewhat closed, self-compensating, self-terminating circuits of interdependent actions" (Goodwin 2018, p. 187).

Overall, our analyses show that throughout collaborative reflection sessions, there is an explicit orientation to the interactional accomplishment of participation in different participation frameworks throughout the phases in this situated activity system. In this new online environment, participants invent new strategies to deal with familiar and sometimes new problems that the setting introduces. This is how participants use the environment as a resource to construct an interactional space that provides for the activities at hand (Mondada 2007). On the one hand, the new environment has affordances that enable participants to creatively display the non-verbal recipiency that results in increased participation by optimally using the complementary nature of two semiotic fields. On the other hand, the same characteristics of the environment (en face access to every participant) also limit the opportunity to ascertain whether embodied contributions are actually observed because of the absence of mutual gaze. Participants deal explicitly with what they perceive as the shortcomings of the new setting: despite the possibly obtrusive/intrusive nature of speech, they decide to leave the microphones open to facilitate direct participation in all phases. Although this does accomplish the production of recipient tokens, for example, it also seems to make it harder to broaden the participation framework.

Two limitations need consideration in interpreting these findings. First, although the recordings frame all those present, they provide just one perspective on the ongoing interaction. Given the known lags in digital in- and output (Seuren et al. 2020), we cannot know what information is received exactly when by whom. This compromises the analysis of the conversation in terms of precise timing. Therefore, we have avoided any firm conclusions in this respect. Second, our analyses are based on three recordings of online interaction in one educational setting. This limited data set prevents us from generalizing to other settings in online education. Yet, it does provide for analytic generalization (Pomerantz 1990). Our description of the interaction in this

online educational setting should be understood as a description of participation practices that anyone taking part in a similar online setting can or could do (Waring 2013).

Admittedly, our analyses may only scratch the surface in terms of the description of practices that participants use to accomplish participation in online settings. However, they do indicate that the study of practices used to produce participation in online collaborative reflection sessions is interesting in its own right. Rather than analyzing these sessions in comparison to co-present reflection sessions, the study of online reflection as an independent activity system (Goodwin 2018), where online participants collaboratively achieve a joint project, may yield several interesting insights. First, our analyses remind us that all interaction is embodied, and that context and activity stand in reflexive relation (Heritage and Clayman 2010). Context is not independent of the activity; that is, the context is not a container that shapes the interaction in any determinate pre-ordained way. Rather, the activity shapes the context, making certain features more prominent and downplaying others. Second, this means that rather than dealing with online collaborative reflection sessions as the same activity in a different environment it might prove useful to study it as an activity in its own right. Although the institutional goals of collaborative reflection are the same in both environments, they constitute very different activities. Both environments highlight specific features of the educational activity. The online environment constitutes a new contextual configuration in the sense of Goodwin (2018, p. 17): a locally relevant array of semiotic fields to which participants demonstrably orient. In this contextual configuration, participants have access to different layers of semiosis (e.g., speech, facial expressions, chat) that allow for new practices to constitute participation. An investigation of how participants use and combine these different layers would be a promising avenue for future research. The study of these new practices may provide new insights into the nature of online interaction—a mode of communication ever more common and ever more vital in our current society.

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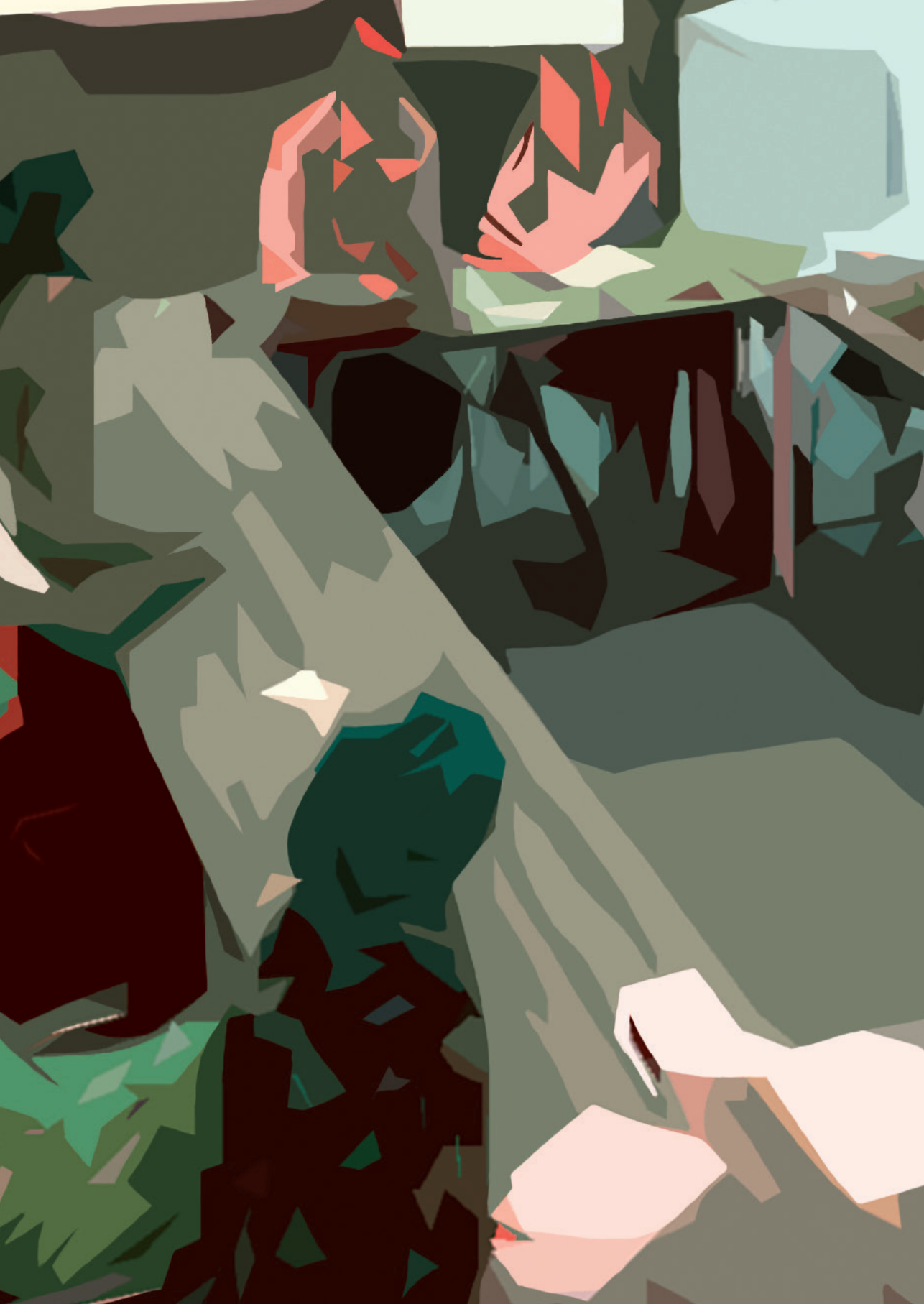

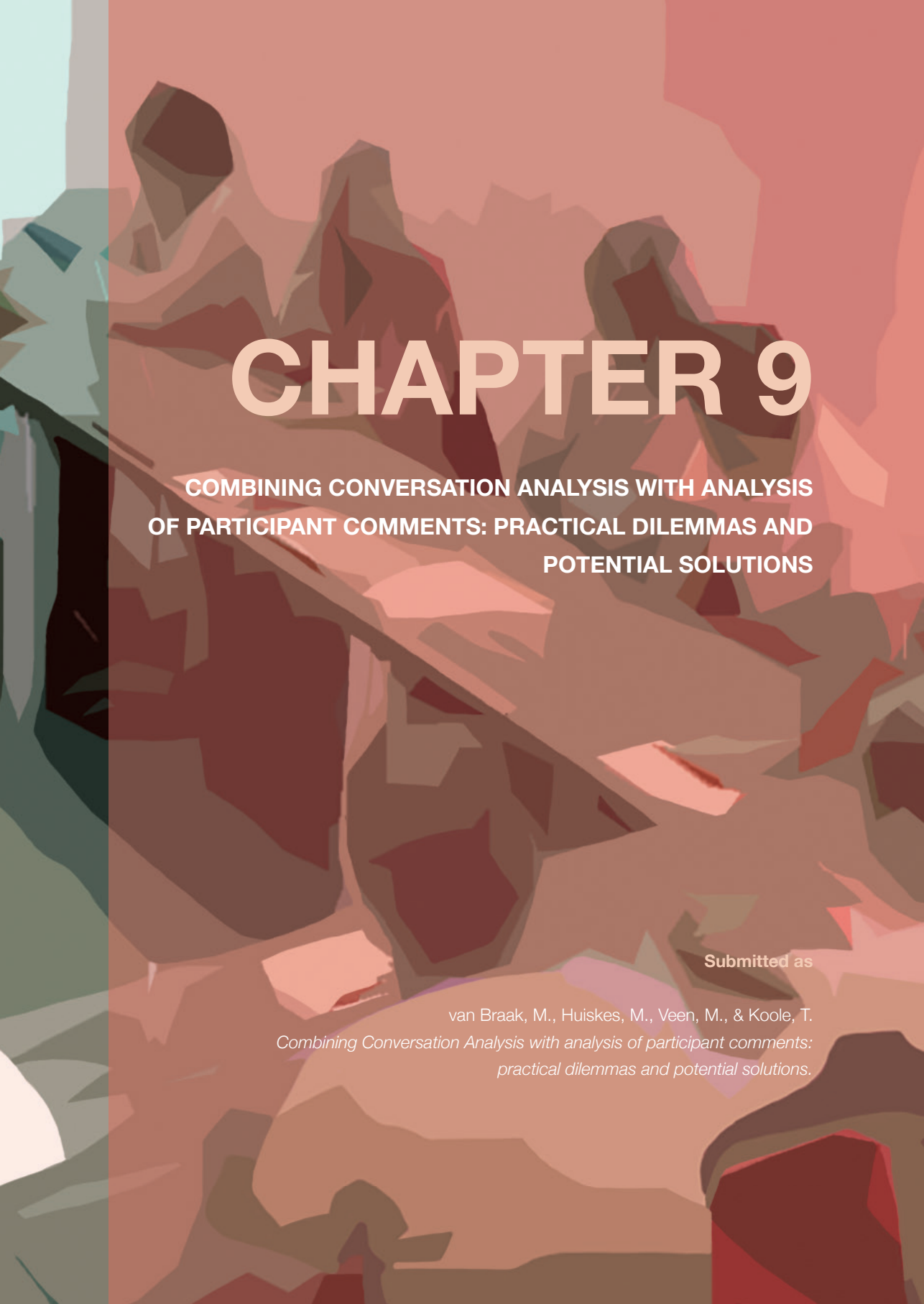

CHAPTER 9

COMBINING CONVERSATION ANALYSIS WITH ANALYSIS OF PARTICIPANT COMMENTS: PRACTICAL DILEMMAS AND POTENTIAL SOLUTIONS

Submitted as

van Braak, M., Huiskes, M., Veen, M., & Koole, T.
Combining Conversation Analysis with analysis of participant comments: practical dilemmas and potential solutions.

Abstract

Interaction research combining Conversation Analysis (CA) with other approaches has gained popularity in the past two decades. Though such combinations have raised discussion about the theoretical implications, their practical consequences are rarely considered. In this article, we discuss the practical dilemmas that may arise in one type of interdisciplinary CA research: CA and analysis of participant comments. Based on earlier reports, we first establish what can be gained by conducting research that combines CA with analysis of participant comments. Second, we use these earlier studies and our experiences in a recent research project to discuss four practical dilemmas that one is likely to face in combining CA with participant comments: 1. What is the *temporal order* of data collection and analysis? 2. *Who* collects and analyzes which data? 3. *What* do we combine? And 4. How and for what audience is the research *reported*? Since the choices related to these dilemmas depend on the research aim, we discuss them in terms of four potential aims. We conclude that combinations of CA and participant-comment analysis can benefit interaction research if correspondence between research aim, design, and reporting choices is ensured.

Introduction

Combining Conversation Analysis (CA) with other methodologies has become a common research practice, especially since the turn of the century. Since quantification, coding, interviewing, and experimentation appeared on the CA horizon, animated discussions on the desirability of combining CA with other approaches have followed in their wake (cf. Ford, 2012; Heritage, 1999; Kendrick, 2017; Nishizaka, 2015; Pomerantz, 2005; de Ruiter & Albert, 2017; Stivers, 2015). The upcoming trend of integrating CA studies in larger projects for funding proposals (cf. O'Reilly, Kiyimba, Lester, & Muskett, 2020) confronts the CA community with practical dilemmas that arise once one embarks on this research journey combining CA with other approaches.

In this article, we focus on the practicalities of combining CA *with analysis of participant comments*. Suppose we combine CA with participant comments elicited in interviews. Can the CA analyst and the interviewer be the same person? Would interviewing and CA analysis need to be carried out consecutively, or can they be conducted concurrently? And how can results of both approaches be combined without losing methodological integrity? Questions like these require careful consideration to ensure sound research practice.

Understanding what is involved in combining CA with analysis of participant comments is particularly salient in the broader discussion of the role of context in CA (Antaki, 2012; Ford, 2012; Pomerantz, 2012; Waring, Creider, Tarpey, & Black, 2012). The use of talk-extrinsic data in CA studies to contextualize interaction is now generally accepted (Plejert, Samuelsson, & Anward, 2019)—given that it is valued for what it is: in-the-moment constructions of members' understandings of the context (Maynard, 2003; Pomerantz, 2005; ten Have, 2004). Those understandings, it is commonly agreed, in no way 'compete' with insights gained from the fine-grained interactional analysis for which CA is known (Ford, 2012; Pomerantz, 2012). In fact, both analysis of participant comments and CA have their own share in creating insights about talk-in-interaction. A combination of both can yield insights that could not have been gained by either approach alone.

We briefly discuss what these contributions are in the next section. We then move on to the major part of the paper, where we describe four practical dilemmas and potential solutions that may rise when researchers set out to combine CA with analysis of participant comments:

1. What is the *temporal order* of data collections and analyses?
2. *Who* collects and analyzes which data?
3. *What* do we combine?

And 4. How and for what audience is the research *reported*?

In discussing the dilemmas, we build on example studies published by others and a recently finished project of our own. Before rounding up, we consider the limitations of combining CA with

analysis of participant comments. We hope that this article will spur thinking about and deciding on the design of future research combining CA with participant perspectives.

What can CA, analysis of participant comments, and their combination contribute to understanding interaction?

CA has become a well-established methodology for understanding and analyzing conversation (Maynard, 2013). The conversation analyst aims to understand "how, in *real time* and *for one another*" (Ford, 2012, p. 489) "any pair or group of people use language to conjure up the social world of which they are part" by analyzing the internal construction of turns and how the next speaker orients to the preceding talk (Antaki, 2011, p. 2). The contribution of CA is at least fourfold.

What can CA contribute?

First, CA can produce accounts of members' procedures for performing an action and explicate "how the practice differs sequentially and relationally from other ways of performing the action" (Pomerantz, 2012, p. 500). Others, such as fellow professionals, can use the description of a practice as a tool to accomplish the action that it constitutes (Pomerantz, 2012). Second, CA can describe interaction-internal evaluations of interactional moves. In conversation, each next turn shows how the interactants treat the previous utterance (Sidnell, 2013), providing the analyst with information about the participants' local interpretation of the utterance (Peräkylä, 2011). Third, CA can identify participant orientations to norms of interactional behavior. Such orientations can provide information on the acceptability of interactional moves in particular interactional contexts. Fourth, CA can identify practices as either interactionally effective or non-effective (Sidnell, 2013). By answering questions such as "What does it achieve interactionally to perform an action of this sort here?", CA analysis yields generalizable knowledge about the context-specific workings of that action (Antaki, 2012, p. 495). Insight into the interactional achievements of particular actions, again, can serve as a resource for participants to employ in future interaction (Stokoe, 2014).

CA's focus on empirically observable conduct precludes answers to questions about interaction-external aspects of social action, such as individual motivations, intentions, objectives, institutional interests, or personal experiences (Antaki, 2012). To answer these normative questions, we need a research approach that elicits participants' perspectives: 'traditional' interviews, video-stimulated interviews, or any other approach eliciting participant comments on concurrent, past or future happenings. As long as we view the thus elicited participant comments as interactional products in themselves, "recipient-designed for the researcher" (ten Have, 2004, p. 72), they can contribute to an understanding of interaction in four ways.

What can analysis of participant comments contribute?

First, participants comments can provide the necessary ethnographical background to understand what is going on (Antaki, 2012; Maynard, 2003). This members' knowledge helps to understand unfamiliar names, terms, and other references, elicitation of which is common practice in CA research (Ford, 2012; Pomerantz, 2005). Members' knowledge may also "help explain the existence of interactional practices, particularly when sequential analysis reveals curious-seeming patterns" (Maynard, 2003, p. 35) or to understand aspects of interactional practice that otherwise might not be understood from the recorded interaction alone (Pomerantz, 2005).

Second, participants' comments can serve to identify the Stocks of Interactional Knowledge (SIKs) behind the interaction under investigation (Peräkylä & Vehviläinen, 2003). SIKs can stipulate norms to which practice should adhere, provide a rationale behind practices, and explain the desirability or undesirability of practices. The interview, then, can help participants to reflect on the norms they orient to and the strategies they employ in interaction. Conversely, participants can use the SIKs to construct interaction-external evaluations of practices (e.g., legitimizing or opposing existing practices). In that way, participants' comments can bridge actual conduct and the institutional interests it might serve (cf. Antaki, 2012).

Third, participants' comments also display to the analyst the language that participants use to talk about that practice. Their language can be a powerful resource in communicating analytic findings with participants or other professionals. And fourth, related to this point, participant comments can hint at what is important or salient to participants (Paskins, Sanders, Croft, & Hassell, 2017), especially if they are retrospective accounts of "issues that the participants highlighted there and then" (Samuelsson & Pjelert, 2015, p. 32).

As we have seen so far, CA and analysis of participant comments afford interpretations of social conduct in non-overlapping realms (Ford, 2012; Pomerantz, 2012; Waring, Creider, Tarpey, & Black, 2012). Depending on the research question at hand (Zinken & Borek, 2012), the combination of approaches can benefit interaction research in the following five ways.

What can the combination of CA and participant comment analysis contribute?

First, participant comments can direct the analytic focus of CA (Ford, 2012; Pomerantz, 2005). Especially when we deal with long stretches of interaction, e.g. full school classes or lengthy business meetings, it can be helpful to have a sense of *where* to look (cf. Sidnell, 2013). Talk-extrinsic data can provide the first hints of places for closer investigation. These places can be anything from particularly troublesome or surprisingly smooth bits of interaction to reports of *what is not done* (Pomerantz, 2005). Note that, ultimately, we are still interested in "whatever details of the talk are relevant to the participants – the observation of any such detail may provide the first glimpse of a collectable phenomenon or practice" (Sidnell, 2013, p. 87). Second, CA data can direct the interview focus. Seemingly odd interaction patterns, for example, can instigate

further investigation in the interview setting (Maynard, 2003; Pomerantz, 2005). Third, in a similar vein, the very combination of CA data and participants' comments, can suggest new venues for analysis (Ford, 2012); see Waring et al. (2012, p. 511) for an example on jokes. Fourth, a combination of the results of CA and analysis of participant comments can yield information on correspondence between experienced, subjectively reported behavior and actual behavior. This information can trigger participants' reflection on their behavior, which can be valuable in the context of professional development, for example. Fifth, the combination of CA and participant comment analysis can illuminate the relation between practices and norms (Ford, 2012; Peräkylä & Vehviläinen, 2003). Participant comment analysis can yield information on formally documented institutional norms associated with an interactional setting. CA can provide evidence for whether and, if so, how people orient to norms in that setting. In combination, the analyses can illuminate the extent to and manner in which institutional, top-down formulated rules and regulations are embodied in daily interactional practice (see also Peräkylä & Vehviläinen, 2003).

In conclusion, combining CA with analysis of participant comments yields more than the sum of its parts. For this combined approach to succeed, however, careful consideration of the practicalities of the research design is crucial.

Practical dilemmas

Based on others' reports (e.g. Danby, Thompson, Theobald, & Thorpe, 2012; Maynard, 2003; Pomerantz, Fehr, & Ende, 1997; Samuelsson & Plejert, 2015; Zinken & Borek, 2012) and our own experience in combining CA with analysis of participant comments, we describe four central practical dilemmas that researchers doing this combination face:

1. What is the *temporal order* of data collection and analysis?
2. *Who* collects and analyzes which data?
3. *What* do we combine (data, results, conclusions)?
4. *How* and *for what audience* is the research *reported*?

We illustrate the various options for each dilemma with examples to ground our discussion in current research practice. Since any choice made in these dilemmas hinges on the aim of the research (Pomerantz, 2012; Zinken & Borek, 2012), we discuss them dilemmas in relation to four potential research aims: to gain an ethnographic understanding of the research setting; to find a focus for analysis; to supplement, complement, or explain CA findings; and to gain a rich understanding of interaction in context. Our intent here is not to be exhaustive, but to provide enough material—pros and cons—for the reader to carefully consider what is best in their own research context.

1. What is the temporal order of data collection and analysis?

Let us start with the temporal organization of data collection which, of course, is closely related to the order of analysis. Two options are available here: a sequential format and a simultaneous format. The preferred choice depends on one's research aim.

If the aim is to gain ethnographical data, a sequential format is most likely. One could start with data collection of participant comments, analyze these either systematically or more pragmatically, and then proceed to collect recordings for CA. The advantage of this two-step approach, which resembles what has been called a sequential exploratory design in mixed method literature (Robson, 2011), is that the ethnographic information gained from participants' comments remains quite general (not about a specific context or recorded interaction). The result is increased understanding of the setting, but limited interference of context-specific background information in the following CA analysis.

If for this purpose one chooses the alternative option, which is to collect participant comments and recordings concurrently, resembling what has been called a concurrent-nested design embedding a secondary method within a primary method (Robson, 2011), the collected ethnographic data could hamper unmotivated looking. In our own project, the first author experienced this issue. Having simultaneously collected recordings of educational interaction and video-stimulated interviews about these interactions, she had to be very careful not to let the participants' comments about specific bits of interaction hinder her initial analytic observations (cf. Pomerantz, 2012). This is one of the reasons that some researchers contend that ethnographic data should be used only *after* an initial CA analysis (Maynard, 2003; Silverman, 1999), prioritizing CA analysis over participant comments. Yet, gaining ethnographic data before doing CA could surely work well when context information is necessary to grasp esoteric elements of the recorded interaction.

If the aim is to find a focus for analysis, one could choose to first collect and analyze participant comments to obtain an idea of potential foci for research that are relevant to the participants. Once the researcher has identified one or several issues of interest, the data collection and subsequent analysis of interaction starts. Ordering the research process this way entails collecting participant comments that link relatively weakly with actual conduct, as the comments pertain to *remembered* conduct (e.g., what has just happened). Also, it impedes unmotivated looking. Yet, collecting and analyzing participant comments prior to recording does provide opportunities for purposeful selection of recording sites, times, settings, configurations, etc. Following this course might be one of the best options to finding valuable answers to complex real-life interactional dilemmas that are salient to the participants in the first place.

To avoid missing out on something that could be of interest either theoretically or practically, one could start collecting both types of data concurrently. Having gained a holistic grip on the interaction, one could then analyze both data sources in unison (much like Pomerantz et al., 1997) or the participant comments only. Danby and colleagues (2012), for example, collected interactions of children playing and video-stimulated interviews with those children. They first

used the video-stimulated interviews to identify strategies they used to initiate friendships. Next, they selected for CA fragments of recorded interaction where these strategies were visible for CA. In this case, the comments have an exploratory function (cf. Robson, 2011). Another example of that in applied context is our recent project combining CA of educational interaction with analysis of teachers' and residents' comments on that interaction. The participant comments pointed to a number of key actions that teachers struggle with during the recorded educational interaction. We chose to analyze these phenomena using CA as their relevance made trainability likely. Indeed, especially if the recorded data include a wealth of potentially relevant phenomena for future training purposes (in applied CA context), such initial participant comment analysis can enhance the applicability of the research for practice.

The other way around, collecting and analyzing interaction prior to collecting and analyzing participant comments about that interaction might help focus the elicitation of participant comments. For example, CA's resulting descriptions of "how, in *real time* and *for one another*" participants jointly construct their social situation could point to significant interactional practices worthy of further exploration in terms of aims, concerns, ideologies, interpretations, and motivations (Ford, 2012, p. 512; Pomerantz, 2012).

If the aim is to supplement, complement or explain CA findings, the data could be collected sequentially or simultaneously, but the analysis should have separate phases. Most commonly, one starts with CA. If interaction and participant comment data were collected simultaneously, the researchers would analyze the interactional material as if additional participant comments had not been collected. Having arrived at the findings, they would then analyze participants' comments *in relation to* the CA findings. These could be normative judgments (O'Reilly et al., 2020) or interpretation of the findings. Koole et al. (2017), for example, studying interdisciplinary meetings on genetic diagnostics, report a strictly sequential design (cf. Robson, 2011). Having finished the CA, they "presented the results to the (…) team and then interviewed team members from all the different disciplines" to be able to evaluate the desirability of the found phenomena (p. 1100).

Typically, research on the SIKs behind institutional practices (cf. Peräkylä & Vehviläinen, 2003) also falls in this category. In CA research that investigates SIKs, there is typically no interaction between the different routes of obtaining results until findings have been obtained. SIKs are analyzed from documentation in guidelines or participant comments, actual conduct from recordings of interaction. The two-tracked approach may suggest triangulation of findings (e.g., Greene, Caracelli, & Graham, 1989), but the findings here relate to different phenomena (actual conduct versus reported or assumed conduct) that are combined into one coherent interpretation of both.

Alternatively, participant comment analysis could be carried out first, followed by CA. During the CA phase, the findings of the first analytic phase should then be "bracketed" (i.e., deliberately set aside from any knowledge or beliefs one might have about the interaction under

investigation (Carpenter, 2007). If carried out by one researcher, this second approach, however, might compromise CA's hallmark of unmotivated looking.

If the aim is to gain a rich understanding of interaction in context, the research design likely features a high level of integration between CA and participant comments in terms of data collection and analysis. This integrated analysis does not prioritize either data source, but analyzes them concurrently, using different modes of analysis in a reciprocal process resembling a convergent or concurrent design (cf. Fetters et al., 2013). Mutual influence between the data types during data collection is unproblematic. Recordings could be made while collection of participant comments of already recorded interaction is in progress, or vice versa. After the integrated analysis, what findings are derived from which source is not entirely deducible. One example of this type of integrated analysis is the research on interaction between young children reported by Theobald (2008). Although the data collection was done in two phases, the analytic procedures of interaction and participant comments were intertwined. As Theobald reports, the analysis of interactions between playing children was "informed by close examination of the children's accounts from the video-stimulated interview" (p. 5).

The above examples show that the degree of temporal separation between collecting and analyzing recordings of interaction and participant comments varies greatly. Choices on the sequentiality of data collection and analysis are consequential for choosing who will be doing the data collection and analysis.

2. Who collects and analyzes which data?

The main question here is whether the person collecting the interaction recordings can also collect the participant comments on these. There are two situations where it would be desirable for the researcher doing the CA to stay out of data collection and analysis of participant comments – at least in first instance. That is, first, when the research prioritizes CA, for example *if the aim is to supplement, complement, or explain CA findings*. In that case, the researcher doing the CA would not want to be engaged or knowledgeable about the participant comments. Appointing two researchers to separately collect interaction data and participant comments is one solution. Another solution is to separate the process in time, to create a sequential format, as discussed above. An example of separation in time would be Lutfey and Maynard (1998), who studied the giving of bad news in oncology. They report that their second author collected the recordings of three medical interviews, analyzed these, and only then conducted ethnographic interviews. Secondary to the recordings, these interviews were meant "to supplement our primary concerns with the recorded interactional material (Kinnell and Maynard, 1996; Maynard, 1989)." (Lutfey & Maynard, 1998, p. 323). Second, but related to the above situation, the researcher doing CA should remain unfamiliar with the participant comment data when unmotivated looking is to be guaranteed. Any participant comments could steer the analytic eye, so if that is to be prevented, participant comments should not be collected by the CA researcher.

If the aim is to gain ethnographic data, the researcher(s) doing the CA analysis should obviously be involved with the ethnographic background, either by having collected the ethnographic data themselves or by familiarizing themselves with that data. In any case, the information collected by participant comment elicitation has to be available to the analyst *prior to* or *during* CA analysis.

For situations where *the aim is to gain a focus for analysis*, being acquainted with participant comments as a CA researcher is most likely not a problem. Not that it is a necessity: someone other than the CA researcher could do the participant comment analysis to find a focus for further CA analysis but usually this is a cumulative process in which the CA researcher is involved as well. In our recently finished project on valuable teaching in the context of training General Practitioner residents, for example, the researchers first identified interactional dilemmas that teachers encounter, based on the teachers' and residents' participant comments. Next, the same researchers continued to analyze instances of interaction where this dilemma could be seen to play out.

Finally, having the same researcher collect and analyze the data is a plus (and there is a case for it being a requirement) if the researcher's aim is to *gain a rich understanding of interaction in context*. In this case, the process of integrating both data sources is hampered when the CA analyst is not the one analyzing the participant comments.

3. What do we combine (data, results, conclusions)?

Turning to the actual combination now, one could ask what is really combined when we combine CA with analysis of participant comments. *If the aim is to gain ethnographic data* or *to find a focus for analysis,* the research usually builds from one data source to another. Ethnographic knowledge gained from participant comments (a result) is used to understand specific members' terms in the CA phase, for example. When participant comments are used to find a focus for analysis, or vice versa, the results of the one analysis are used as a starting point for the next so in that sense, strictly speaking, not much combining is going on.

The situation is different when participant comments are used *to supplement, complement, or explain CA findings.* In that case, most commonly the two types of results (findings from CA, findings from participant comment analysis) are combined in one coherent conclusion. In terms of interpretation, however, participant comment findings cannot replace or refute CA findings; they merely complement, supplement, or explain (Ford, 2012; Pomerantz, 2012), "grant[ing] us greater access to a more complex picture of what expired" (Waring et al., 2012, p. 489).

When the aim is *to gain a rich understanding of interaction in context*, this is the only situation where we combine both data sources in an integrated analysis. Here the researcher aims to construct a coherent understanding of the interaction as it takes place. Pomerantz et al. (1997) report an illuminating example of such an interwoven analysis. In their study on strategies that supervising physicians and trainees use to manage interactional difficulties, the researchers analyzed two data sources: videotapes of medical interaction and participants' commentaries

regarding the interactions. Central to the analysis were the concerns of supervisors and trainees regarding "the emerging definitions of their relationship to each other and to the patient in opening the interaction and in taking history from the patient" (p. 589). Under the assumption that participants "may not be fully aware of their concerns and/or may choose not to express them to us", the researchers identified "concerns either by participants'/informants' articulation of them and/or by conduct" (p. 594). Their analysis of both commentaries and actual conduct led to a coherent description and evaluation of the strategies that supervisors and trainees use to manage difficult supervision situations. Pomerantz later reflected on this dynamic analytic endeavor, positioning her research in an approach that assumes that "cognitive phenomena such as *understandings, aims* and *concerns* exist and, at times, even influence the selection and employment of specific practices" (2005, p. 96). In this approach, the absence of a common epistemological ground does not hinder fruitful and methodologically sound interaction between different disciplines. Indeed, this interdisciplinary interaction can result in an integrated answer to a complex question or a dynamic problem (van den Besselaar & Heimeriks, 2011). The value of that answer hinges on "the integrity with which CA's core methods are used and reported" (Ford, 2012, p. 512). Integrity, then, seems the core challenge of the involved researcher.

4. How and for what audience is the research reported?

Regardless of the research aim, the mutual influence between data sources and modes of analysis makes clarity of reporting vital to ensure readers understand what the different data types afford and contribute to the final conclusion of the research. Generally, then, the quality of reporting research that combines CA with participant comments depends on clarity about what data led to which findings in what ways. Mirroring the analytic process (in time, or in analytic moves) in the way one presents the findings is a powerful way to obtain that.

To some extent, all CA is accompanied by some (light) version of gaining an *ethnographic understanding* of the analyzed setting. As Ford (2012, p. 512) notes: "It is a practical fact that when the CA researchers are not familiar with crucial details regarding names and references, participants are consulted. This begs the question of whether and how the analyst reports the use of this ethnographic data gathering, a grey area indeed" (cf. Barnes, 2005). When reporting research that combines participant comments with CA for ethnographic purposes, therefore, researchers could consider explicating when, by whom, and how the ethnographic data were collected. Such transparency could potentially illuminate the status of the background information and its role in analysis. If ethnographic data were gained prior to CA analysis, that data could be described prior to presenting the analytic results. If the data were used along with or during analysis, that information could be presented throughout the results section of the report, aligning the report with the analytic process and mirroring the interaction between the two types of data along the way. If the aim was to *find a focus for analysis,* the same principle applies: match the reporting to the analytic process. That way, readers can follow the process and be clear on what type of data was used for which purpose and at which level of integration.

Reports of research that aims *to supplement, complement, or explain CA findings* tend to present CA findings first, followed by participant comment findings (e.g., Lutfey & Maynard, 1998). Such practice communicates the status of both, giving the reader the opportunity to appreciate the findings as they are temporally and 'hierarchically' ordered (what has been called a "contiguous approach" to narrative integration of findings; Fetters et al., 2013, p. 2142). We strongly recommend this order to facilitate readers' understanding of the participant comment findings as complementary, supplementary, or explanative.

Reports of research that aims to *gain a rich understanding of the interaction in context* should present integrated, neatly intermingled, yet carefully separated findings (what has been called a "weaving approach" to an integrated narrative, Fetters et al., 2013, p. 2142). Key to such reports is the explicit acknowledgment of the different sorts of claims that the two data types permit (Pomerantz et al., 1997). To that end, consideration of language use and data presentation is crucial: "Language guides us in our analyses, and it models for others the norms and standards for formulating relationships between the results of these different methods in mixed method projects." (Ford, 2012, p. 511). An important consideration, then, is about the words used to describe the CA and participant comment findings, as well as the nature of the relation between the two. Second, one should carefully consider ways to communicate the source of any findings. Explicit mentions of the type of data at the outset of data fragments (cf. Pomerantz et al., 1997) is one way to communicate their origin. Such clarity once again helps prevent potential misinterpretations of what the data and their analyses can afford (Ford, 2012).

More broadly, what one reports and how one reports it also depends on the journal choice. Here, the options range from 'hard core' CA journals to journals that focus on discursive approaches to interaction, to journals that are friendly to CA but feature all other types of research too, to journals that match the context of the research (e.g., medical journals) but are altogether unfamiliar with the methodology. Especially if the primary audience is unfamiliar with CA (e.g., if one chooses to publish in a non-CA journal), clear reporting of the conclusions that both modes of analysis afford is crucial.

Since the combination of interaction and participant comments is commonly used in applied research context, 'hard core' CA or CA-oriented journals may not always suit the audience best. These journals give researchers the space to describe their research in their own terms, but they are rarely read by practitioners. Journals related to the field of research (e.g., medical education) might be an option if the practice field is the primary audience. These journals, however, often have tight word limits and might force the researcher to make uncomfortable concessions, such as excluding data fragments from the body text. Reviewers of this type of journals may ask for "less detailed" analyses, as these also "communicate the point". Such requests may be acknowledged by moving the original CA analyses to a supplemental material section, while including condensed analyses in the article text. The report may serve its purpose well as long as the research is answerable to the initial research question, and taking the audience's background into account, it assures clarity in language and reporting.

Conclusion

Research combining CA with analysis of participant comments can have important benefits for interaction research. Its success and relevance depend heavily on the correspondence between the analytic aim of the research and methodological choices. Careful consideration of design and planning are key to sound research. As a first step to smoothen the integration of CA in larger, non-CA research projects, we have shared the pros and cons of combining CA with participant comments (e.g., in the form of interviews) based on earlier studies and our own experience in a recent project. This methodological exploration may move CA beyond the boundaries of the field, but at the same time it also expands the horizon of other research fields. Crossing borders like this, we believe, ties in with the broader academic trend of tackling complex everyday questions with methods that do just that: finding answers to questions that require approaches from various directions. Compassing informativeness and pragmatic usefulness (cf. Kitzinger, 2011), combining CA with participant comments can be a powerful tool in our search to understand—and maybe even improve—the complex, jointly constructed social world to which we all belong. We hope this report gives some guidance along the way.

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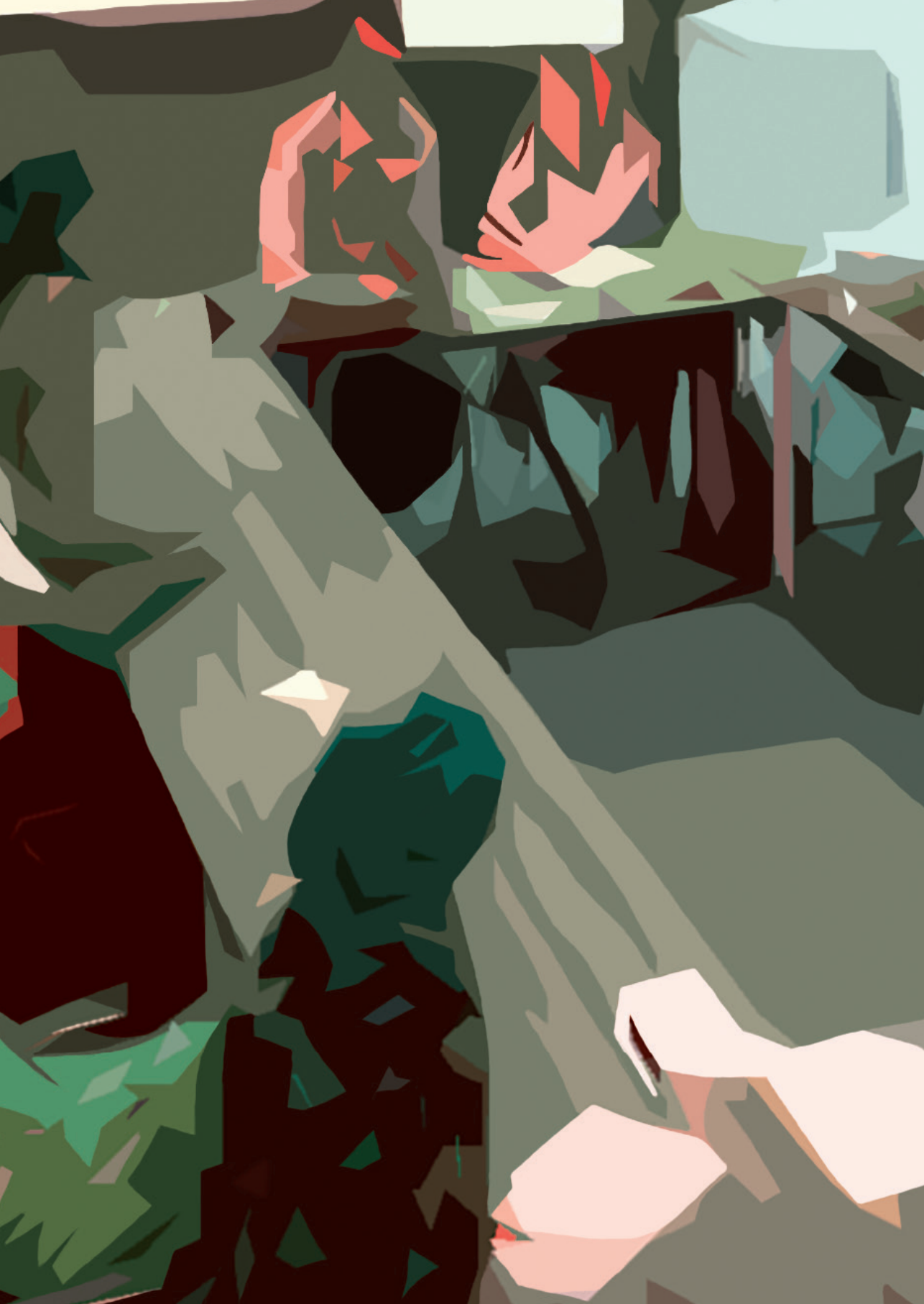

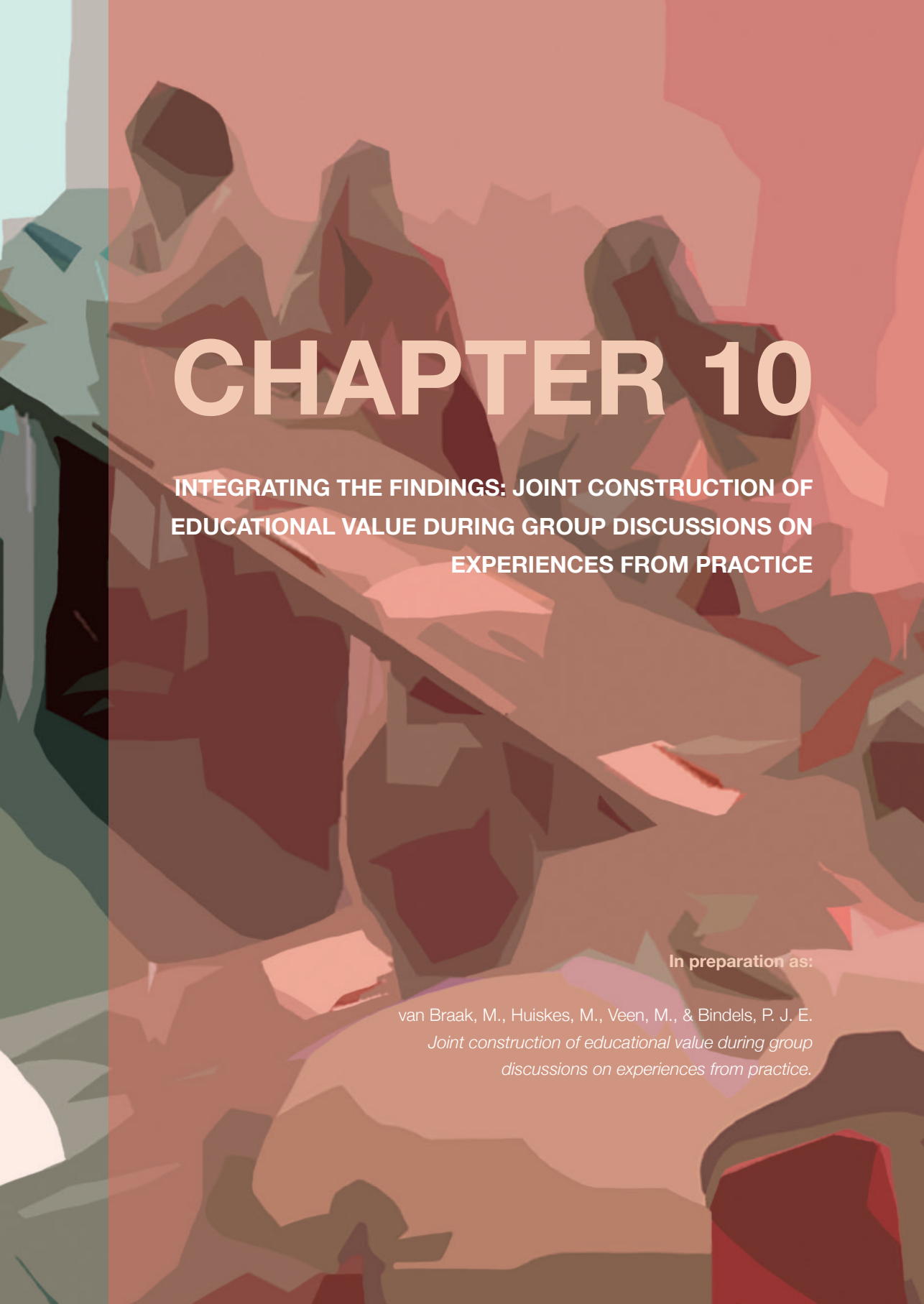

CHAPTER 10

INTEGRATING THE FINDINGS: JOINT CONSTRUCTION OF EDUCATIONAL VALUE DURING GROUP DISCUSSIONS ON EXPERIENCES FROM PRACTICE

In preparation as:

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Joint construction of educational value during group discussions on experiences from practice.

Abstract

In this chapter, we report on the integration of conversation analyses of videorecordings of Learning from Experiences sessions and analyses of participant comments on these sessions in video-stimulated interviews. These interviews provide general participant norms for valuable interaction. The recordings of those interactions provide descriptions of actual practices. Coupled with specific assessments of those practices, also derived from the interviews, these practices give us insight into how participants accomplish the explicated overarching norms for valuable Learning from Experiences. We formulate these insights as an ethnomethodological description of the process of creating value during the education activity of Learning from Experiences.

Given the explorative nature of this research, we chose to focus on two recorded sessions and the accompanying interviews. In an analytic integration resembling one reported by Pomerantz, Fehr and Ende (1997), we first use the general norms for value to characterize the telling, exploration, discussion, and conclusion phases of Learning from Experiences. For each phase, we describe how participants orient to these norms in actual interaction, selected using the specific assessments of conduct reported in participant comments on the actual interaction. We conclude that throughout the phases participants orient to the importance of establishing and retaining a focus for discussion in practices that constitute a collaborative achievement of educational value for, primarily, the teller, and secondarily, others in the group.

Theoretically, this descriptive endeavor has created new and detailed understandings of how groups collaboratively construct meaningful educational interactions. Practically, the resulting description can function as a consultable record that shows how teachers co-construct educational value – with various effects. The teacher consulting the record can experiment with the various options in their own situated, locally constituted practice.

Introduction

This chapter integrates the findings from the interview analyses and conversation analyses reported in the preceding chapters in what we see as a novel capstone analytic activity. Teachers and residents in the interviews (Chapters 4 and 5) have described *generic, overarching norms* for the 'value' generated in these sessions. These include the importance of shared experiences in terms of their recognizability and potential for reaction by others (Chapter 4), and an orientation to the importance of diversity and inclusivity, safety, and efficiency for creating educational value for all during the discussion of experiences (Chapter 5). To create educational value for all means telling and discussing experiences from practice in a way that makes individual experiences collectively relevant beyond the specific situation (Chapter 5). That requires specific action from teachers and residents, such as teachers' moderating, expert, and evaluator moves (i.e., *actual behavior*, see Chapters 6-8).

To understand how teachers' and residents' behavior accomplish the generic norms, we need to link the norms to actual behavior. That link can be found in teachers' and residents' *specific evaluations of actual behavior* in the video-stimulated interviews. Here, the participants 'translate' a generic norm into an assessment of actual behavior, constructing the value of that behavior toward the generic norm. In this study, we use those links to describe exactly how teachers and residents collaboratively construct educational value for all.

The medical education literature seldom describes what the process of constructing individual experiences as educationally relevant for others looks like in interaction. Veen and de la Croix, researching this educational activity, describe how sharing and discussing experiences during Learning from Experiences is done in four activities: telling an experience, accounting for the reason for telling the experience, identifying learning opportunities, and constructing the uptake of the discussion (Veen & de la Croix, 2017). These activities allow residents to make an individual experience "shared, reflectable, learnable and valuable" (Veen & de la Croix, 2017, p. 331).

The first task in this process is for one resident to introduce the experience. At stake is "to select the kind of present experiences that live fruitfully and creatively in subsequent experience" (Dewey, 1988, p. 13; Zemel & Koschmann, 2014). That happens in the form of *telling* about supposedly relevant experiences from practice. Tellings are powerful tool that people use to construct the reality of past experiences (Arminen, 2004; Bruner, 1991; Warmington & McColl, 2017}. Some go as far as to say that "subjects are the effect of the discursive processing of their experiences" (van Alphen, 1999, p.25). A telling creates opportunities to negotiate one's view of the self, others, and the profession (Hardy, 2017). It provides a narrative structure (such as "first X happened, then Y, and I did Z") within which individual experiences make sense and become recognizable to others. Tellers will orient to those co-present (McVittie, Craig, & Temple, 2019) and design their telling so that it projects a type of reaction (e.g., alignment, affiliation; Stivers, 2008) and signals what is important in the telling (Mandelbaum, 2013). During Learning from

Experiences, the main task of the teller is to share the experience in such a way that it is specific and general enough for others to recognize the experience and respond to it.

For experiences to become recognizable for others, the experienced situation needs to be "given a kind of abstract status" (Sacks, 1992, Lectures, Vol. II, Part IV, p. 245). For instance, a challenging consultation experience with Ms. Jones, who frequents the GP office and has for the nth time requested advanced medical tests to come to grips with her so far medically unexplained symptoms, becomes shareable when categorized as a *token* of a *type* of experience (e.g., challenging consultations with demanding patients). Categorization by abstraction makes the experience collectively recognizable for others as an experience of this and that type. Also, categorization allows residents to make comparisons of differences in dealing with experiences of this and that type. Sharing experiences for educational value, then, becomes a matter of abstracting from an individual situation *relevance beyond that specific situation*.

The responsibility for establishing a focus for discussion in this educational context has been described as shared especially between the teachers and teller of the experience (Veen & de la Croix, 2016). Similarly, in Problem-Based Learning activities (Barrows, 2000; Torp & Sage, 2002), the group, potentially with some help from the teacher (Koschmann, Glenn, & Conlee, 1997), collectively establishes a learning issue that is relevant to clinical practice and timely for discussion at this point in their training (Davis & Harden, 1999; Hmelo-Silver, 2004; Glenn, Koschmann, Conlee, 1999; Koschmann, Glenn, & Conlee, 1997). The process of identifying learning issues is considered key to the success of the next phase, where students explore the issue further (Hak & Maguire, 2000; Koschmann, Glenn, Conlee, 1997), and thus seems crucial in the process of creating value from individual experiences or cases.

Once the relevance of the experience and the focus for discussion are established, the actual discussion of the experience can begin. We know from the interviews (Chapters 4 and 5) that residents commonly display the recognizability of an experience by sharing a *second story* – a phenomenon we also know from other experience-telling settings (e.g., therapeutic sessions; e.g., Logren, Ruusuvuori, & Laitinen, 2019). Second stories are "told in a series in which later stories are designed to achieve a recognizable similarity with the first (or previous) story" (Arminen, 2004, p. 319). The generalizability of an experience may allow others to describe similar experiences – in a second story –, resulting in "reciprocal revelations" of individual issues (Arminen, 2004, p. 341; Kääntä & Lehtinen, 2016). Second stories have the power to transvaluate experiences (Arminen, 2004) by focusing on aspects of the first story and providing a re-interpretation in the form of a new perspective on the first story (Siromaa, 2012) that may point to potential resolution (Arminen, 2004).

The potential for second stories or any form of recognition in response to first tellings requires teachers to "manage, on one hand, the uniqueness of an individual experience and, on the other hand, the accessibility, shareability, and comparability of experiences (…)." (Logren, Ruusuvuori, & Laitinen, 2019, p. 2). If managed well, the process leads to co-constructing collectivized understanding of shared experiences that allows participants to make sense of

their *own* and *others'* experiences (Bülow, 2004; McVittie et al., 2019). Exactly how that co-construction of educational value is enacted throughout the phases of experience sharing, we aim to describe in this chapter. To do so, we integrated generic norms for the co-construction of educational value (identified in the video-stimulated interviews) with specific evaluations based on norms for actual behavior (also identified in the interviews) and the behavior itself (video-recorded during sessions). The resulting report can be read as an exhibition: a curation of the educational activity of Learning from Experiences.

Methods

For an extensive account of the methodological considerations involved, see Chapter 9.

Data

Given the explorative nature of our methodological approach, we chose to focus on a selection of recordings and interviews from the entire thesis data set: recordings for which we had an interview with one resident teller of an experience, one with a resident audience member and one with a teacher. Two recordings met these criteria, each from a different local training institute. The current data set thus includes two videorecordings of a group session (recording 1: 72 min. with one teacher and six residents; recording 2: 69 min. with two teachers and nine residents) and six video-stimulated interviews (one teacher and two residents per recording). The recordings and interviews were transcribed using Jeffersonian transcription conventions (Hepburn & Bolden, 2013), see Appendix A in Chapter 6 of this thesis.

Analytic procedure

We analyzed the interviews and recordings in several steps, going back and forth abductively between interviews and recordings (Tavory & Timmermans, 2014) in a process that resembled the analytic endeavor reported by Pomerantz and colleagues (Pomerantz, Fehr, & Ende, 1997). Our analytic goal was ethnomethodological (Heritage, 2013; ten Have, 2016): we aimed to describe recognizable, meaningful, and orderly practices used by participants to construct this educational setting (ten Have, 2016).

Our analytic point of departure was participants' generic views on the educational value of group discussions of experiences from practice. From Chapter 5, we know that residents view the aim of Learning from Experiences as *to create educational value for all*. In this study, we first identified in the interviews participants' formulations of overarching, situation-unspecific norms for creating collective value from individual experiences throughout the phases of the experience sharing (telling, exploration, discussion, conclusion; Veen & de la Croix, 2017). We summarize these norms for each phase in a typification of that phase.

Next, in the interviews we identified specific evaluations or normative judgments about actions that participants do in the recordings and their relation to educational value for all. An example of a normative judgment is shown in the following:

Interview fragment: resident's normative judgment of teacher intervention

1	R	wat eh die docent doet is dat-ie (.) die vraagt Qok tipsQ zegt
		what eh that teacher does is that he (.) he asks Qok tipsQ he
2		ie,=
		says,=
3	I	=ja=
		=yes=
4	R	=maar hij moet ↑eigenlijk vragen,
		=but ↑actually he should ask,
5		vind ik,=
		I think,=
6	I	=ja,=
		=yes,=
7	R	=ehm Q↑o↓kee,
		=erm Q↑o↓kay,
8		nou je je vraagt van zijn er nog meer mensen die dat (.) zijn,Q
		well you ask yourself like are there other people who are (.) like that,Q
9	I	ja,
		yes,
10	R	Q↑zijn die d'r.Q
		Q↑are there.Q
11	I	jaja.
		yeah yeah.
12	R	ehm en dat was denk ik (.) waar ik stiekem eh (.) naar op zoek
		erm and that I think (.) was what I secretly eh (.) was looking
13		was.
		for.

Here the resident evaluates an actual teacher turn in terms of what the teacher does and what he should have done in relation to 'value' – specified here as "what I was looking for" (lines 12-13). This normative judgment shows the resident's orientation (Hamilton, 1985; Maynard & Heritage, 2005) to shared educational value (line 8), which can be linked to actual teacher behavior (quoted in line 1) in the recorded sessions. Normative judgments like this form the linking pin between generic norms and participant actions: they connect an orientation to a norm with an instance of the behavior that does, does not, or potentially could contribute to that norm.

In a third analytic step, in the video recordings it becomes possible to identify the practices participants use to accomplish the actions formulated in the normative judgments. Moving away from the actual instance which prompted the normative judgment, the identification of the action in step 2 also allows for identification of practices used to accomplish that action in

other instances beyond the one evaluated. We describe the normative judgments and related practices in an integrated analysis following the typification per phase.

Results

Telling phase

Typification based on generic norms distilled from interviews. The telling phase usually starts off with a multi-unit turn (Mandelbaum, 2013), where the teller presents the first version of the experience in a telling format. Participants in the interviews orient to a general norm of clear, complete and focused tellings. The prime responsibility for that is seen as the teller's. Other residents position themselves as listeners, a role on which one resident commented that she contributes to the overall aim of this phase by listening to identify the issue or question "behind" the experience. In this phase teachers are expected to actively contribute to the telling by establishing or checking its focus *when needed*. The teacher's contribution here is seen as secondary, in the sense that while the teller has first rights and responsibilities to present the experience and suggest a focus for discussion, the teacher is held responsible for steering the process of defining that focus for discussion if it is unclear, not relevant, or otherwise in need of intervention (compare Chapter 6).

Specific orientations observable in actual conduct. In the video-stimulated interviews, residents and teachers orient to the norm of clear, complete and focused tellings in specific assessments of the way tellers present their experience. In Extract 1, while commenting on her own telling, the teller (R) orients to the responsibility of tellers to clearly articulate "the problem" (I = interviewer):

Extract 1: comment on own telling from video-stimulated interview with teller U81121TBa2

1	R	e:h ik vind het wel grappig om te zien dat ik het best wel (.)
		e:rm I think it's funny to see that I can ↑formulate it (.)
2		kan ver↑woorden.
		quite well.
3		he[hehe
4	I	hm hm,
5		ja,=
		yes,=
6		=dat ik- dat ik volgens mij beter dan ik zelf door heb (.) het
		=that I- that I- I think I can present and explain the problem
7		probleem kan neerzetten en uitleggen,
		(.) better than I realize myself,

The positive self-evaluation of her clear presentation of the "problem" (line 7) projects an orientation to the importance of a clear focus for discussion. That orientation is visible in two practices visible in her telling: (1) the fronting of the projected focus for discussion, and (2) the repeated reference to it at the marked end of her telling. In Extract 2, the teller from Extract 1 (R) starts by framing the experience ("iets"; "something", line 3) as relevant to the general theme of "letting people walk all over me" (lines 14-16).

Extract 2a: start of a telling from session recording U81121TB

1	T	((naam verteller)) ga je gang.
		((name of teller)) off you go.
2	R1	ehm (.) ja.
		erm (.) yes.
3		ik wilde (.) iets met jullie eh even bespreken,
		I wanted (.) to discuss something eh with you,
4		even sparren,
		to spar a bit,
5		en misschien wel tips over krijgen;
		and possibly get some tips;
6		ehm een thema waar ik al langer wel wat mee bezig ben,
		erm a theme that's been keeping me busy for quite a while,
7		en waar(.)van ik denk dat is een beetje een valkuil voor mij,
		and which (.) I think is a bit of a pitfall of mine,
9		en en °nou misschien kan ik
		and and °well maybe I can
10		wat tips van jullie daarbij krijgen,°=
		get some tips for it from you,°=
11		=en dat gaat over (.) e:hm:: (.) dat ik (.) ehm: (.) in het
		=and it's about (.) e:rm:: (.) that I (.) erm: (.) in the
12		contact met bijvoorbeeld de ↑zorg,
		contact with the ↑nurses for example,
13		°nu (.) in eh° (.) het verpleeghuis,
		°now (.) in eh° (.) the nursing home,
14		ehm (.) VOOR↑AL wil dat de re↑latie goed blijft,
		erm (.) ABOVE ↑ALL want the re↑lationship to stay good,
15		en daarin soms een beetje over me ↑heen laat lopen
		but then I sometimes let them walk all ↑over me
16		voor mijn gevoel,
		the way I feel it,

((lines omitted, further explanation of theme))

43		en (.) gister was daar een voorbeeld van,
		and (.) yesterday was an example of that,
44		toen eh (.) eh had ik een heel drukke middag,
		when eh (.) eh I had a very busy afternoon,

In Extract 2b, the same person ends her telling with reference to the general theme mentioned in lines 14-16 of Extract 2a):

Extract 2b: end of same telling from session recording U81121TB

74	R1	en (.) >naja< (.) dat is één voorbeeld waarvan ik denk;
		and (.) >okay< (.) that's one example that makes me think;
75		(1.2)
76		misschien moet ik soms gewoon;
		maybe sometimes I should just;
77		(0.3)
78		dan maar even geen vriendjes willen zijn,=
		not want to be friends at the moment,=
79		=maar gewoon;
		=but just;
80		(.)
81		zeggen van Qja (.) ik snap dat >het vervelend is<,
		say like Qyeah (.) I understand that >it's annoying<,
82		maar >we doen het gewoon even op deze manier<.
		but >we'll do it this way for now<.
83		punt.Q
		period.Q

The resident treats her telling as a good practice that accomplishes the specific norm of articulating the problem in a way that generates a focus for discussion. As teachers and residents pointed out in several interviews, a clear focus for discussion is essential for two reasons. First, it hones potential topics for exploration and discussion. Second, it provides a signpost for determining when the discussion has been 'enough': once the established issue is solved or the question is answered.

Not only residents, but also teachers orient to the norm of clear, complete, and focused tellings. In Extract 3, a teacher evaluates his own intervention in terms of how it contributes to clear and focused telling:

Extract 3: teacher judgment of never-ending telling from video-stimulated interview with teacher U81121TBd1

1	T	˚oke˚.
		˚okay˚.
2		(3.2)
3		nou het interes↑sante is als je dit nu bemerkt,
		well the interesting thing is if you notice this now,
4	I	hmhm,
5	T	is ehm (1.8) ze stopt niet eens auto↑matisch.
		is erm (1.8) she doesn't stop even auto↑matically.
6	I	hmhm,=
7	T	=ze had- als ik niks had gedaan was ze misschien nog wel
		=she would've- if I hadn't done anything she probably would've
8		↑verder gegaan.
		↑gone on.
9	I	ja.
		yes.
10	T	dus het is niet dat ze ergens naartoe praat heb ik nu het
		so it's not as if she's getting to the point that's my
11		idee van,=
		idea now,=
12		Qoke jongens dit is m'n vraag,
		Qokay guys this is my question,
13		dit is de introductie,
		this is the introduction,
14		kunnen jullie me nu helpen.
		can you now help me.
15		punt.
		period.
16	I	ja [ja.
		yes [yes.
17	T	[zeg maar hè?
		[you know eh?
18	I	ja.
		yes.
19	T	en dan (.) kost het mij dus ook nog blijkbaar- dan geef ik nog
		and then (.)apparently it also takes me another- then I give
20		vijf minuten de ruimte om dat te doen,
		another five minutes of space to do so,
21		en da- (.) ja dat is altijd een innerlijke (.) strijd.
		and tha- (.) yes that's always an inner (.) struggle.
22	I	ja ja.
		yes yes.
23	T	dat ge- levert je informatie op,
		that gi- gives you information,
24		hoef je minder te vragen,
		you need to ask less,
25		maar soms- ja (.) ˚is het overbodig.˚
		but sometimes- yes (.) ˚it's superfluous.˚

Here the teacher gives a negative evaluation of an unfocused telling: “it’s not as if she’s getting to the point” (lines 10-15). By intervening in this telling, the teacher shows an orientation to his responsibility to limit a telling when it no longer contributes to finding a focus for discussion. This orientation is visible in the form of explicitly pursued suggestions for focus, shown in Extract 4. Here the teller starts sketching the issue in general strokes: a situation where she disagreed with other staff about the condition of a patient (lines 4-18), vaguely signaling what she wants for focus: “bespreken” (“discuss”, line 4) and “om met één van jullie te sparren” (“so I thought it would be nice to spar with one of you”, lines 13-14). The first time we see the teacher’s orientation to a lack of focus is when, in the middle of the telling, he takes a turn on the candidate focus for discussion (lines 21-24):

Extract 4a: start of telling without clear focus for discussion from session recording U81121TB

1	T1	ehm
		erm
2		(.)
3		((kijkt R1 aan)) wil jij?
		((looks at R1) do you want to go?
4	R1	ja ik wilde:: eh een patiënt bespreken,
		yes I wante::d eh to discuss a patient,
5		e::h (.) ja (.) waarvan- bij ik vond dat die meneer termi↑naal
		e::m (.) yes (.) who- I found that this mister was
6		was,
		termi↑nal,
7		en e::h ja juist twee andere mensen=
		and e::rm yes indeed two other people=
8		=de eigen huisarts en de nieuwe huisarts in de hospice ↑niet.
		=the own GP and the new GP in the hospice ↑didn’t think so.
10		waarbij ik echt zoiets had van Q↑ohQ van e::h (.) zie ik het
		whereby I really thought like Q↑ohQ like e::h (.) is my view
11		nou verkeerd of wil je niet zien wat ik zie;
		so *wrong or don’t you want to see what I see;*
12		omdat hun in mijn ogen veel te rooskleurig eh waren.
		because in my eyes they were much too rosy.
13		dus ik vond het wel leuk om met één van jullie te sparren
		so I thought it would be nice to spar with one of you
14		van ja van e::h-
		like yes like e::h-
15		zeker omdat ik wel vaker >casussen< zie dat je denkt van Qja
		especially because I see these >cases< more often that you
16		maar het is toch duidelijk dat dit pallia↑tief is?Q=
		think like Qyes clearly this is palliative, isn’t it?Q
17		maar andere mensen er toch een soort van andere- ↑rooskleuriger
		but other people have a sort of different- more ↑rosy view
18		beeld over eh hebben,
		eh of it,

```
19              ehm nou ja ik zit eh (heb) één afdeling ehm (.) reva[lidatie-
                em well yes I'm eh (have) one department em (.) reva[lidation-
21      T1                                                          [(en) is je
                                                                    [(and is
22              vraag dat wij gaan meebeslissen [over of die patiënt terminaal
                your question that we co-decide [on whether that patient is
23      R1                                      [nou   nee    maar    meer
                                                [well  no     but  more
24      T1      is?]
                terminal?]
25      R1      van] hoe ga je daarmee [om.=
                like] how do you deal with [that.=
26      T1                             [((knikt))
                                           [((nods))
27              =als een collega- van ja dat jij denkt nou iemand is
                =like a colleague- like yes that you think well someone is
28              pallia↑tief van- of terminaal,
                pallia↑tive- or terminal,
29              maar andere collega's dat ↑niet vinden,=
                but that other colleagues ↑don't think so,=
30              =en eigenlijk andere oplossingen zien.=
                =and actually they see other solutions.=
31              =terwijl jij zoiets hebt van Qnee diegene is echt met het
                =while you are like Qno that person is really in the
32              laatste stukje van het leven bezig,
                last bit of their life,
33              we moeten ons op ↑andere dingen focussen.
                we have to focus ourselves on ↑other things.
34              ja dat [een beetje.
                yes something [like that.
35      T1             [((knikt))
                             [((nods))
36              eh maar de casus is=
                eh but the case is=
37              =((describes situation of patient))
```

The proposed focus is formatted as a candidate understanding (lines 22-24), which treats the accountable activity of making the focus clear for discussion as insufficient. The candidate focus, however, is quite directly set aside at the first possible point of completion (line 23). Instead, the resident posits a different focus, which abstracts from the specific situation (which the teacher's proposal addressed) to a more general type of experience which others are likely to have experience with. The focus is still sketchy ("hoe ga je daarmee om", "how do you deal with that", line 25), but the teacher treats it as good enough for now: he does not pursue it further, not until slightly later (see Extract 4b).

After a few minutes of describing the specific situation (starting line 36, Extract 4a), the teller seems to come to some sort of conclusion about the specific situation of disagreement between doctors (lines 181-186). At that point, the teacher steps back in (line 188):

Extract 4b: pursued teacher intervention for focus from session recording U81121TB

181	R1	dus ja (.) ik vond het best wel indrukwekkende casus;=
		so yes (.) I thought it was a rather impressive case;=
182		=dat toch (.) twee ervaren huisartsen daar toch heel ↑anders
		=that (.) two experienced GPs still had very ↑different
183		over dachten.=
		ideas about it.=
184		=terwijl ik en mijn opleider ↑toch iets heel ↑anders zagen.
		=while my supervisor and I ↑saw something very ↑different.
185		en dat die patiënt en familie dat ↑ook wel aanvoelden dat
		and that patient and family ↑also felt that that hospice
186		hospice de juiste plek was.
		was the right place.
187		(0.8)
188	T1	ok [ik] denk dat de situatie helder is,
		okay [I] think the situation is clear,
189	R1	[ja]
		[yes]
190		ja.
		yes.
191	T1	waar wil je nu op inzoomen.
		what do you want to zoom in on now.
192		(want je [zegt je)-
		(because you [you say)-
193	R1	[nou ja wat e::hm pt (.) ja van eh (.) ja ik was-
		[well yes what e::rm pt (.) yes like eh (.) yes I was-
194		ik ging een beetje meer ook aan mezelf ↑twijfelen.=
		I started ↑doubting myself a bit more.=
195		=terwijl (.) ((herformuleert focus m.b.t. twijfel))
		=while (.) ((reformulates focus in relation to doubts))

By intervening with "okay, I think the situation is clear" (line 188), the teacher treats the telling so far as complete for formulating the focus for discussion. His next move, "what do you want to zoom in on" (line 191) pivots the telling to a search for that focus. The teacher's continued pursuit of a focus for discussion shows that he treats the telling as still too broad for discussion. He invites the teller to choose an aspect (*just one* aspect) for further discussion (line 191) and starts accounting for that invitation (line 192) when the teller starts and restarts to reformulate a focus for discussion (lines 193-195). Restarts can be an interactional means to secure the floor (Goodwin, 1980), in line with how the "nou" ("well", line 193) functions as a prelude to her extended turn. Here, the restarts could probably also indicate a trace of resistance against further

refining the already refined focus ("well yes", line 193). Nonetheless, the reformulation ends in a claimed realization that the focus may be more about her problems with being held accountable (see Extract 4c, line 201, below). In response to this reformulated issue, the second teacher, who up to now has not been an active participant, provides a summary formulation (line 206, below; Barnes, 2007) for validation by the teller:

Extract 4c: pursued teacher intervention for focus from session recording U81121TB

201	R1	ja dat ↑deed toch wel wat met mij.
		yes that ↑did do something to me.
202		( ) dat ik dacht van ↑ja van eh;
		( ) that I thought like ↑yes like eh;
203		>voelde een beetje< alsof ik mezelf moest ver↑dedigen.=
		>felt a bit< like I had to de↑fend myself.=
204		=dus misschien zit ↑daarin wel meer mijn vraag,
		=so maybe ↑that's more like my question,
205		van e:h=
		like e:h=
206	T2	=ter verantwoording [geroepen worden.]
		=being held [accountable.]
207	R1	[ja ja.]
		[yes yes.]
208		(2.5)
209	T1	zullen we dat onderzoeken?=
		shall we explore that?=
210	R1	=[ja.=
		=[yes.=
211	T1	=[dat eh-
		=[that eh-
212		((open palm gesture to group))
213	R2	>ik ik weet- ik weet niet of het nou bij het ↑stuk past<,=
		>I don't know- I don't know whether it fits the ↑focus<,=
214		=maar ((start formuleren van vraag aan verteller))
		=but ((starts formulating question to teller))

Although the teller readily acknowledges the summary formulation (line 207), T1 provides another opportunity for her to nuance that focus by formally eliciting her agreement on taking it as the starting point for further exploration (line 209). Again, the teller validates this focus for discussion. In doing so, she pre-empts further elaboration by the teacher, presumably on what the focus exactly would be. The "that eh" (line 211) could be another start to summarize the focus, and with that a further indication of the importance of having a clearly formulated issue for discussion.

Summing up, we see the general norm for complete, clear and focused tellings in participants' normative judgments about specific practices that constitute the actions that are evaluated, and in the orientations to that norm in the actual interaction itself. The norm is enacted in the form of tellers fronting and marking the focus for discussion while describing their

experience, and teachers' asking for a teller's formulation of that focus when it is absent or not clear enough in the telling.

Exploration phase

Typification based on generic norms distilled from interviews. Once the telling has ended, the situation or the issue usually needs a bit more unpacking. Participants regard clarifying the situation and the issue as a collaborative task in the exploration phase. Based on the participant comments in the interviews, we distilled three main responsibilities for this phase: (1) to establish the focus for discussion (the issue), (2) to elicit more information about the shared situation if necessary, and (3) to retain the focus in the process. The interviewees distributed these responsibilities over the group, the teacher, and the teller. The teacher is seen as having the main responsibility for the established focus, the teller has the prime responsibility for identifying or validating a proposed focus, and the group is indispensable in working toward achieving the focus when it is not yet clear.

Specific orientations observable in actual conduct. These norms are visible in participants' positive assessments of situations where residents and teachers propose, test, or pursue a focus for discussion. In Extract 5, a teacher labels his own intervention as "trying to establish focus" (line 3):

Extract 5: teacher comment on intervention in Extract 8 from video-stimulated interview with teacher U81121TBd1

1	I	wat doe je met jouw bijdrage hier?
		what do you do here with your contribution?
2		(4.1)
3	T	weer: lijn proberen te bepalen en kijken of de groep (.)
		again:: try to establish focus and check if the group (.)
4		het volgt,
		is still following,
5		even heel kort samenvatten van eh (.) is dit ook een beetje-
		just summarize it very briefly like eh (.) is this also a
6		(dus) ↑haar (.) vragen,
		little bit- (so) ask (.) ↑her,
7	I	hmhm,
8	T	dus vragen van hé is dit nou wat jij ↑wil,
		so ask like hey is this what you ↑want,
9		is dit de goeie kant waar jij heen wil,
		is this the right track you want to go on,
10		en ook aan de groep (.) toetsen van eh (.) Qnou zullen we hier
		and also check with (.) the group like eh (.) Qwell shall we
11		dan op in gaan zoomenQ.
		zoom in *on this point thenQ.*

12	I	ja.
		yes.
13	T	is eigenlijk een soort eh (.) mediator.
		it's actually a sort of eh (.) mediator.
14	I	hm ja.
		hm yes.
15	T	dus we kijken van (.) klopt het wat jij zegt?=
		so we check like (.) is what you say right?=
16		=want ze zegt vijf minuten wat,
		=because she says things for five minutes,
17		dan probeer je in:: (.) >vijftien< seconden wat te zeggen,
		then you try to say something in:: (.) >fifteen< seconds,
18	I	ja,=
		yes,=
19	T	=zeggen Qnou dan gaan we dat doenQ.
		=say Qwell then that's what we're going to doQ.
20	I	hm ja.
		hm yes.
21		dat is dan het startpunt van de discussie.
		so that's the starting point of the discussion.
22	T	voor mij wel.
		for me yes.
23	I	ja.
		yes.
24	T	het startpunt van ↑eigenlijk de vraag hè,=
		↑actually the start of the question eh,=
25		want dat weet de groep ook,
		cos *the group knows that too,*
26		we gaan nu vragen- in principe is 't de bedoeling om te vragen.
		now we're going to ask- in principle it's the intention to ask.
27	I	ok.
		okay.
28	T	dus dat eh dat is de eerste inzet vaak.
		so that eh that's often the first move.

Here the teacher categorizes his intervening action as mediating between the teller and the group (line 13). More than *figuratively* mediating by proposing a focus for discussion for validation by the teller and acknowledgment by the group, the intervention *literally* mediates a multi-unit turn by the teller, and alternating turns between group members and the teller. One of the residents evaluates this moderating interactional move (see Chapter 6) positively. In her evaluation, the resident orients to a norm of progression in terms of the focus of the discussion – the implied norm of *efficiency* that we identified in residents' discourse on valuable sessions (Chapter 5):

Extract 6: resident comment on intervention in Extract 8 from video-stimulated interview with resident U81121TBa1

1	R	het was best wel een lang verhaal,
		it was a rather long story,
2	I	ja,
		yes,
3	R	ik- ook als je nu in de tijd kijkt,
		I- also if you look at the time now,
4		dat hij ↑even concretiseert van dit hier is sprake van en (.)
		he takes a moment to concretize like this here is what we
5		zullen we hier op inzoomen.
		are looking at and (.) shall we zoom in on that.
6	I	hmhm,
7	R	dus hij geeft ook eigenlijk al de suggestie van welke kant we
		so actually he's already making a suggestion for the direction
8		op gaan.=
		to take.=
9		omdat je (.) ook als groep het risico anders loopt dat je op
		because (.) otherwise as a group you risk responding to
10		allerlei verschillende dingen aan het reageren bent.
		all sorts of different things.

Slightly before this interaction, the resident positively evaluated the summarizing skills of the teacher (in general). Here, she comments on how the summary helped her focus. She orients to the importance of creating focus by treating an interaction that is fanning out as a "risk" (line 9). The teller in her interview also treats this specific focus proposed by the teacher as helpful in discussing the issue:

Extract 7: resident's report about proposal to zoom in on example from video-stimulated interview with teacher U81121TBa2

1	R	het is makkelijker om: (.) zo'n thema als leidinggeven,
		it is easier to: (.) discuss a theme like managing,
2		te bespreken aan de hand van een casus.=
		using a case study.=
3		=denk ik dan- dan gewoon als thema op zich (.)
		=I think then- instead of just a theme by itself (.)
4		want dan (.) ja (.) dat maakt het gewoon net wat concreter
		because then (.) yes (.) it just makes everything a bit more
5		allemaal.
		concrete.

This resident notes that focusing on the one example benefits the following discussion in terms of concreteness. Together, the specific assessments in these interviews orient to the importance of establishing and retaining a focus for discussion.

We see this orientation play out in the actual interaction in Extract 8, which the participants in Extracts 5, 6 and 7 commented on. This interaction is a continuation of the telling presented in Extract 2b (see also Chapter 7, Extract 2). As we have seen there, the resident clearly ends her telling with a conclusion to her story (lines 1-10). The teacher (T) picks up on this ending by proposing to focus on the example just told (as an illustration of the issue to discuss) (lines 12-28). His proposal is directed at the teller, orienting to her prime role in this part of the session:

Extract 8: teacher proposal for focus of discussion from session recording U81121TB

1	R1	en (.) >naja< (.) dat is één voorbeeld waarvan ik denk;
		and (.) >okay< (.) that's one example that makes me think;
2		(1.2)
3		misschien moet ik soms gewoon;
		maybe sometimes I should just;
4		(0.3)
5		dan maar even geen vriendjes willen zijn,=
		not want to be friends at the moment,=
6		=maar gewoon;
		=but just;
7		(.)
8		zeggen van Qja (.) ik snap dat >het vervelend is<,
		say like Qyeah (.) I understand that >it's annoying<,
9		maar >we doen het gewoon even op deze manier<.
		but >we'll do it this way for now<.
10		punt.Q
		period.Q
11		(0.2)
12	T	vind je (dat) goed om daar in te zoomen?
		would you mind zooming in on that?
13		(0.3)
14		(want) je hebt een mooie casus,=
		(because) you have a nice CASE,=
15	R1	=j[a.]
		=y[es.]
16	T	[je] schetst de casus- gisteren het is vijf uur,
		[you] sketch in the case- yesterday at five o'clock,
17	R1	ja.
		yes.
18	T	ik wil twee casus zien,
		I'd like to see two CASEs,
19	R1	ja.
		yes.
20		°([ ) zien°]
		°([ ) see°]
21	T	[ehm ma]ar ze geven mij de ↑wind van voren,
		[um bu]t they gave me an ↑earful,
22		en op dat moment (.) gaat er iets in mijn ge↑dachten,

		and at that moment (.) I changed my ↑mind,
23		en besluit ik één (.) casus te zien.
		and I decided to see one (.) case.
24	R1	ja.
		yes.
25	T	°en eentje niet.°
		°*and not the other.*°
26	R1	ja.
		yes.
27	T	[((looks][around))]
28		[>zullen we daarop< eh inzoomen?][((handgebaar groep))]
		[>shall we zoom in< uh on that?][((hand gesture to group))]
29		((looks [at R))]=
30	R1	[prima.]=
		[ok.]=
31	T	=((looks [around the group))]
32	R2	[maakte het nog] uit hoe: be↑langrijk je het vond?=
		[did it matter] how: im↑portant you thought it was?=
33		=die tweede?=
		=the second one?=
34		=want (waarom maakte je die-)
		=because (why did you decide tha-)
35		(0.2)
36	R1	((clears throat, starts responding))

The teacher's summary formulation (Barnes, 2007) not only highlights one aspect of the telling for discussion, thus proposing a focus for further exploration, it also closes the telling phase and opens up the floor for others (R2) to explore the issue or elements of the experience (see lines 32 and further). In that sense, here the teacher constructs his role as responsible for establishing the focus for discussion.

In contrast to the situation just presented, sometimes establishing the focus for discussion still needs a lot of interactional work. In the next example, it takes quite a while before the teller, teacher, and other residents agree what the focus for discussion is going to be. Several questions have already been asked about the telling, and now, a few minutes into the exploration phase, one of the residents (R2) asks the teller (R1) to elaborate on her use of the word 'blame' (line 1):

Extract 9a: collaborative building toward an issue for discussion from session recording G80524DA

1	R2	en je noemt het woord >verwijten<.
		and you mention the word >blame<.
2		waarom denk je dat ze jou iets verwijt?
		why do you think that she blames you for something?
3	R1	nou (omdat) ze twee keer bij mij is geweest natuurlijk,
		well (because) she came to me twice of course,
4		en ik heb gezegd Qnou het past bij e::h psychische klachtenQ,
		and I said Qwell it fits the e::h psychological complaintsQ,
5	R2	hmhm.
6	R1	((nods))
7		ehm en ze komt bij de opleider daarna,
		ehm and afterwards she visits the supervisor,
8		en die stuurt haar ↑wel direct door.
		and he ↑sent her in directly.
9		˚met spoed.˚
		˚*urgently.*˚
10	R3	ja=
		yes=
11	R1	=en dat blijkt ook echt iets te ↑zijn.
		=and it turned out to ↑be something real.
12		namelijk dat hypotensief [( )
		namely that hypotensive [( )
13	R2	[ja pre↑cies.=
		[yes e↑xactly.=
14		=maar uiteindelijk ↑wat is nou de con↑clusie.
		=but ultimately ↑what is the con↑clusion now.

After a short account by the teller for her feeling of blame, the fellow resident moves the interaction from 'blame' to the medical conclusion of the case (line 14). Several turns ahead, the teacher picks up again on the 'blame' issue. She transforms it into a formulation of a potential dilemma for discussion, again showing an orientation on the importance of establishing a focus for discussion:

Extract 9b: collaborative building toward an issue for discussion from session recording G80524DA

```
25      T       maar volgens mij zit jouw dilemma (als ik              )
                but I think your dilemma is in (if I may              )
26              bij jou↑zelf.
                your↑self.
27      R4      ja.
                yes.
28      T       jij hebt ↑zelf het idee van Qhee heb ik daar (.) iets gedaan
                you your↑self have the idea that Qhey did I do (.) something
29              wat mogelijk door haar als een ver↑wijt wordt gezien,
                that she could possibly see as an accu↑sation,
31      R1      [ja.
                [yes.
32              [((nods --[-----------------------------------------
33      T                  [en dat zou ik eigenlijk ook met haar willen
                           [and I would actually like to discuss that
34      R1      ----------]—[--))
35      T       bespreken,]
                with her, ]
36                         [en dan zegt jouw opleider Qnou doe maar even
                           [and then your supervisor says well ↑don't do that
37              ↑niet,
                for now,
38              en das eigenlijk ook het dilemma wat je (.) ↑hier wil delen.
                and that is actually the dilemma that you (.) want to share
                ↑here.
39      R1      [ja klopt.]
                [yes that's right.]
40              [ ((nods--]---[-))
41      R4                    [wat ver↑wijt je jezelf (precies) in deze casus?
                              [what exactly do you ↑blame yourself for in this
                case?
42    R1        ((explains that she does not blame herself, but expects the
43              patient to blame her))
```

The teacher formats the dilemma as inferred from the preceding discussion (see the "if I may", line 25). It is constructed as a check for confirmation, which is promptly provided by the teller. What exactly the dilemma is, however, remains ambiguous. A fellow resident tries the issue of blaming *yourself* (probably in relation to the implied blame in line 29), but that appears to not be the issue at stake (line 41 and further). The interaction evolves into a discussion of whether or not the teller should contact the patient on her own initiative, resulting in the teacher's pursued attempt to pinpoint the real issue (lines 140-142):

Extract 9c: collaborative building toward an issue for discussion from session recording G80524DA

133		((talk about whether teller should contact the patient and what
134		she could achieve with that))
135	R1	ja ja.
		yes yes.
136		dat ik denk dat het ge↑zin ↑ook wel een beetje in de picture
		that I think that the ↑family should ↑also be kept a bit in
137		moet worden gehouden.
		the picture.
138	R5	ja.
		yes.
139		((unclear, overlapping talk by several participants))
140	T	is dat ↑ook een een een ding van jou?=
		is that ↑also a a a thing for you?=
141		=of gaat het vooral eigenlijk om het verwijt wat je zou willen
		=or is it really the accusation that you'd most like
142		weten of dat- of dat er speelt.
		to know if that- if that is at play.
143	R1	a-a- van alles wel.
		a-a- all of it actually.
144		ja (alles).
		yes (everything).
145	T	ja.
		yes.
146	R3	wat zou je zelf in die situatie willen.
		what would you yourself want in that situation.

Still, what is at stake remains undefined ("a-a- all of it actually", line 143). The next question by R3 (line 146) slightly diverts the course by eliciting a reflection on what the teller would have preferred her doctor to do, had she been the patient. Though on first sight that does not seem to help find the stake in this situation, it does create room for another resident to refocus on the role of the supervisor in this decision to contact or not (lines 165-166). The teacher pursues this aspect of the experience in an eventually accepted formulation of the dilemma (lines 174-186), which is treated as the start of discussion (line 187 and further).

Extract 9d: collaborative building toward an issue for discussion from session recording G80524DA

164		((talk about contacting the patient))
165	R5	maar daar ben je dan over gaan ↑twijfelen door je opleider
		but you started ↑doubting that because of your supervisor
166		denk ik of niet?
		I think or not?
167	R1	ja [klopt.]
		yes [that's right.]
168	R5	[want als] die er] niet was geweest (.) dan;=
		[because if] he had] not have been there (.) then;=
169	R6	[>jij had dat]al gedaan ja<]
		[>you would have] done that already<]
170	R1	=had ik al gebeld.
		=I would've called already.
171	R5	ja.
		yes.
172	T	ja.
		yes.
173	R1	ja.
		yes.
174	T	dan is de vraag misschien wel meer van;
		then the question is probably more like;
175		ik weet zelf als dokter eigenlijk wel wat voor be↑leid ik hier
		as a doctor I actually know what kind of ↑policy I would like
176		zou willen [voe]ren,
		to follow [here],
177	R5	[ja.]
		[yes.]
178	T	maar mijn opleider eh geeft een ander eh geeft een andere
		but my supervisor eh gives another eh gives a different
179		advies,=
		advice,=
180	R1	=ja.=
		=yes.=
181	T	=zeg maar,=
		=you know,=
182	R1	=ja.=
		=yes.=
183	T	=en hoe ga ik daar dan mee ↑om.
		=and how do you ↑deal with that.
184		[is dat het meer;
		[is it more like that;
185	R1	[((nods))
186		ja.
		yes.
187	R4	wie zou d'r het beste weten wat het juiste moment is
		who would know best when is the right moment for such
188		voor zo'n gesprek?
		a conversation?

So, what we have seen in Extract 9 is the moment-by-moment unfolding of a collaborative establishment of a focus for discussion. The pursued attempts to formulate the issue at stake in the form of proposals of candidate foci show the participants' orientation to the importance of settling on a focus. As in Extract 8, the teacher uses formulations to check the focus of discussion with the teller, directly after the telling if the focus is clear enough, and as interventions in ongoing explorative interaction when the focus still needs to be established. In both cases, the teacher's pursuit is valued positively for its contribution to establishing a clear focus for discussion. In the exploration phase, then, we see a joint pursuit of formulating an issue for discussion. In the next phase, discussion, the roles and responsibilities for creating educational value change slightly.

Discussion phase

Typification based on generic norms distilled from interviews. Having established the focus, participants now see two tasks in the discussion phase: (1) to 'open up' the issue by suggesting new perspectives and other viewpoints, and (2) to provide information or otherwise relevant contributions that address or even solve the issue. In that sense, the group and the teacher are seen as 'resources' who collaborate to help the teller. Generally, the norm is to stick to the focus for discussion unless the relevance of a detour warrants wandering around it.

Specific orientations observable in actual conduct. An orientation to the 'provider function' of anyone beyond the teller is visible in, for example, the following teacher comment on a piece of information shared by a resident. In that comment, the teacher shows a clear preference for contributions by fellow residents over contributions by the teacher(s):

Extract 10: teacher comment on residents helping each other from video-stimulated interview with teacher U81121TBd1

1	T	((stops the recording)
2		dit is wel heel leuk hè,=
		this is rather nice eh,=
3		dit is (.) die die aios zelf,
		this is (.) that this resident,
4	I	hmhm,
5	T	die maakt het nu erg persoonlijk hè,
		she makes it very personal now eh,
6		Qwaar waar zit nou eigenlijk de angel van jouw inbreng.Q
		Qwhat what actually is the point of your story.Q
7		en dat (.) komt (.) bij haar eigen onzekerheid of haar eigen
		and that (.) comes (.) down to her own insecurity or her own
8		ka↑raktereigenschappen kom je dan eigenlijk terecht,
		↑character traits actually,
9	I	hmhm,
10	T	haar eigen valkuilen,

		her own pitfalls,
11		en dat- nou dat vind ik heel leuk dat zij dat dan >aanhaalt<,
		and that- well I like it a lot that she >mentions< that,
12	I	ja.
		yes.
13	T	en dan scherp ik hem even aan maar dat is- dat is minor.
		and then I sharpen it a bit but that is- that's minor.
14	I	ja.
		yes.
15	T	dus dat vind ik heel leuk als je de ↑groep soms gebruikt,
		so I like it a lot when you sometimes use the group,
16		en dan heb je wel (.) een kwar↑tiertje voor nodig.
		and then you do need (.) fifteen minutes.
17	I	ja.
		yes.
18	T	.h maar daar daar kom je wel tot de ↑kern.
		.h but at at that point you do reach the ↑core.

Here, the teacher talks about his role as 'minor' monitoring. This role may compromise the efficiency of the interaction (line 16; compare the norm of efficiency reported in Chapter 5) in the view of the teacher, but it is still worth pursuing (line 1, 18) because of the room it creates for residents' contributions in progressing the discussion in relation to its focus.

The underlying norm here is that residents should help *each other* address or solve the issue under discussion. This norm is related to the creation of educational value, in the sense that it is assumed that the process of discussing the issue is more valuable if residents – not the teacher – question each other. Extract 11 shows the practices used to accomplish the actions that answer to this norm. Here residents are asking questions that progress the discussion in terms of its established focus. R2 can be seen to be working toward the prominence of wanting to be liked (lines 1-11), culminating in line 21. The teacher, who has not contributed to the discussion so far, corroborates the relevance of the implied 'problem' by formulating it even more sharply (lines 13-16):

Extract 11: teacher contribution corroborates ongoing resident discussion from session recording U81121TB

1	R2	en eigenlijk;=
		and actually;=
2	R1	=ja.=
		=yes.=
3	R2	=is dat mis↑schien [(.) zonde] van mijn energie.
		=that ↑maybe is [(.) a waste] of my energy.
4	R1	[beetje too much.]
		[a bit too much.]
5		ja.=
		yes.=
6	R2	=of is dat wel nodig binnen mijn professionele-

```
                =or is that actually necessary in my professional-
7       R1      tenminste ik constateer dat (.) [  dat   ] dat ik dat ik bang
                at least I observe that (.) [that  ] that I that I'm afraid
8       R2                                      [grenzen.]
                                              [limits]
9       R1      ben dat dat too too much is.=
                that that's too too much.=
10      R2      =ja.=
                =yes.=
11      R1      =ja.
                =yes.
12      T1      sterker nog,
                more than that,
13              het gaat zelfs ten koste van pa↑tiëntenzorg.=
                it's even at the cost of ↑patient care.=
14              =ik zet het nu iets tegen elkaar af.
                =I'm contrasting it a bit.
15      R1      [hehehe
16      R2      [nou ja,
                [well yes,
17      T1      want [je ] ziet een patiënt niet.
                because [you ] don't visit a patient.
18      R2           [ja.]
                        [yes.]
19              nee ↑zeker.=
                no in↑deed.=
20      R1      =(        ) (.) °ja°.
                =(        ) (.) °yes°.
21      R2      en hoe <be↑langrijk> is het voor jou (.) wat mensen van je
                and how <im↑portant> is it for you (.) what people think of
22              vinden.
                you.
23      R1      ja nee dat is natuurlijk de cru-
                yes no that of is course the cru-
24              ik denk dat-
                I think that-
25              ik hoop tenminste dat het ook een beetje herkenbaar is voor
                I hope at least that it's also slightly recognizable for the
26              mensen hier,
                people here,
```

Here the teacher intervenes in second position, when the teller and fellow resident are nearing the point that later turns out to be "the crux" (line 23), which is not picked up further. He formats his turn as building on the prior one ("more than that", line 12) but going one step further. He orients to the 'sharp' edge of his implicit evaluation of the teller's behavior ("it's even at the cost of patient care", line 13) by choosing a polemic position ("I'm contrasting this a bit", line 14). Since providing good patient care is the core task of the teller, this is quite an assessment. Still, R2 acknowledges

and confirms it. The teller responds only minimally before R2 continues with another question that builds onto this track of the importance of being liked by others. In this sense, the teacher's contribution is formulated and treated as rather minimal and secondary.

That resident contributions are seen as having more value than teacher contributions does not mean, however, that anything goes. In their comments on the specific instances of the discussion phase, participants orient to the importance of retaining the focus for discussion. In Extract 12, one resident orients to the teacher's task of monitoring the discussion for detours. She holds the teacher accountable for not intervening when the discussion seems to move off-track (lines 4-6):

Extract 12: resident's comment on no teacher action from video-stimulated interview with resident U81121TBa1

1	R	ik vind ↑dat een taak van de docenten.
		I think ↑that's a task of the teachers.
2		dat zij ehm (.) eh in de gaten houden (.) welke kant het
		that she ehm (.) eh keeps an eye on (.) which direction
3		goed is >om op te gaan<.=
		is good >to follow<.=
4		want ik denk dat zij- omdat zij er iets verder van af staan.
		cos *I think that they- because they're further away from it.*
5	I	ja,
		yes,
6	R	eh soms (.) ja >wil ik daar ook van- denk ik van nou< misschien
		eh sometimes (.) yes >I also want like- I think like< maybe
7		is het wel nuttig dat het blijkbaar zo gaat,
		it is indeed helpful that it happens like this,
8		want ze <grijpen niet in> of zo?
		because they <do not intervene> or anything?
9	I	ja ja.
		yes yes.
10	R	ehm (.) dus ik denk ↑wel dat als zij dat- ↑juist die
		ehm (.) so I ↑do think that if they see that- ↑indeed when they
11		mogelijkheid zien,=
		see that possibility,=
12		dat dat zij daar wel iets meer in mogen sturen.=
		that that they could steer a bit more in that.=
13		=>en aan de andere kant< (.) denk ik ↑ook niet dat een docent
		=>and on the other hand< (.) I ↑don't think that a teacher
14		mensen kan gaan afkappen van Qhé nee dat is niet de goeie
		can cut people off like Qhey no this is not the right
15		↑vraag op dit moment.=
		↑question at this point.=
16	I	=[nee.
		=[no.
17	R	=[want ze willen ons ook ↑leren om die goe- om die ↑vragen goed

```
                =[because they also want to ↑teach us to ask those right- to
18              te stellen.
                ask the ↑right questions.
```

Here the resident orients to the teacher's responsibility for keeping the discussion on track, heading toward the heart of the issue (lines 1-4). She explicitly links this responsibility to the teacher's professional objectivity (distance from the topic), which she assesses as granting a good position to decide what is valuable to discuss. She also orients to potential conflicts in value that the teacher possibly weighs in deciding on the desirability of keeping to a certain track (lines 10-18). We cannot know these considerations, but we do have a representation of what happened in the interaction (Extract 13). Here we see the practices associated with the normative judgment in Extract 12:

Extract 13: resident question diverts discussion from issue, no teacher intervention from session recording U81121TB

```
1       T2      maar misschien meer de andere ↑kant.
                but maybe more the other ↑side.
2       R1      [ja.     ]
                [yes.    ]
3       T2      [dat jij ] (.) wat teveel (.) het gevoel hebt (.) dat je soms
                [that you] (.) have the feeling that (.) sometimes (.) you let
4               (.) over je↑zelf (.) laat lopen dan?
                people walk over your↑self (.) a bit too much then?
5       R1      ja [ja.
                yes [yes.
6       T2         [dus ↑dat aspect (.) dat je te aardig bent.=
                   [so ↑that aspect (.) that you are too nice.=
7       R1      =ja te ↑aardig (.) willen zijn.
                =yes wanting to be (.) too ↑nice.
8       T2      ja.
                yes.
9               (.)
10      R1      ja.
                yes.
11      R2      ik was nog benieuwd van eh (.) kon je je verplaatsen in eh
                I was still curious like eh (.) could you imagine eh
12              hun eerste re↑actie.=
                their first re↑action.=
13              =van eh- als je het zeg maar vanuit ↑hun bekijkt.
                =like eh- if you see it from ↑their point of view.
14              wat [je-
                what [you-
15      R1          [ja.
                     [yes.
16      R2      hoe het een beetje op ↑mij overkwam,=
                how it came across to ↑me,=
```

```
17              =is je had het ↑niet vooraf aangekondigd,=
                =is that you did ↑not announce it beforehand,=
18              =maar je kwam daar gewoon binnen met (.) eh deze vraag.
                =but you just jumped in with (.) eh this question.
19              van e:h;
                like e:h;
20      R1      e:h ja >ze wisten dat ik die middag< zou komen,
                e:h yes >they knew that I would come< that afternoon,

((lines with elaboration on situation omitted))

35      R1      >ik kon me daar wel in ver↑plaatsen.<
                >I could imagine how they ↑felt.<
36      R2      ja.
                yes.
37              (.)
38              had je ↑daar nog iets over kunnen teruggeven;
                could you have reported back something about ↑that;
```

The resident's question in lines 11-19, which the resident in Extract 12 treated as off-track, concerns the teller's standing toward the other's reaction. It is formatted as a 'post' after an explicit reference to one of the key aspects of the situation established for discussion (lines 6-7). Yet, it is supported by several follow-up questions that for a considerable amount of time keep the discussion away from the theme of people-pleasing. During that interaction, both teachers do not intervene.

A similar absence of teacher intervention happens in Extract 14 (see also Extract 4c). Here, the resident orients to her question being potentially off-topic, right after the collaboratively constructed (by R1, T1 & T2) focus for discussion (only partly shown, lines 1-11):

Extract 14: first question after telling, orientation on fit with focus from session recording U81121TB

```
1       R1      ja dat ↑deed toch wel wat met mij.
                yes that ↑did do something to me.
2               (     ) dat ik dacht van ↑ja van eh;
                (     ) that I thought like ↑yes like eh;
3               >voelde een beetje< alsof ik mezelf moest ver↑dedigen.=
                >felt a bit< like I had to de↑fend myself.=
4               =dus misschien zit ↑daarin wel meer mijn vraag,
                =so maybe ↑that's more like my question,
5               van e:h=
                like e:h=
6       T2      =ter verantwoording [geroepen worden.]
                =being held [accountable.]
7       R1                  [   ja       ja. ]
                            [yes   yes.   ]
8               (2.5)
```

9	T1	zullen we dat onderzoeken?=
		shall we explore that?=
10	R1	=[ja.=
		=[yes.=
11	T1	=[dat eh-
		=[that eh-
12		((open palm gesture to group))
13	R2	>ik ik weet- ik weet niet of het nou bij het ↑stuk past<,=
		>I I don't know- I don't know whether it fits the ↑focus<,=
14		=maar ik ben toch geïntrigeerd.=
		=but I'm still intrigued.=
15		=want (.) als ik het nou hoor,
		=because (.) when I hear it,
16		((continues formulating question))

Resident 2 orients to a possible diversion from the focus for discussion: "I- I- I- don't know whether it fits the focus, but I'm still intrigued…" (line 13-14). By acknowledging the focus, while orienting to the possible misfit between her question and the focus, she orients to the importance of a focus for discussion in directing the discussion, while also treating the focus as provisional by pursuing an "intriguing" (line 14) aspect of the experience despite its potentially indirect relation to the established focus. R2's question is not pre-empted or cut short by the teacher or teller; it is at least tolerated. In fact, a few turns into this question, when the teller interrupts the questioning resident, the teacher cuts off the teller to create room for the questioning resident to finish speaking (not shown), thus acknowledging the slightly different topic as relevant.

Although the interviewees frequently spoke of tellers as having prime access to what the discussion should be about to make it valuable for themselves, tellers do not often redirect the discussion. It seems that tellers rely on the teachers to do so. Interpretations of absent teacher action in terms of a "missed chance" to move forward or prevent "going back" construct the taking of that chance as mainly a teacher responsibility. Incidentally, fellow residents do redirect or ask permission to go down a side path—again showing an orientation to the importance of staying in line with the issue for discussion.

In contrast to Extracts 13 and 14, Extract 15 is a potentially off-topic situation where the teacher does intervene. He links this intervention to staying on track and progressing in terms of the focus for discussion. He treats the intervention as an attempt to move the discussion efficiently forward, pre-empting work by the group:

Extract 15: teacher's comment on steering to issue from video-stimulated interview with teacher U81121TBd1

1	T	dus ik ben hier zeker sturender geweest,=
		so I've been directing more here for sure,=
2		=heb niet afgewacht tot iedereen eh de groep (.) dus ik liet
		=didn't wait till everyone eh the group (.) so I let
3		een paar mensen in de groep klein beetje sturen en dacht
		a few people in the group steer a little bit and then I
4		ik Qoke (.) nu gaan we iets meer eh (.) hè naar
		thought Qokay (.) now we're going a bit more eh (.) to
5		voors- tegenargumenten en en meer begrip krijgen voor de
		pro and con arguments and and getting more understanding of
6		situ↑atieQ.
		the situ↑ationQ.
7	I	ja.
		yes.
8	T	wat zij nodig had.
		what she needed.
9		[°dacht ik.°
		[°I thought.°
10	I	[ja.
		[yes.

"What she needed" (line 8) refers to an earlier collaboratively constructed issue for discussion. By redirecting to that, the teacher orients to the importance of staying with the established focus.

In the interaction assessed by this teacher, the discussion lingers on the specifics of a situation, which has already been described quite extensively. The teacher steps in by eliciting arguments (lines 5-7), an action related to the established focus for discussion (not shown):

Extract 16: teacher intervention redirects discussion from specifics to issue from session recording U81121TB

1	R1	naja hij zei ↑meer iets in de trant;
		well he said something ↑more like;
2		Qnou ja vergeleken bij andere mensen die ik hier binnenkrijg
		Qwell yes compared to other people that come in here
3		vind ik deze man nog heel goed.=
		I think this man is still very good.=
4		=(van [eh-)
		=(like [eh-)
5	T1	[kan je argu↑menten verzinnen,=
		[can you think of ↑arguments,=
6		=waarom ze dat vinden?=
		=why they think so?=
7		er zijn twee huisartsen die dat ( )

		there are two GPs who ( )
8		(.)
9	R2	( )
10	R1	↑ja.
		↑yes.
11		(.)
12		e:::hm nou ik dacht wel die eigen huisarts die eh: die heeft
		e:::rm well I did think that their own GP he eh: naturally was
13		het proces natuurlijk al ↑langer meegemaakt,
		involved in the process for a ↑longer while,

We could understand the teacher's invitation for "pro and con arguments" as just another question. In the broader context of this interaction, however, the question pivots between situational details elicited in the prior discussion and the focus-related search for understanding the subsequent situation. He thus redirects the discussion to the focus for discussion.

In sum, participants talk about the discussion phase by referring to the norm of collaborative production of value, where the residents' input is primary and the focus for discussion is retained. This norm is accomplished by a marked absence of teacher interventions – interpreted as acknowledging the course of interaction – and redirects back to the focus of the discussion, primarily by teachers' pivoting the interaction with a focus-related question or suggestion. In a sense, keeping in line with the discussion's focus is instrumental to the eventual aim of achieving educational value. That aim is very prominent in the conclusion phase of Learning from Experiences.

Conclusion phase

Typification based on generic norms distilled from interviews. If the telling, exploration, and discussion have been a joint construction of educational value, the conclusion features explications of that value. The main activity here is to formulate the uptake (Veen & de la Croix, 2017) of the prior discussion (compare Chapter 8). Participants, however, are not unanimous on the importance of establishing the value of the past interaction: some residents comment that value may also arise way beyond the limits of this particular educational session.

Specific orientations observable in actual conduct. The conclusion phase is usually initiated by (one of) the teacher(s), which shows an orientation of the participants to the ultimate responsibility of the teacher in monitoring, establishing and checking the creation of educational value. Also, residents and teachers orient to the primacy of value for the *teller* of the discussed experience. Value for other residents beyond the teller is seen as secondary – though still a key condition for the session to be valuable to all. Responding to a question about the value of a session, the teacher in Extract 17 specifies what that value could be – for both the teller and the group:

Extract 17: teacher's comment on value from video-stimulated interview with teacher U81121TBd1

1 I is het wel de bedoeling dat het er uit komt of of is het ook
is it the intention that it comes out of it or or is it
2 gewoon goed als het een bespreking is zeg maar?
just okay if it is a discussion you know?

((lines omitted, teacher talks about focus for discussion in this specific experience discussion))

11 T en soms (.) kan het (.) zijn dat er bij ↑haar niks geland is,
and sometimes (.) it can be (.) that nothing lands with ↑her,
12 maar de rest van de groep heeft ↑wel (.) eh allemaal dingen
but the rest of the group has indeed (.) eh been able to say
13 kunnen zeggen,
all kinds of things,
14 I [ja,
[yes,
15 T [en d'r zaten behoorlijk wat people pleasers in de groep,
[and there were quite a few people pleasers in the group,
16 I ja.
yes.
17 T dus eh (.) het hoeft niet alleen voor ↑haar een les te zijn,
so eh (.) it doesn't need to be a lesson for ↑her alone,
18 maar de ↑rest heeft ↑wel wat kunnen leren.
but the ↑rest ↑could have learned something too.
19 I [ja.
[yes.
20 T [in dat op zicht.
[in that sense.
21 I ja.
yes.
22 en voor haar is het (.) winst dat ze denkt ja weet je ze heeft
and for her it is (.) beneficial that she thinks yes you know
23 toch even op re- kunnen reflecteren,
she still has had the opportunity to re- reflect,
24 waar de (.) waar de (.) ja waar de eh () dreiging zit,
on where the (.) where the (.) yes where the eh (.) danger is,

((lines omitted, teacher specifies value for teller))

40 maar >het is natuurlijk< JAMMER (.) aan de andere kant
but >of course it is< a SHAME (.) on the other hand
41 jammer dat zij nu niet (.) heel veel (.) dingen heeft dat ze
it's a shame she doesn't (.) have very many (.) things now
42 zegt Q↑oh (.) wat ↑goedQ.
to says Q↑oh (.) how ↑niceQ about.
43 I ja.

yes.

44 T maar goed ja dat is (.) dat is ook uitwisselen.
but well yes that's (.) that's sharing experiences too.

45 I ja [ja.
yes [yes.

46 T [ehm (.) soms heb je dat ↑wel en soms eh (.) heeft de
[ehm (.) sometimes it ↑does happen and sometimes eh (.) the

47 persoon in kwestie niet ↑heel veel dingen nieuws,
person in question doesn't gain ↑very many new things,

48 maar kan het ook voor de groep wel nuttig zijn.
but it can still be helpful for the group.

Although in this specific case the teller does not readily acknowledge the value of the discussion, the point of this Extract is that the teacher orients to the primacy of value for the teller (as opposed to value for the group): "it doesn't need to be a lesson for her *alone*" (line 17). He does treat the limited value for the teller as something that makes relevant justification for this discussion of the experience having taken place, in the way he draws attention to the positive effects: "the rest of the group has indeed been able to say lots of things" (lines 12-13), "the rest could have learned something too" (lines 18-20), and "it can still be helpful for the group" (line 48). In a sense, then, discussions that have limited value for the teller are accountable.

That said, let us turn to the practices participants use to check the educational value of the prior discussion. In the following example, we see how the teacher initiates the conclusion phase by producing a summary formulation (Barnes, 2007) of the past discussion (lines 1-4). This is accepted by the teller (line 5), after which the teacher continues with a check of the prior discussion being enough (line 7).

Extract 18: teacher checks whether discussion was enough for teller from session recording G80524DA

1 T maar d- het mooie is dat jij signaleert dat jij eigenlijk-
but th- the nice thing is that you notice that you actually-

2 dat er eigenlijk iets ↑anders gebeurt dan jij misschien zelf
that actually something ↑else happens than what you

3 wel zou ↑willen,
might have ↑wanted,

4 en dat je denkt Qoeh da- daar wil ik ↑toch wat mee.Q
and that you think Qoh tha- that's something I ↑do want to address.Q

5 R1 ja.
yes.

6 T en ja de vraag is eigenlijk;
and yes the question is really;

7 heb je nog meer ↑input nodig of weet je alles nu.
do you need any more ↑input or do you know everything now.

8 R1 ↑nee ik kan hier wel wat mee.

```
                ↑no I can work with this.
9               [˚ik vind die van jou wel een mooie aanvulling.˚
                [˚I think your one made a nice addition.˚
10              [((looks at R2))
11      R2      nou ik ben wel be↑nieuwd.=
                well I'm ↑curious.=
12              =ik hoor ↑wel graag-
                =I'd ↑like to hear-
13              want we zien je nu hierna een paar weken niet meer,
                because after this we won't see you anymore for a few weeks,
```

In checking whether the past discussion has provided enough input for the teller to deal with the issue under discussion, the teacher orients to the responsibility she shares with the group to provide what the teller is asking for (see the 'provider function' in the discussion phase). Directing the check for (enough) value to the teller, the teacher shows an orientation to the teller as having the prime right to assess the value of the discussion in light of the focus for discussion. Any lack of value could prompt further discussion, but here the teller readily claims (line 8) and demonstrates (line 9) the adequacy of the discussion so far.

Further evidence of the primacy of the teller in establishing the discussion's value comes from the situation in Extract 19, where the teacher revises her concluding action to redirect its focus from group to teller. The teacher starts to propose a closing for the discussion directed at the group ("guys", line 3), but reformulates her proposal into a check of value with the teller (line 4).

Extract 19: teacher proposes closing and reformulates to check value for teller from session recording G80524DA

```
1       T       zo komen we weer terug bij het begin.
                that takes us back to the beginning again.
2       R2      hahaha
3       T       ↑jongens zullen we het eh-=
                ↑guys shall we eh-=
4               =kan je hierbij verder eh ((naam verteller))?
                =can you work with this eh ((name teller))?
5       R1      ja ik heb wel wat dingen opgestoken hier.
                yes I've learned a few things here.
6               vooral van het technische aspect ook,
                mainly about the technical aspect also,
7               van eh moeilijkheden (met de doseringen              ) had ik
                like eh problems (with the dosages                  ) which I
8               nog niet heel scherp,
                didn't have very clear for myself,
9               en eh ja >misschien toch ook< verder nog inhaken op eh
                and eh yes >maybe also< pursue more of a discussion of eh
```

```
10              wat ze nu moeilijk vinden aan euthanasie.=
                what they think is actually so hard about euthanasia.=
11              =blijkbaar is (            )    staat ze d'r wel open voor,
                =apparently she (           ) she is open to it,
12              maar er is toch iets wat haar nog echt ↑tegenhoudt denk ik ook.
                but there is still something that truly holds her ↑back I
                think too.
13      R3      nou ja d- dat.=
                well yes th- that.=
14              =maar ook over wat er he?
                =but also about what eh?
15              hoe is dat dan nu om om zo op zestigjarige leeftijd toch dat
                how is it then now to to at the age of sixty that
16              het dan toch dat het je nog inhaalt,
                still then that it still overtakes you,
```

The reformulation in lines 3-4 signals that establishing the value of discussion is necessary before conclusion is initiated. Also, it constructs the teller as having the first right to validate the discussion in terms of personal value. Here, the teller outlines that value without detailing it beyond suggesting she "pursue more of a discussion of what they think is actually so hard about euthanasia." This uptake formulation is not taken up by the teacher but acknowledged by a fellow resident as a relevant point (line 13). After a short addition to that point (line 14 and further), the teacher reproposes to close the interaction on this topic.

More than being valuable to the teller alone, there may also be 'bycatch': incidental value for other residents. A practice associated with establishing this additional value is apparent in Extract 20. Here, the teacher initiates the concluding phase with an invitation to *everyone* to formulate the uptake of that discussion. That particular discussion began with the specific situation of one teller, who told his experience as an update. During the discussion, several themes were identified and picked up on. The teller had not specified a need or issue for discussion, leaving the construction of value open to collective interpretation. That may explain the open invitation to explicate the value in lines 1-3:

Extract 20: elicitation and explication of collective value from session recording G80524DA

```
1       T       wat conclu↑deren we.
                what do we con↑clude.
2               (.)
3               hebben we iets [(    )
                do we have something [(      )
4       R2                     [dat het [moeilijk is (om dokter te zijn) hehe
                                      [that it [is difficult (to be a doctor) hehe
5       R3                              [dat het best lastig is.
                                              [that it is rather difficult.
6               hahaha
7       R3      conclusie van <alles:.>
```

		conclusion for <everthing:.>
8	R4	onder de streep komt ((naam R2)) daar altijd op uit of niet?
		that's what ((name R2)) always comes to the bottom line isn't it?
9	R2	jahahaha
10	R3	je (wil) nog steeds een voor en nadelen lijstje maken.
		you still (want) to make a little list of pros and cons.
11		hahaha
12	R2	negatief.
		negative.
13		((several people laugh softly)
14	T	nee maar neemt iemand hier nog een ander ge↑zichtspunt mee?=
		no but does someone here take a different ↑view of it?=
15		( ) of zegt iemand Qik heb toch nog iets gehoord waarvan ik
		( ) or does someone say QI've heard something that makes me
16		denk van eh ((knipt vingers))Q
		think like eh ((snaps fingers))Q
17		(5.3)
18	R1	(nou) dat je wel altijd heel be↑wust moet zijn van wat je
		(well) that you always do need to be careful about what you
19		zegt eigenlijk dan.
		actually say then.
20	R3	ja.
		yes.
21	R1	als mensen je zoiets ↑vragen.
		when people ↑ask you something like that.
22		(.)
23	R2	ja.
		yes.
24	R1	da- dat je een dubbele rol hebt.
		tha- that you have dual role.
25	T	°ja dat is (meer) zo.°
		°yes that's (more) like it.°
26	R1	ja.
		yes.
27	T	(ja jij hebt ook zo'n casus).
		(yes you also have a case like that).
28		↑eigenlijk in al die situaties die dubbele rol die eh
		↑actually that dual role comes back in all these situations
29		terugkomt he?
		doesn't it?
30	R1	ja.
		yes.
31		(.)
32	T	(en hoe verschillend je d'r mee omgaat).
		(and how differently people deal with it).
33		(.)
34	R5	nee wat jij nog zei dat eh dat viel mij ook wel op- toen-
		no what you also said that eh that I also noted- when-

35 wij waren- toen was mijn zoontje opgenomen;
we were- when my little boy was hospitalized;
36 ((continues about situation))

The teacher invites explications of value using the inclusive 'we', opening up the floor for everyone present to formulate their perceived value. The invitation is accepted in overlap by two residents other than the initial teller with a general conclusion that is interpreted as individually relevant, especially for R2 (lines 4-13). The teacher treats her value formulation as semi-serious by the contrastive "no but" (line 14) with which she invites further responses. Here the teller is the first to provide a heuristic based on the past discussion (lines 18-24). Despite the general focus on the group in this value check, this teller action could be interpreted as another indication of the primacy of the teller in this phase. Two other residents and the teacher corroborate the teller's heuristic, and some more interaction involving several other residents jointly constructing potential take-aways from this discussion follows (line 34 and further).

In sum, then, in the conclusion phase participants orient to the norm of creating educational value for all by establishing the value of the past discussion. Teachers commonly initiate this collaborative process in a checking format (has the discussion been valuable enough) or invitation to explicate the value (what did you gain from it). Tellers are granted and take prime responsibility in establishing value, visible in their first response positions. Sometimes, value is not only jointly constructed throughout the phases, but also jointly 'owned' as a collective value beyond the individual teller in this last phase of the experience discussion cycle.

Discussion

This integration of norms and assessments from interview analyses and practices from interaction analyses has yielded a rich description of practices that constitute Learning from Experiences. This description can be read as a "consultable record" (Geertz, 1973) for teachers seeking ways to co-construct educational value for all residents in the group. Summarizing the description, we conclude that Learning from Experiences is seen and constructed as a *joint construction of educational value*. Participants orient to the importance of establishing and retaining a focus for discussion in practices that constitute a collaborative achievement of educational value for, primarily, the teller, and secondarily, others in the group. In the following, we unpack each element of this general typification by summarizing the findings and relating those to prior chapters and related research.

First, Learning from Experiences is a *joint* construction of educational value. That is, the responsibilities for the construction of that value are distributed (cf. Hmelo-Silver, 2003) over the participants in all their different roles. In the telling phase, the primary speaker is responsible (norm) and held accountable (practice) for presenting a clearly focused version of a problem for discussion. That is commonly done by fronting a proposed focus for discussion in the telling

and repeating that at its end. The teacher's role here is minimal and secondary. As we have seen in Chapter 6, teachers ideally step in only to invite formulation of the focus for discussion (practice) when the telling is incomplete, not clear or focused. In this phase, fellow residents position themselves in the listener role and enter the conversational floor usually only after the telling is markedly ended by the teller or teacher. Their role becomes more prominent in the exploration phase, where the collaborative task is to define or refine the issue for the discussion phase next. Participants orient to the norm of a clear focus for discussion (norm) by pursuing provisional formulations of potential foci and proposing candidate foci for validation by the teller (practice). They do this even more so in the discussion phase when their contributions of new perspectives and relevant input are valued (norm) for working toward educational value. Here again, the teacher is seen as primarily responsible for the process (norm), but only secondarily involved in terms of ensuring what has collaboratively been established as the 'right' course for discussion (practice). By transforming a specific situation as an instance of a type of recurrent situation (see the teacher's actions described in Chapter 7), the group and teacher collaboratively establish a common theme for discussion (practice; see Chapter 4) that makes the experience shareable and respondable (norm). The value resulting from that process is explicitly established and oriented to in the conclusion phase. This explication is crucial (norm) to the process. Mostly the teacher invites the teller to formulate their individual gains from this discussion (practice), or to indicate the adequacy of the prior discussion (practice) as a substitute for establishing value in the form of claiming *that* the discussion has been valuable *enough*. In sum, the *joint* nature of this process – normatively oriented to in interviews and observably enacted in the recordings – entails a final responsibility for the teacher(s), prime responsibility for the teller, and a key role for the group (see Chapter 5 for an elaboration). That is, all participants are indispensable in the process.

The social nature of group reflective interaction has been reported as more valuable than its individual counterpart (e.g. Hetzner, Heid, & Gruber, 2012). The crux of its social nature is not just in the fact that a *group* of people work on a shared task. The crux lies in the *jointness* of people working on a shared endeavor. Zemel and Koschmann (2014), observing operating interaction between medical specialists, attendings, and students, state that finding something of value for learning (a learnable) is an interactional accomplishment by all present. That shared accomplishment drives the subsequent creation of educational value. Shared responsibility for creating value fits a sociocultural perspective on learning (e.g., Vygotsky, 1978; Wells, 1999), where learning is seen as a social phenomenon (Cubero & Ignacio, 2011; Mercer, 2004). In this view, the creation of meaning, the sense making process, is a negotiatory process *between* people (Cubero & Ignacio, 2011). That brings us to our next point.

Second, Learning from Experiences is a joint *construction* of educational value. Peräkylä and Bergmann (2020) describe how in the psychoanalytic context people collaboratively create meanings for objects or events in dreams. Likewise, in this study, we have described how residents and teachers collaboratively construct meanings of experiences relevant to their

professional life. As jointly constructed understandings (Mercer, 2004), meanings "emerge from the interactions of participants in the contexts where they develop" (Cubero & Ignacio, 2011, p. 240). The consensus that is negotiated throughout the process could be seen as an intersubjective "creation of a shared social reality" (Cubero & Ignacio, 2011, p. 242) for which all participants are responsible. Talk plays a key role in this creation. Through talk, participants explicate objects for discussion (Hmelo-Silver, 2003). In our study, we have seen how the interactional format of telling an experience is particularly instrumental to this end (something we discussed briefly in Chapter 5, too). In fact, the telling of experiences appears to be the key mechanism that creates educational value.

Thirdly, Learning from Experiences is a joint construction *of educational value*. The telling of an experience functions to create collective educational value from a specific, personal experience. The *experience* itself catalyzes meaningful discussion, as it situates the discussion in actual practice. That creates a sense of urgency, relevance, and relatability for others in this professional context, which in turn impacts the potential value created from it. In other educational contexts, the *telling* of the experience has been related to educational value (or, 'learning') as well (e.g., Biesta, Fiel, Hodkinson, Macleod, & Goodson, 2011; cf. Hakanurmi, 2017). First, the telling is a positioning device (Bamberg, 2003; Day & Kjaerbeck, 2013; Depperman, 2013), in that tellers of the experience position themselves in relation to the experience, to themselves, to the profession, and others; really, to the entirety of the part of the social world that is relevant in this particular educational context (Kjaerbeck & Asmuß, 2005). Such positioning work makes experience telling part of identity formation processes (Bamberg, 2011; Biesta et al., 2011; Hakanurmi, 2017), which are part and parcel of becoming a GP. Indeed, the interactional context creates opportunities for socialization into the profession, but also to "come into presence" and position oneself as a unique professional within that community (Biesta, 2010; see also Chapter 2). Second, the telling of an experience also brings to the open 'material' for others to position themselves to, to respond to, and to 'work' with (Veen & de la Croix, 2016). That is, the telling is an interactional resource (Karlsson, 2013) that fuels the joint process of constructing educational value. Third, the telling of an experience also "makes upcoming future events the focus for narrative interaction" (Karlsson, 2013, p. 136). As such, it is future-oriented at least to some extent (Hakanurmi, 2017). That quality makes it valuable for education aimed at developing established membership in the professional community of GPs (Lave & Wenger, 1991).

Our typification of educational Learning from Experiences is conditional on the affordances of the methodological approach we have taken in this study (see also Chapter 9). The interview analyses gave global orientations per phase, which say nothing about the actions participants do to accomplish those norms. The interviews also yielded assessments of specific actions in relation to that norm, for example, to focus the telling or to open the discussion. These constitute a discourse of value situated in authentic practice, but how exactly these actions are enacted and with what effect is analyzable only in transcripts of actual practices in the recorded sessions. What conversation analysis of the accompanying bits of interaction offers, then, are descriptions

of the very conduct that is treated as helpful (or not) in accomplishing the global norms to which participants orient. These descriptions form a mixed sample card of practices used to jointly construct educational value. Identifying those practices granted the possibility to identify similar practices in other situations, under the assumption that these practices are different instances of the same phenomenon. In sum, then, the specific assessments of those practices in the video-stimulated interviews form the *interface* between norms and practices. The assessments allowed us to integrate interactional phenomena into a higher-level description of the joint construction of educational value.

Theoretically, this challenging enterprise has created novel, detailed understandings of how groups collaboratively construct meaningful educational interaction. Mainly, we have gained insight into the potential of *experiences* in serving individual educational interests while avoiding jeopardizing collective value (Logren et al., 2019). This "double reference" (Vanderstraeten & Biesta, 2006, p. 168) to individual and group constitutes the challenge for teachers in this setting.

Our description of the educational activity offers several suggestions for teachers. Here, however, we also face a potential limitation of the study: the impossibility to formulate tips with guaranteed success for future practice based on the current interactional analysis of two sessions and accompanying interviews. The problem here is in the type of conclusions that the analyses afford (Ford, 2012; Pomerantz, 2012; Waring, Creider, Tarpey, & Black, 2012; see Chapter 9). This type of analysis in a complex, dynamic context does not allow for tips about 'what works' (Biesta, 2007). Still, we can draw a few fairly general hints from the current analytic activity. First, if the educational value derived from Learning from Experiences is highly dependent on the *process* of creating shared meaning from individual experiences, then the success or failure of sessions should not be located in what are sometimes called the "reflective skills" of the residents or the didactic skills of the teacher (Mercer, 2004). A perceived lack of educational value may better be remedied by attending to the way an experience is shared (the telling: what can be gained in completeness, sufficiency, and clarity?), how the group (teacher and residents) collaboratively abstracts a topic for discussion from the individual experience (is the issue valuable for the teller *and* the group in some way?) and whether the focus on the collaboratively established issue is retained throughout discussion. In general, a focused telling, exploration, and discussion contribute to valuable discussion. Second, it is important for teachers and residents alike that value is also contained in the telling itself (Hakanurmi, 2017). Rather than seeing it only as instrumental for the subsequent discussion, telling serves an educational purpose on its own, too. Teachers could actively orient to that value by at the very least ensuring enough room for tellings and second tellings. To put it bluntly (and with the nuance that efficiency of interaction counterbalances this advice): to cut a telling short may be to hinder a sense making process that is utterly valuable to the teller's and listeners' formation as professional members of the GP community. And third a final tip for teachers: observe each others' practices – that may give strategies to experiment with in the next Learning from Experience session.

Bearing in mind the limitations and potentials of the current study, a few open ends remain for future investigation. First, given the established importance of experience tellings, how are these tellings constructed exactly? What is their structural organization and how does it relate to the abstraction of a general theme for subsequent discussion? Also, in relation to an instance in this data set where the teller in the conclusion phase constructed the discussion as not having provided anything specific of value to her situation, can we discern patterns of interaction in case discussions that residents and/or teachers consider valuable versus case discussions that are considered of no specific value? Finally, an extended analysis of the joint construction of educational value could focus more on the multimodal features of the process. These appear key in collaborative constructions in other contexts (e.g., brainstorming, Bietti & Galiana Castello, 2013; Yasui, 2012). To the extent that we have attended to the multimodality of actions in our analysis, they could play an interesting role in the current educational setting, too. Coming to grips with these additional aspects of the interaction during Learning from Experiences could advance current teacher training (based on showing and discussing actual educational situation) about the challenge of co-constructing educational value for the formation of GPs in training—a challenging task that welcomes whatever advice systematic scrutiny supplies.

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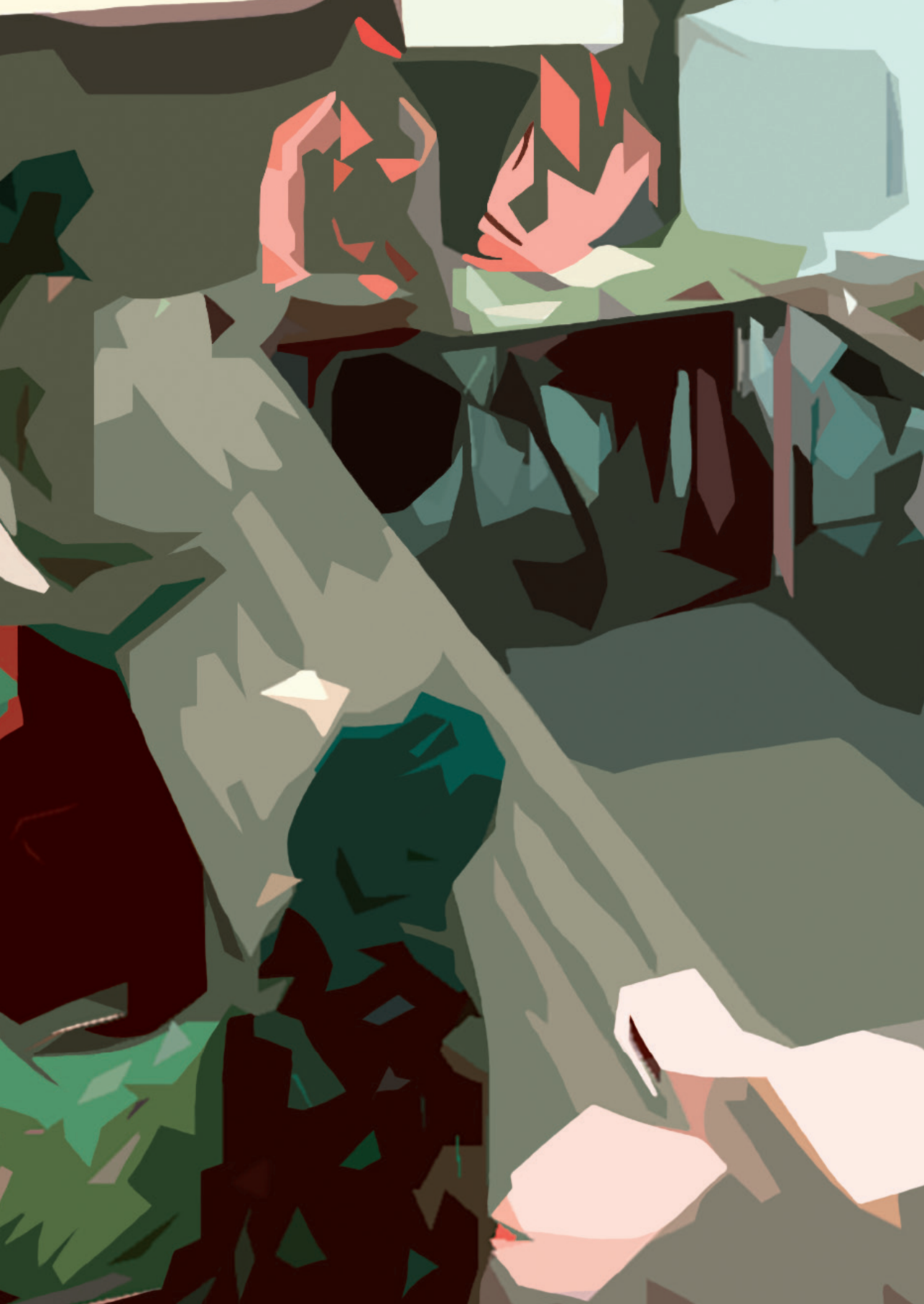

CHAPTER 11

GENERAL DISCUSSION

If the Introduction of this thesis concluded that the focus of this thesis is "how do teachers co-construct educational value during Learning from Experiences?", you could expect this Discussion to center on the answers to that question. Well, there is no definitive, omni-applicable answer. What I have given so far is an abundance of answers in the form of diverse practices and overarching orientations whose applicability is contingent on the unique educational situation. To echo the practical promise of this thesis, in the following I will first summarize the main conclusions from this research and contextualize them in the medical educational and interaction analytic field, next discuss what these tell us about the key ingredients that power Learning from Experiences, and formulate how these ingredients point to non-recipe-like tips for teachers. Finally, I *reflect* (more on the unfortunate choice of this term below) on the research project and discuss avenues open to further investigation.

Building on the work reported in this thesis, then, what do we now know about the way teachers co-construct educational value during the activity of Learning from Experiences? First,

The *educational activity* is diverse in terms of the aims it achieves and the ways participants achieve these. This diversity constitutes the power of Learning from Experiences.

That Learning from Experiences is a diverse activity in terms of structural organization, topical agenda, and participation of teachers and residents is not new information (Veen & de la Croix, 2016). From the research in this dissertation, we now know that this diversity may be an artifact of the plethora of aims these sessions *can* and *are expected* to serve, and the variety of ways to achieve those aims (**Chapter 4**). Two main developmental aims derived from institutional documents and teacher comments on their teaching show the layeredness of the activity. For one, Learning from Experiences is an activity that creates room to 'learn by reflecting'. On top of that, participation in this activity also contributes to 'learning to reflect'.

This variety of aims can be related to three domains of purpose relevant to professional education (**Chapter 2**): professional qualification, socialization, and subjectification. Aims related to technical, medical, 'hard' knowledge or skills address *professional qualification*. Aims related to getting acquainted with the norms and values of the profession, how the wheels spin, address *professional socialization*. The broader medical education literature regards socialization into the profession by way of discussing experiences from practice together with peers and role models (Hafferty, 2009; MacLeod, 2011; Monrouxe, 2010) as a process of developing a professional identity (Chandran, Iuli, Strano-Paul, & Post, 2018; Mann, 2011; Monrouxe, 2010). In addition to identity formation, however, we also need room for the *uniqueness* of the professional in training. Juxtaposing different individuals' uniqueness creates comparability and leaves space to act in a variation of ways that color the professional community as a whole. Aims related to gaining independence of what Biesta calls the social orders of the profession (Biesta, 2010) address

professional subjectification. As long as we color inside the lines, subjectification will not impede socialization or hamper qualification, but support both.

Based on our observations, I suspect that diversity is the very power that charges this type of education. With not much set in stone, teachers and residents can carve the process of their formation as they go. That leaves room for tailoring the educational activity to *this* group of residents at *this* point in time *as the activity unfolds*. While the setting frames its boundaries, the participants shape its opportunities (cf. the conversation analytic idea of action as context-*shaped* and context-*renewing;* Heritage, 1989). Calls for adaptive medical education have pointed to the benefits of this openness, as it creates possibilities to simultaneously "polish the diamonds" and "smooth the pebbles" (Harden, 2018, p. 1012; Jason, 2018). Running counter to contemporary attempts to board up curricula and construct tick-box lists of knowledge, skills, and attitudes to be 'mastered' (de la Croix & Veen, 2018), I think this thesis proves that education as a "magical mystery tour" (Harden, 2018, p. 1012), with the opportunity to adapt to the instantaneous needs of a group of unique individuals, does not fog the route from peripheral to established membership in the profession (Lave & Wenger, 1991). Rather, it opens up fabulous riches: educational value for all. What do we now know about this value co-constructed during the educational activity of Learning from Experiences?

The *educational value* lies in the meaning for future practice constructed during the discussion of collaboratively relevant types of experiences abstracted from specific experiences.

This type of value balances individual and collective interests, as I describe in **Chapter 5**. From the combined analysis of interviews and recordings reported in **Chapter 10**, I conclude that the telling and discussion – essentially, the entire cycle of Learning from Experiences – can be seen as a negotiation of collectively meaningful (recognizable, valuable for future practice) issues from individual experiences (cf. Logren et al., 2019). Individual experiences are shared in the form of stories, in which tellers construct the reality of the situation to be responded to by others. Those stories do identity work (Warmington & McColl, 2017), but they also provide opportunities to abstract from the individual experience (token) a collectively relevant category of experiences (type) for discussion. The construction of issues for discussion is a shared responsibility: introduced and first presented by the teller resident, negotiated by the group, monitored, proposed and altered by the teacher, validated by the teller and agreed upon by all – that's how shared 'learnables' (Zemel & Koschmann, 2014) are constructed. In the discussion phase, individual perspectives on the issue provide a variety of views, solutions, explorations, critics, and (I hesitate to use the term) reflections that each may be differentially valuable to the individual training situation of each participant. In that sense, *meaning* is constructed and exists in the social practices that constitute the educational activity of Learning from Experiences

(Verstraeten & Biesta, 2006; cf. the basic tenet of Conversation Analysis: reality is constructed in and through social action; Goodwin & Heritage, 1990; Sidnell, 2013).

The co-construction of educational value, I conclude from our study of resident comments on recorded Learning from Experiences sessions (**Chapter 5**), is conditional on diversity and inclusivity, safety, and efficiency in and of the interaction. In the medical education literature, diversity and inclusivity commonly refer to meso-level processes, for example selection into educational programs (e.g., Chiavaroli, Blitz, & Cleland, 2020; Jackson, 2020). In our research, diversity and inclusivity refer to micro-level issues related to participation in the educational activity. Teachers report it as one of their main tasks to facilitate participation by everyone and anyone in telling and discussing experiences (**Chapter 4**). Residents consider it important that the educational environment is safe enough for everyone to share different perspectives, participate in the discussion, and share difficulties, problems, issues, and challenges without being disapproved of in return (cf. Johnson, Keating, & Molloy, 2020 for a discussion of psychological safety in medical educational context; Sandars, 2009 on the importance of a safe learning environment for reflective activities). While everyone should be able to have their say, residents also value process efficiency: getting down to the core of the experience, its value for all, in as much or as little time needed. Efficiency, however, should not compromise safety (time can buy safety) or diversity and inclusivity (time allows for the participation of many).

Now we also know how participants achieve diversity and inclusivity, safety, and efficiency. In **Chapter 5**, I detail activities that contribute to these norms. Important here is that what is valuable for the one, may not be valuable for the other. Even for one resident, what is valuable at one point in time, may not be valuable at a different stage of their development toward established membership in the profession. This is a key observation. 'Value' does not exist in and of itself. 'Value' is always contingent on what is relevant for this group of residents at this time in this interaction. What constitutes value is constructed interactionally and collaboratively during the educational activity. That is why the interaction itself is so powerful: it is a way to formulate, explore, and address educational 'needs' that may not have been explicit or recognized before.

If value is defined and constructed as the interaction unfolds, facilitating that interaction is challenging. For one, there isn't much guidance, as research is scarce and didactical guidelines are sketchy (**Chapter 4**). Add to that the dynamic mix of highly training professional individuals who all expect to gain something from it (**Chapter 5**), and the scene is set. What do we know now about the teachers' role in co-constructing educational value during Learning from Experiences?

The teachers' role during Learning from Experiences is a constant balancing act occasioned by and situated in the contingencies of ongoing interaction.

'Doing being a teacher' (Sacks, 1995; Skovholt, 2018) during Learning from Experiences involves a constant juggling of dilemmas (**Chapters 6–8**). These can be summarized in one general consideration: whether, when, how, and to what degree to steer the interaction. Generally speaking, Benwell and Stokoe (2002) observe that it is a "robust finding of numerous educational and linguistic studies" that teachers "control classroom discourse" (p. 431). In the context of Learning from Experiences, some teachers are observably 'present' in terms of their number of interventions and high degree of steering of those. Others are prone to act 'in the second instance'. For example, acting mainly when invited (**Chapter 7**) or almost exclusively at the end of an experience discussion (**Chapter 6**) corresponds with the traditional idea of the Balint groups (Balint, 1957) in which Learning from Experiences is rooted. The leader in a Balint group "does not give a specific recommendation or advice like in a supervision group. He or she encourages the members to arrive at their own conclusions after exploring how they feel and think about the situation" (Rüth, 2009, p. 381). The latter type of intervention resembles the moderating role that teachers adopt throughout the telling and discussion (**Chapter 6**), which is the least steering type of intervention. More directive expert and evaluator interventions tend to be done more toward the end of experience discussions, signaling how refraining from intervention – except in case of unhelpful derailment from the main focus, obvious untruths, or recognizably unproductive group dynamics – seems to be the preferred option. When teachers do intervene, their intervention is always *occasioned by* and thus *situated in* the contingencies of the local interaction. Teacher actions are shaped by the prior turns (i.e., context-shaped; Heritage, 1989). That is, what the teacher does can never been seen in isolation from what the others have done just before the teacher's turn. In that sense, 'doing being a teacher' is a collaborative enterprise. That is not to say that 'good' teaching (if I may) is the shared responsibility of teachers and residents. It is just to say that teacher actions are never context-free and are therefore never trainable in isolation.

With the risk of stating the obvious, the second conclusion from these interactional studies is that teachers' actions are consequential for both the progress (see efficiency, **Chapter 5**, and the case of "over-moderating" in Section 3.3 of **Chapter 8**) and the topical agenda (see especially **Chapter 6**) of the interaction. Not just that, but the interactional consequences of the action are again dependent on the local context. Practically, dependency on local context means that an intervention of sorts may work in situation A, but may work out completely differently in situation B. Indeed, what worked in one Learning from Experiences session, may not work in the next (Biesta, 2007) precisely because its initiation and consequentiality are contingent on the very interactional detail of the situation. As Van Kruiningen asserts in her methodological consideration of the value of Conversation Analysis for teacher training, "The situatedness of knowledge construction and problem solving, and the context-driven development of interaction

mean that it is not possible to provide a strict format for effective interaction in change processes." (2013, p. 199). How teacher training could be designed based on these empirical descriptions of teachers' contributions to the collaborative construction of educational value for all, I will discuss below. First, let me summarize the conclusions in three key ingredients that define and power Learning from Experiences.

In sum: the educational value of the activity of Learning from Experiences hinges on the power of the group, the openness of the activity itself, and storytelling as a main tool for accomplishing sharedness.

First, **the group**. Group discussion on experiences from practice is acknowledged for its benefits beyond similar individual pursuits. In a variety of professional contexts, researchers describe how working in groups allows diverse perspectives and new ideas (e.g. Burgess, Diggele, Roberts, & Mellis, 2020; Løvaas & Vråle, 2020; Smit & Tremethick, 2017; Staempfli & Fairtlough, 2019). Group discussion on experiences from practices also allows mutual identification (Humbred & Rouse, 2016), recognition (Løvaas & Vråle, 2020; Sandars, 2009) and normalization (Bennett-Levy et al., 2001). These processes contribute to positioning oneself in the ways of doing and being of the profession (Mann, 2011)—the identity work of socialization (Biesta, 2020). While acknowledged for its benefits, group discussion does require special attention to ensure a safe learning environment (Bennet-Levy et al., 2001; Sandars, 2009). Safety seems conditional for the benefits to play out.

Second, **the openness of the activity itself**. In contrast to formal reflective activities such as supervision (Løvaas & Vråle, 2020) and intervision (Staempfli & Fairtlough, 2019), Learning from Experiences sessions generally do not follow a preset structure. The absence of such structure poses challenges for teachers, as I have described above, but simultaneously creates room for creation and construction. It is a space for things to bubble up, to emerge, for people to "come into presence" (Biesta, 2010, p. 80) and to exist as a unique subject with those who are different from us. Formal structures and especially learning 'outcomes' would restrict that uniqueness and adaptivity to whatever any member of the group needs at that moment (i.e., adaptive education).

Third, **story telling**. As I have discussed in **Chapter 10**, the story is a powerful vehicle to give meaning to personal experiences. Story telling is a sense-making device (Bruner, 1991) with "an important therapeutic aspect" (Sandars, 2009, p. 691). Its structural organization in interaction allows others to be part of the sense-making, for example by asking questions, offering alternative interpretations, and (dis)affiliating (Warmington & McColle, 2017). Stories invite similar stories (Arminen, 2004), which can be understood as 'doing empathy' or 'understanding' (Logren et al., 2019; Stivers, 2008), in turn creating a shared, 'we are all in this together' vibe.

With all of this in mind, it is time to *reflect*. In the first place,

What is the value of this research project for medical education *research*?

Conceptually, this research is firmly situated in educational philosophical ideas (especially those described in the work of Biesta). Part of it is an attempt to introduce these ideas into the field of medical education research and apply them in medical education research as well (see **Chapter 2**). The three domains of purpose (qualification, socialization, and subjectification) run like a thread through the framing of the empirical studies. A close evaluation of the usefulness of these concepts is in place here, though, and a slightly more critical stance towards the conceptual framework could advance the educational-philosophical grounding of this work. As an example: in formal and informal contact with scholars in the field, I encountered ambiguous interpretations and uneasiness with the concept of subjectification. The concept triggers association with authenticity, individuality, identity, personhood, and uniqueness. But what does it really mean, and what does that meaning mean for its use in medical education? This conceptual question with practical (research and practice) consequences surely needs further exploration.

Methodologically, I have tried to show how an interactional approach to medical education, like Conversation Analysis of recorded educational sessions, results in rich and detailed descriptions of the teaching work entailed in medical education. Providing descriptions of practices that people use to accomplish educational aims is the gist of conversation analytic research in educational context (Skovholt, 2018). Such descriptions are what lends the approach its power for applied purposes (Antaki, 2011; Stokoe, 2014). At the same time, its prescriptive nature precludes any 'evidence' and 'best practices' – objects of reference that teachers commonly ask for in professionalization training. In this research project, however, the detailed analysis of authentic interactions has resulted in a wealth of training material that, to date, teachers across various GP training institutes have found valuable.

Another key feature of the research methodology reported in this thesis is the use of video-stimulated interviews with teachers and residents. I outline the exact benefits of such interviews in **Chapter 3**. Here I want to underline the opportunities these create to link member's perspectives to actual behavior (see **Chapters 9 and 10** and also Theobald, 2012, for a discussion of the benefits of this coupling in the context of children's play). Since video-stimulated interviews are formatted to elicit comments directly related to the recorded behavior, they are the perfect tool to make the connection between the two. That connection allowed us to make normative statements about valuable teacher behavior, something only Conversation Analysis of actual interactions or analysis of interviews could not provide. Of course, video-stimulated interviews should be acknowledged for what they are: post hoc constructions of an educational situation. They cannot be taken as 'the truth' about what motivated someone to do something and as such are limited in analyzing what drives teacher behavior (in case we would be interested in describing motivations for conduct).

Both the interactional analytic focus and the use of video-stimulated interviews have contributed to our pursuit of gaining understanding of what it means to teach in the educational activity of Learning from Experiences. Two issues require additional attention, though. First, we have given relatively little attention to the multimodality of the conduct in the video-recordings. Where relevant, we did take into consideration eye gaze and gestures, but a closer analysis of the multimodal features of the interactions could probably yield additional information relevant to, for example, participation issues (i.e. turn allocation practices). A complicating factor here is that in order to capture *all* participants, the camera view was quite broad – and even with that, sometimes participants moved out of screen during the recording. This hampers multimodal analysis of facial expressions. The second issue concerns the complexity of the recorded interactional context. There is so much to be seen and heard from the 41 video-recorded Learning from Experiences sessions. In no way have I captured the complexity and richness of the setting to its full extent. The descriptions of teaching that I have reported so far represent just a few little chips of what is going on when teachers teach and residents participate in the educational activity of Learning from Experiences.

Even so, using Conversation Analysis of recordings and analyzing participant comments to answer practical questions about 'good' teaching (i.e., teaching that is desirable for the purpose of education) is in my view a promising approach that could be applied to other activities in medical educational context too. In the current context, the approach could be used to further explore the range of dilemmas that teachers report facing in Learning from Experiences: whether, and if so when and how, to round up a discussion; the interactional collaboration between two teachers in one group; whether, and if so when and how, to dig for the emotional layer beneath the surface of an experience; and how participants use storytelling to construct their first presentation of the situation and problem for discussion. Each dilemma justifies a systematic interactional analysis of the actions and practices involved. Together, these analyses could further enrich our current understanding of the complexities of teaching in this context and provide new material for teacher training.

One additional note on the use of video-stimulated interviews. Here, we mainly used the interviews as a research tool. The interview, however, can also be seen as an educational intervention for teacher professionalization purposes. It could be used as a training tool that allows teachers to replay, comment on, and discuss their own didactical practice. The broadscale use of video-stimulated interviews for teacher professionalization could in itself be a topic for further applied research in this educational context: what is it potential for structural use in teacher training (cf. Fukkink, Trienekens, & Kramer, 2011)? That brings me to a *reflection* on the value of this research for educational practice:

What is the value of this research project for *teachers* of Learning from Experiences?

Although the ingredients outlined earlier invoke the semantic field of recipes, the complexity and context-dependent nature of teaching during Learning from Experiences does not allow for cookbook-like instructions for teachers in this educational activity. What I provide in the next section are probably best seen as tips with a normative flavor: good to try, better to take seriously.

The first tip is directed more at GP training institutes than at teachers themselves, although I think it is certainly relevant for them, too:

Don't call this educational activity 'reflection'.

Calling Learning from Experiences 'reflection' mispresents both this educational activity and reflection, too. The educational value of Learning from Experience does not necessarily result from what is formally considered reflection, nor is the activity of Learning from Experiences necessary for 'doing reflection'. Calling it 'reflection' is an imprecise characterization of the very activity. But why is the exact labelling of this activity crucial?

In this thesis, I have described Learning from Experiences as a very diverse, variably constructed and loosely structured educational activity. I have also suggested that this flexibility and diversity in form and function is probably what powers its value for all. In that case, referring to the activity with a term contaminated by associations with structure, steps, formats, predefined outcomes, and 'you must' instead of 'we could' (de la Croix & Veen, 2018) could be detrimental to realizing the potential of telling and discussing experiences from practice. Why bother calling it 'reflection', if all we do and all that matters for constructing educational value is telling a story about a past situation, responding to that story, and creating a meaning fit for any individual's training situation along the way? This is not to say that by not calling it reflection, the activity will change. I am suggesting that sketching in the borders instead of imposing (the idea of) structural requirements will relieve a (potential) burden. What would I call the activity instead? Probably 'the joint construction of educational value through collaborative story telling' but that descriptive mouthful could exceed the number of tokens that fit in a training schedule. For now, however, I think 'Learning from Experiences' will satisfactorily cover what is believed to be going on during this educational activity. Yet, the longer description could be functional in introducing the educational activity to first year residents: each element highlights an aspect of the activity, from its *collaborative* nature, to the process of defining and building value *in interaction*, and the role of *stories* in exploring one's profession.

My second tip is rather specific and closely related to the dilemmas involved in 'doing being a teacher' during Learning from Experiences:

When in doubt, don't intervene.

A teacher once shared this tip as his motto for teaching in Learning from Experiences. The tip (note its resemblance with the medical *in dubio abstine*) should not be taken literally, but interpreted as an illustration of a bigger issue. Based especially on the research reported in **Chapters 6, 7 and 8**, it seems that more steering interventions by teachers do not necessarily contribute to more educational value. Sure, being available and intervening when needed is the minimum a teacher can and should do in this educational context. At the same time, the construction of educational value, as I have shown in **Chapter 10**, is regarded and 'enacted' as a shared responsibility by teachers and residents. We have seen several examples where teachers participate only minimally, while the interaction progresses toward what is later oriented to as something valuable for various residents. Also, an action done by a teacher is an opportunity lost for participation by a resident.

This tip should not be understood as a plea for minimal teacher intervention, nor as undermining the teacher work in this educational context. What I am doing here is sharing the observation that no intervention does not mean no influence in the progress of the interaction toward educational value for all. For example, not intervening may in itself already do 'validation' of what is said. That is, being silent probably does as much as taking the floor, especially in interactionally crucial slots, such as the first turn after a telling.

Finally, a tip that is rather general but also as far as I can judge hugely valuable in the context of teacher training:

Observe yourself and others.

Our descriptions of teacher practices in Learning from Experiences have shown that what works depends a lot on the interactional situation at hand. That means that to learn the trade, one could best watch as many different interactional situations as possible, and observe what is done, how that turns out, and consider what else could be done. Rather than specifying *best* practices, enrich your *palette* of practices. Enrichment of that palette can be done in at least two ways (see Biesta, 2012, for an argument about teacher education in line with these suggestions).

One way is to record one's teaching and watch it (cf. Lewis, 2018). Look at it again. Replay it while watching it with a fellow teacher, or on your own. Choose a situation (a moment, a sequence of actions) that elicits your attention, no matter the reason. Formulate what you see happening. Provide an educational judgment (that is, whether what is done contributes to what is educationally desirable in terms of qualification, socialization and subjectification, Biesta, 2012; cf. the notion of tact, Lewis, 2018; van Manen, 1991). Come up with alternative courses of action and the interactional consequences you expect from them. Finally, jot down one 'thing' (an action, an intervention, a strategy, a practice) that you will experiment with in the next Learning from Experiences session.

Another way is to observe not yourself, but someone else teaching. To achieve virtuosity in 'doing being a teacher' of Learning from Experiences, teachers need to practice educational

judgment "in the widest range of educational situations possible" (Biesta, 2012, p. 19). Observing a colleague do the very thing you are supposed to do is one format that allows for such practicing. Many of the pilot workshops I have given in the past two years were structured around a teacher dilemma (e.g., 'stepping in' in **Chapter 6**, 'bringing in one's own experience' in **Chapter 7** and 'co-constructing educational value' in **Chapter 10**). In a CARM-like (conversation analytic role-play method; Stokoe, 2014) fashion, the workshops were organized in a display and discussion of several recorded examples of that dilemma. I would play a situation line by line, stopping the interaction at crucial points to discuss what the participants in the interaction were doing, what the teachers in the (digital) room would do and why, and what the interactional consequences of what was done or could have been done in that situation were. The working ingredient of this type of workshop seems to be the *sharing of alternatives between participants*, and their motivations for and experiences with using those options. This is just about what makes Learning from Experiences, the object of their training, valuable, too…

One last consideration in relation to training teachers. If 'good' teaching is as context-dependent as any educational situation is different from the next, we cannot describe teaching in rules that guarantee success (Biesta, 2009). Instead, I propose describing teaching in this context as an art that can be mastered by practice (see Dawe, 1984; Lupton, 2013). The aim of teacher training in this sense should not be to *think about* practice, but to *be in conversation with* authentic examples of that practice (Biesta, 2019). This type of training helps to develop "an educational 'feel'" (Biesta, 2019, p. 129). Such development, however, requires enough material and time to practice. Time is an *organizational* issue and I would strongly encourage institutes to schedule structural moments for opportunities to practice. As *researchers*, we can provide descriptions of past practices (fragments of recorded interaction) for teachers to be in conversation with. Indeed, I contend that describing not the *evidence base* of best practices, but the *palette* of any practices should be the focus of medical education research. If describing and enriching that palette contributes to teachers doing what they do when they do what they do, the research has served its purpose.

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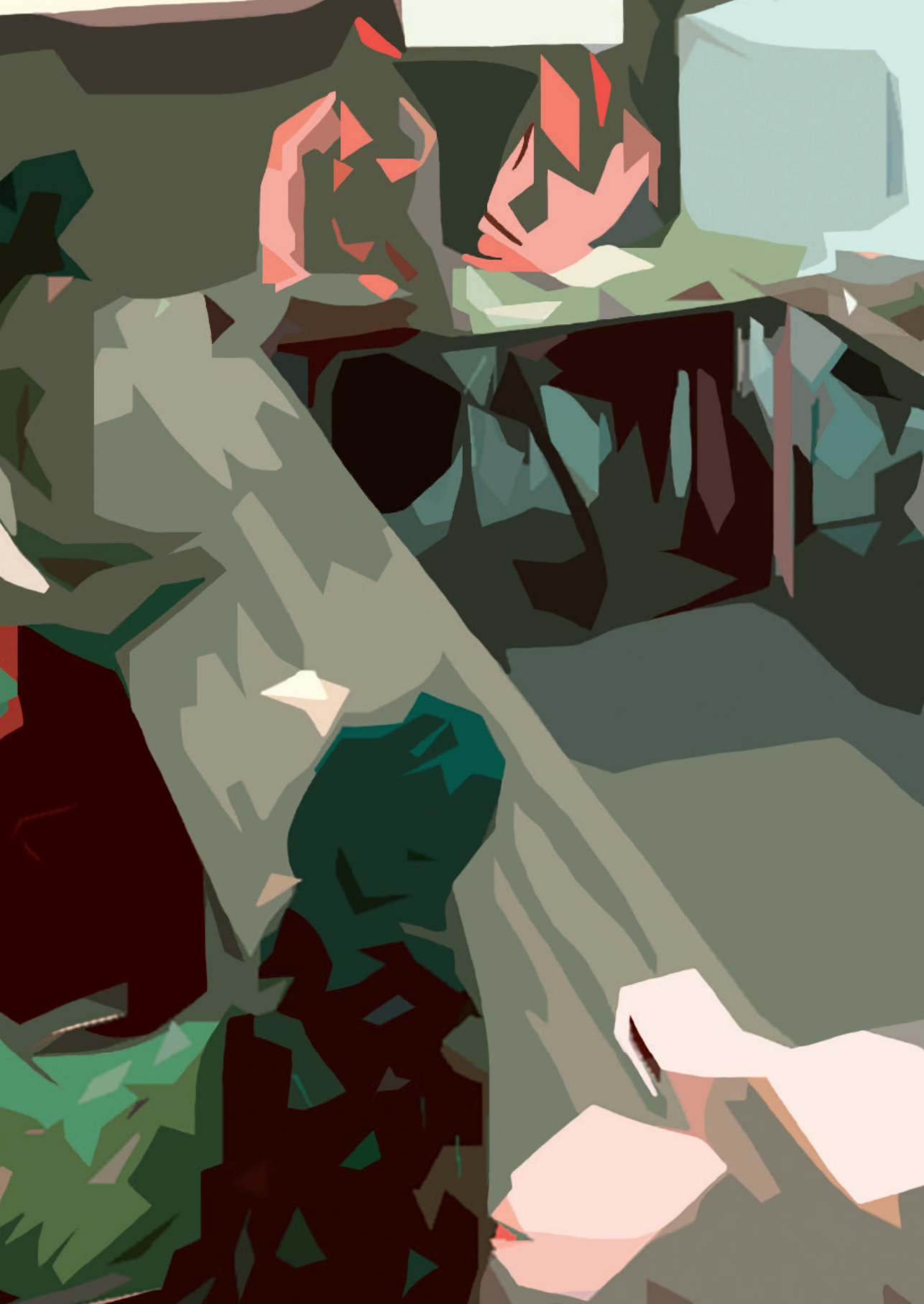

CHAPTER 12

NEDERLANDSE SAMENVATTING

PHD PORTFOLIO

LIST OF PUBLICATIONS

DANKWOORD

CURRICULUM VITAE

NEDERLANDSE SAMENVATTING

Gezamenlijke constructie van educatieve waarde: Leren van Ervaringen in de huisartsopleiding

Dit proefschrift komt voort uit een praktische vraag van docenten op de huisartsopleiding:

Hoe kunnen we als docenten de onderwijsvorm Leren van Ervaringen zo begeleiden dat het waardevol is voor huisartsen in opleiding?

In essentie gaat dit proefschrift daarmee over docentbegeleiding tijdens het Leren van Ervaringen (zie **Hoofdstuk 1**). Het Leren van Ervaringen is een specifieke **onderwijsvorm** die uniek is voor de huisartsopleiding. Dit onderwijs is meestal gepland aan het begin van de wekelijkse terugkomdag en duurt één tot anderhalf uur. Tijdens zo'n sessie bespreken huisartsen in opleiding (haios) in groepjes van gemiddeld tien haios ervaringen uit de praktijk. Dit kan bijvoorbeeld een moeilijke medische casus zijn, een persoonlijk dilemma, of een opleidinggerelateerde vraag. Meestal volgt zo'n bespreking een vast patroon. Eerst wordt geïnventariseerd wie er een ervaring in wil brengen. Daarna worden alle geagendeerde ervaringen één voor één besproken: de inbrenger vertelt de ervaring, vervolgens exploreert de groep de ervaring om de situatie en de focus voor discussie helder te krijgen, daarna bediscussieert de groep de ervaring, en als laatste wordt de conclusie of het geleerde van deze ervaringsbespreking geformuleerd. Dit soort besprekingen worden begeleid door één of twee docenten (vaak een ervaren huisarts en een gedragswetenschapper). De hoofdstukken in dit proefschrift beschrijven steeds een onderdeel van de manieren waarop deze docenten het Leren van Ervaringen begeleiden. Daarmee levert het proefschrift een bijdrage aan de beantwoording van de praktische vraag van deze docenten, in de vorm van suggesties en materiaal voor docenttraining. Tegelijkertijd dragen deze beschrijvingen van het handelen van docenten bij aan theorievorming over onderwijzen in medisch vervolgonderwijs.

Het onderzoek in dit proefschrift is gebaseerd op drie soorten bronnen:

1. alle relevante schriftelijke documenten over het Leren van Ervaringen die in de acht huisartsopleidingen in Nederland gebruikt worden als informatiebron voor docenten en haios. Hierin staan bijvoorbeeld instructies voor docenten, en informatie over de manier waarop een Leren van Ervaringen sessie zou moeten verlopen volgens het huisartseninstituut.
2. video-opnames van 41 Leren van Ervaringen sessies verspreid over de acht huisartsopleidingen in Nederland. Deze opnames laten allerlei manieren zien waarop docenten het Leren van Ervaringen begeleiden – altijd in interactie met de aanwezige haios.

3. voor elke opname een aantal video-gestimuleerde interviews met één of twee haios (totaal: 31 interviews) en één of twee docenten (totaal: 37 interviews). Deze haios en docenten werden individueel geïnterviewd door ze stukjes uit de opgenomen video (waar ze dus zelf aanwezig waren geweest) te laten zien en te vragen om daarop te reageren. Deze interviews geven inzicht in de ervaringen en percepties van docenten en haios over het Leren van Ervaringen.

Deze drie bronnen vormen de basis van de analyses in de Hoofdstukken 4-8 en 10. Die analyses samen geven een beeld van wat het betekent om als docent het Leren van Ervaringen te begeleiden.

In **Hoofdstuk 2** geef ik eerst een conceptuele beschrijving van *leren* en *onderwijzen* in medisch onderwijs. Leren en lesgeven worden vaak gezien als twee kanten van dezelfde medaille: als een docent lesgeeft, leert degene die deelneemt aan het onderwijs. Het verband tussen leren en lesgeven is echter niet causaal: onderwijs is zo dynamisch, complex, en open (in de zin dat er zoveel factoren zijn die een rol spelen in het proces) dat onderwijs geven niet de garantie kan bieden voor leren. Dit betekent dat *evidence based* onderwijs in de praktijk een illusie is: wat in de ene situatie met die groep haios en die docenten op dat tijdstip van de dag werkte, kan zo maar *niet* werken bij een andere groep op een ander moment in de sessie met andere docenten.

De term *leren* op zich is ook geen erg precieze term als we willen beschrijven wat er *gebeurt* als docenten onderwijs geven en – in dit geval – haios deelnemen aan het onderwijs. Dat kan preciezer als we onderwijs beschrijven in termen van drie doeldomeinen, die aangeven *waartoe* iemand leert: kwalificatie (een vak technisch beheersen, de juiste vaardigheden te hebben), socialisatie (onderdeel worden van de beroepsgroep, weten 'hoe de hazen lopen'), en subjectificatie (leren om te handelen als zelfstandige, eigen professionals). Tijdens het Leren van Ervaringen komen alle drie de doeldomeinen in meer of mindere mate aan bod.

Hoofdstuk 3 is een methodologisch hoofdstuk, waarin de interviewmethode (bron 3) centraal staat. Vaak worden video-gestimuleerde interviews gebruikt om deelnemers zich iets te laten *herinneren* over momenten die in de video te zien zijn. In dit onderzoek gebruikte ik het op een andere manier: als *post hoc reflecties* op wat er in de video te zien is. Dit hoofdstuk is een bespreking van de voor- en nadelen van de twee benaderingen (*herinneren* versus *reflecteren*). De conclusie is dat de reflectieve benadering nuttig kan zijn voor gebruik in onderzoek naar medisch onderwijs. Ik geef daarvoor een aantal praktische suggesties: erken de *onmogelijkheid om als interviewer neutraal* te zijn, je neemt altijd je eigen kennis en mening mee; gebruik geschikte cues om de geïnterviewde 'te laten praten' en *start met minimale cues* (bijv. het stilzetten van de opname zonder daar al direct een vraag bij te stellen); zie het interview als een *mogelijkheid voor gezamenlijke betekenisconstructie* (je vormt samen een idee over de onderwerpen die je bespreekt tijdens zo'n interview).

Met deze conceptuele en methodologische uitgangspunten begint nu het analytische deel van het proefschrift. **Hoofdstuk 4** begint met de vraag: wat zijn de doelen en strategieën van docenten bij het begeleiden van het Leren van Ervaringen? Een antwoord hierop is te vinden in de instituutsdocumenten (bron 1) en de docentinterviews (bron 2). Deze analyseerden we met Template Analyse, een vorm van inhoudsanalyse waarbij vooraf opgestelde (in dit geval: doel, strategie) en tijdens de analyse ontwikkelde (subdoelen en substrategieën) codes worden gebruikt om stukjes van de documenten en interviews te categoriseren, daarna te beschrijven, en uiteindelijk samen te vatten in een coherente duiding van de inhoud van de documenten en interviews.

Uit deze analyse blijkt dat instituten en docenten een enorm breed palet aan doelen voor zich zien die ze met het Leren van Ervaringen kunnen en/of willen bereiken. Dit zijn enerzijds leerdoelen voor haios (bijv. 'leren reflecteren'), anderzijds onderwijsdoelen voor docenten (bijv. 'participatie faciliteren'). Voor elk doel is weer een variatie aan strategieën te gebruiken (bijv. voor het doel 'participatie faciliteren': 'wijs een haio-voorzitter aan', 'geef stille haios een beurt'). Docenten zagen het leren en ontwikkelen van haios (heel algemeen dus) als belangrijkste overkoepelende doel. Hun eigen bijdrage daaraan zagen ze vooral in het faciliteren van participatie in reflectie, bijvoorbeeld door te zorgen dat iedereen meedoet, het creëren van een veilig leerklimaat, en het waarborgen van de noodzakelijke voorwaarden voor leren. Deze beschrijving van doelen en strategieën laat dus zien hoe divers de onderwijsvorm en de begeleiding daarvan kan zijn. Die diversiteit is misschien wel wat het begeleiden van Leren van Ervaringen zo moeilijk maakt. De beschrijving van doelen en strategieën in dit hoofdstuk biedt zowel ervaren als beginnende docenten tools om uit te proberen tijdens het begeleiden van Leren van Ervaringen.

Naast het docentperspectief, is het van belang om te weten wat de andere deelnemers in Leren van Ervaringen vinden: wat waarderen haios (niet) in het Leren van Ervaringen? Dat analyseerden we in een Template Analyse van de interviews met haios (bron 3). In **Hoofdstuk 5** staat beschreven dat uit al die honderden evaluaties blijkt dat er wat variatie bestaat in wat haios waardevol vinden aan Leren van Ervaringen. Tegelijkertijd is er wel globale overeenstemming over een aantal gedeelde normen.

Haios geven aan dat Leren van Ervaringen waardevol is als er *educatieve waarde wordt gecreëerd voor iedereen*. Dit betekent dat *inclusiviteit en diversiteit*, *veiligheid*, en *efficiëntie* in de interactie belangrijk zijn. Deze normen zie je terug in de verschillende fasen van een ervaringsbespreking (vertelling, exploratie, discussie, conclusie). Haios vinden het bijvoorbeeld belangrijk dat er in de vertellingfase ruimte is voor ervaringen die bediscussieerbaar zijn door hun herkenbaarheid. In de exploratiefase moet vastgesteld worden wat de focus voor discussie wordt, maar moet ook ruimte zijn om te verkennen hoe 'zwaar' een ervaring voor iemand is voordat de discussie echt start. In de discussiefase moeten verschillende perspectieven worden ingebracht en mogelijke oplossingen worden aangedragen. In de concluderende fase is het belangrijk dat de opbrengst van de bespreking wordt geformuleerd. Deze ideeën van haios geven een indicatie

welke activiteiten docenten kunnen faciliteren om bij te dragen aan door haios als waardevol ervaren Leren van Ervaringen sessies.

Dat iets waardevol wordt *gevonden* door haios of docenten, wil echter nog niet zeggen dat het ook daadwerkelijk waardevol *is.* Het zegt ook niets over wat docenten daadwerkelijk doen tijdens Leren van Ervaringen en of dat bijdraagt aan wat als waardevol wordt gezien. Hoe docenten het Leren van Ervaringen daadwerkelijk begeleiden is het onderwerp van de drie volgende studies. **Hoofdstuk 6** vertrekt vanuit het dilemma 'wel of niet interveniëren?' dat verschillende docenten in de interviews formuleerden. Zij gaven aan soms te twijfelen of ze nu *wel* of *niet* zouden ingrijpen in een discussie, en zo ja, *hoe* dan. Dit hoofdstuk bevat een Conversatieanalyse van de timing, functie, manier en het interactionele effect van alle eerste keren dat een docent in een lopende ervaringsbespreking 'instapt' in de opgenomen sessies (bron 2). Conversatieanalyse heeft als doel om de methodes te beschrijven die mensen in interactie gebruiken om bepaalde acties te doen (zoals complimenteren, beschuldigen).

Eerste interventies komen het vaakst voor in de exploratie- en discussiefase van de besprekingen. Als docenten instappen, laten ze daarmee vaak zien dat een docentactie 'noodzakelijk' is. Ze oriënteren zich daarmee op iets dat 'mis' is in de manier waarop de interactie verloopt, bijvoorbeeld: niet iedereen doet mee in de discussie, of de discussie mist focus. De interventies hangen dus sterk samen met wat er daarvoor gebeurt. De interventies zelf hebben vaak een modererende functie (sturen het interactionele proces), soms een expertfunctie (input vanuit ervaring), en soms een beoordelende functie (evaluatie van medisch handelen). De manier waarop haios reageren op deze interventies laat zien dat de interventies niet puur handelingen zijn die door de docent gedaan worden: het is een gezamenlijk product van haios en docenten in interactie. De drie typen acties die docenten daarbij kunnen 'uitvoeren' (modereren, expertise inzetten, en beoordelen) kunnen docenten in toekomstige situaties helpen om af te wegen welk type interventie op dat specifieke moment nuttig zou kunnen zijn – en in welke vorm.

Een ander aspect van het begeleiden van Leren van Ervaringen waar docenten in de interviews aangaven tegenaan te lopen is de manier waarop je als docent je expertise in zet. Hoe kun je je ervaring als huisarts of gedragswetenschapper gebruiken om het Leren van Ervaringen waardevol te maken voor haios als beginnende professionals? **Hoofdstuk 7** beschrijft een Conversatieanalyse van de timing, de handeling, de vorm, en de interactionele consequenties van alle momenten waarop docenten iets van hun ervaring lieten zien (bron 2).

Er zijn drie contexten waarin docenten in de opnames zichzelf als expert 'neerzetten': wanneer haios daar expliciet om vragen ("Hoe ga jij als ervaren huisarts om met…?"), wanneer de voorgaande interactie expertise relevant maakt (bijvoorbeeld als een haio zegt dat hij of zij iets niet weet en de groep dat ook niet blijkt te weten) en zonder duidelijke aanwijzing op eigen initiatief van de docent. De functie van de ingebrachte ervaring (bijv. corrigeren, adviseren) is verschillend voor elk van die contexten. Ongeacht de functie dragen deze demonstraties van expertise op drie

verschillende manieren bij aan de socialisatie van haios binnen het huisartsenvak: door zichzelf te positioneren of gepositioneerd te worden als ervaren lid van de professie, kunnen docenten (1) toegang geven tot de cultuur, tradities en praktijken van de professionele gemeenschap, (2) mogelijkheden creëren om de spanning aan te kaarten die soms ontstaat tussen formele richtlijnen en de complexiteit van de praktijk, en (3) bijdragen aan 'professionele' manieren van kijken naar en begrijpen van beroepssituaties. De precieze beschrijving van de manier waarop docenten expertise inzetten geeft inzicht in de interactionele manieren die men in onderwijscontext kan gebruiken om expertschap te 'doen'. Daarnaast geeft zo'n beschrijving docenten tips voor het inzetten van hun ervaring tijdens het Leren van Ervaringen.

Het derde aspect van begeleiding van Leren van Ervaringen beschreven in dit proefschrift is de manier waarop docenten omgaan met participatie in online Leren van Ervaringen sessies. Tijdens de COVID-pandemie waren Leren van Ervaringen sessies via Zoom – en dat werd als moeilijk ervaren door zowel haios als docenten. Een van de dingen die zij daar moeilijk aan vonden was *participatie* in die online omgeving (zie **Hoofdstuk 4** voor het belang daarvan): Hoe kom je ertussen? Hoe komt iedereen aan bod? Hoe krijg je de omgeving veilig genoeg om ook daar kwetsbare dingen te bespreken? **Hoofdstuk 8** is een rapportage van een Conversatieanalyse van drie Zoomopnames. De focus van die analyse is de manier waarop haios en docenten deelnemen aan zo'n online Leren van Ervaringen sessie.

Hoe haios en docenten deelnemen in de gesprekken wordt gevormd door en is afhankelijk van het online platform (bijvoorbeeld de mogelijkheid om zonder in overlap te hoeven spreken mee te doen in de vorm van een chatberichtje). Deelnemers komen in deze omgeving met nieuwe manieren om deel te nemen aan het Leren van Ervaringen – weliswaar binnen de kaders van hoe zo'n sessie normaal gesproken globaal gezien verloopt. Dit heeft gevolgen voor de manier waarop docenten de sessies begeleiden. Deze analyse laat dus zien dat gesprekken tijdens het Leren van Ervaringen *situationeel* zijn (ze worden – letterlijk – gevormd door de omgeving) en dat deelnemers creatief gebruik maken de mogelijkheden om binnen dit online platform het doel van het Leren van Ervaringen te bereiken.

De laatste twee hoofdstukken van dit proefschrift vormen het slotstuk. **Hoofdstuk 9** is een methodologische beschouwing van het nut van de combinatie van Conversatieanalyse van opgenomen interactie en inhoudsanalyse van interviews over die interactie. In deze combinatie leveren de interviews bijvoorbeeld interactie-externe normen over die interactie op, terwijl de opnames laten zien hoe mensen in de interactie zich oriënteren op die normen en hoe zij met hun handelen vorm geven aan die normen. De combinatie van beide analyses levert een link op tussen daadwerkelijk handelen en uitspraken over dat handelen in het licht van bijvoorbeeld interactionele doelen van de activiteit. Dat kan nuttig zijn, maar tegelijk praktisch gezien complex. Het tweede deel van dit hoofdstuk behandelt daarom vier praktische afwegingen in relatie tot mogelijke onderzoeksdoelen van studies die een dergelijke combinatie overwegen: (1) *In welke*

volgorde verzamel en analyseer je de data? (2) *Wie* verzamelt en analyseert de data? (3) *Wat* combineer je precies (data, resultaten, conclusies)? (4) *Voor welk publiek en op welke manier* rapporteer je de bevindingen van zo'n gecombineerd onderzoeksproject? De conclusie hiervan is dat een combinatie van Conversatieanalyse van opgenomen interactie en inhoudsanalyse van interviews over die interactie waardevol kan zijn, *mits* het onderzoeksdoel, het onderzoeksdesign, en de rapportagekeuzes in lijn zijn met elkaar.

Een voorbeeld van zo'n combinatie van Conversatieanalyse en interviewanalyse staat beschreven in **Hoofdstuk 10**. Het doel van deze gecombineerde analyse was om een empirisch antwoord te formuleren op de vraag: Hoe creëren docenten en haios nu educatieve waarde tijdens het Leren van Ervaringen? De analyse is een integratie van eerdere bevindingen in een nieuwe analyse van twee 'setjes' opnames en interviews: twee opnames (bron 2) met bij elke opname een interview met een haio die reflecteert op zijn of haar eigen vertelde ervaring, een haio die onderdeel was van de groep tijdens die ervaringsvertelling en daaropvolgende discussie, en een docent die aanwezig was tijdens de sessie (bron 3).

De interviews bieden *algemene* normen over hoe je nu op een waardevolle manier individuele ervaringen kunt gebruiken om collectieve waarde te creëren voor alle deelnemers (zie ook **Hoofdstuk 5**). Daarnaast doen docenten en haios in de interviews ook normatieve uitspraken over *specifieke* momenten in de opgenomen interactie. Die normatieve uitspraken zijn gekoppeld aan de algemene normen, en vormen tegelijkertijd de sleutel tot het daadwerkelijke handelen waarin volgens die geïnterviewde de norm al dan niet zichtbaar werd: de interactionele situatie waarover de normatieve uitspraak gaat. Conversatieanalyse van deze situaties leverde inzicht in de handelingen van deelnemers op die momenten. Die handelingen vormen dan weer het startpunt om op zoek te gaan naar andere momenten waarop die handelingen ook gedaan werden – en mogelijke uitspraken daarover in de bijbehorende interviews.

De algemene conclusie van deze geïntegreerde analyse is dat het Leren van Ervaringen *een gezamenlijke constructie van educatieve waarde* is, waarbij het format van *een verhaal vertellen* en *daarop reageren* cruciaal is. Hoe deze gezamenlijke constructie wordt vormgegeven, illustreren de fragmenten in dit hoofdstuk.

Als we dit nu allemaal samennemen, wat weten we dan over het begeleiden van Leren van Ervaringen? In **Hoofdstuk 11** concludeer ik dat de onderwijsvorm Leren van Ervaringen divers is in termen van doelen en strategieën en stel ik dat deze diversiteit juist datgene is wat het waardevol maakt als onderwijsvorm. Die flexibiliteit geeft ruimte om in te spelen op wat *deze* groep op *dit moment* in de interactie van *deze docent* nodig heeft – een open benadering van begeleiding die goed past bij de complexiteit van het verband tussen leren en onderwijzen beschreven in **Hoofdstuk 2**. De waarde van het Leren van Ervaringen zit in het groepskarakter (een variant op 'twee weten meer dan één'), het open karakter van de activiteit zelf (wat werkt moet per situatie worden uitgevonden, dat biedt ruimte voor creativiteit), en het format van een verhaal als inbreng

(zie **Hoofdstuk 10**). Kortom: de waarde zit in de gezamenlijke betekenisconstructie tussen haios en docenten, waarbij de specifieke ervaring nodig is als input, en de abstractie ervan cruciaal is voor het waarborgen van educatieve waarde voor iedereen. De rol van de docent in dit proces is een balanceer act, waarbij wat de docent doet of niet doet altijd geworteld is in wat er vlak daarvoor gebeurt en tegelijk mogelijkheden schept of beperkt voor wat er daarna gebeurt. In die zin is de rol van de docent altijd modererend en altijd sturend – en het is goed om je daar als docent bewust van te zijn.

Onderzoeksmatig bieden deze uitkomsten richting voor medisch onderwijskundig onderzoek. Conceptueel gezien zou naar mijn mening dit type onderzoek er minder vanuit moeten gaan dat een bepaalde interventie causaal gerelateerd is aan een bepaald leereffect. 'Wat werkt?' of 'Werkt het?' is een veelgestelde vraag in medisch onderwijsonderzoek, maar wat nu als dat per situatie verschilt? Inzoomen op specifieke situaties in de vorm van interactieonderzoek zou wat mij betreft een nuttige, relatief nieuwe, onderzoeksrichting zijn in het medisch onderwijskundig veld. Daarnaast zie ik de drie onderwijsdoeldomeinen waar ik in Hoofdstuk 2 mee begon als een krachtig startpunt voor dit type onderzoek. Vooral onderzoek naar de manier waarop subjectificatie een plek zou kunnen krijgen in medisch onderwijs zou veel kunnen bijdragen aan de manier waarop wij professionals de ruimte bieden als hun eigen zelf binnen de kaders van medische (vervolg)onderwijs.

Methodologisch gezien draagt het onderzoek bij aan Conversatieanalyse in toegepaste context. Het gebruik van video-gestimuleerde interviews laat zien hoe die nuttig kunnen zijn in onderzoek wat inzicht zoekt in participantperspectieven die gedetailleerde interactie-gerelateerde informatie bevatten. Ook de combinatie van analyse van video-gestimuleerde interviews en Conversatieanalyse van interactie is een aanvulling op het Conversatieanalytische arsenaal. In het huidige onderzoek was de combinatie een manier om normatieve uitspraken te kunnen doen over 'waardevolle' begeleiding van Leren van Ervaringen – hoewel *best practices* nog steeds lastig te formuleren zijn.

Theoretisch gezien draagt dit proefschrift bij aan de kennis over manieren waarop docenten medisch vervolgonderwijs begeleiden. Deze interactionele bevindingen verbind ik in dit proefschrift met het onderwijs-filosofische raamwerk van kwalificatie, socialisatie en subjectificatie. Daarmee vormt het proefschrift een schakel tussen het interactionele en onderwijskundige onderzoeksveld.

Praktisch gezien heb ik op basis van dit onderzoek drie suggesties voor docenten: (1) Noem het Leren van Ervaringen geen 'reflectie' – dat beperkt het open karakter van de onderwijsvorm; (2) Bij twijfel, niet ingrijpen – of, anders verwoord, er ontstaat soms meer dan je denkt wanneer je even *niet* ingrijpt en de groep het werk laat doen; (3) Neem een kijkje in de keuken van anderen – observeer elkaar en jezelf, je ziet altijd weer iets nieuws om uit te proberen! Dit is dan ook direct de waarde van dit onderzoek voor de praktijk: het geeft een beeld van en suggesties voor het megapalet aan mogelijkheden die docenten hebben in het begeleiden van Leren van Ervaringen. De fragmenten vormen de basis voor docenttraining die ik inmiddels op verschillende instituten gegeven heb, met als doel hen te helpen met te doen wat zij doen: onderwijzen. Een nobele taak.

PHD PORTFOLIO

Erasmus MC Department: General Practice

PhD period: 09/2017 – 08/2021

Activity	Year	ECTS
Courses/Training		
Erasmus MC – EndNote	2017	0.2
CA and Healthcare Interactions (Loughborough, UK)	2017	0.6
CARM training (Loughborough, UK)	2018	0.6
Interaction analysis and conversation analysis in kindergarten and school (Vestfold, Norway)	2018	5.0
Research Management for PhDs and postdocs	2019	0.6
BKO (Risbo, EUR)	2020	2.9
Eramus MC – Scientific Integrity	2020	0.3
Presentations		
Poster presentation HGOG project meeting (Utrecht)	2017	1.0
Oral presentation VIOT conference (Groningen)	2018	1.0
Oral presentation NHG wetenschapsdag	2018	1.0
Oral presentation AWIA symposium (Nijmegen)	2018	1.0
Oral presentation NVMO congres (Egmond aan Zee)	2018	1.0
Oral presentation Conversation as a tool for practice (Vestfold, Norway)	2019	1.0
Oral presentation Research visit Merran Toerien (Nijmegen)	2019	1.0
Oral presentation LANSI conference (New York, USA)	2019	1.0
Oral presentation NVMO congres 2019 (Rotterdam)	2019	1.0
Workshop NVMO congres 2019 (Rotterdam)	2019	1.0
Oral presentation ECCA 2020 (online)	2020	1.0
Oral presentation AMEE 2020 (online)	2020	1.0
Poster presentation NVMO congres 2020 (online)	2020	1.0
Workshop NVMO congres 2020 (online)	2020	1.0
Conference attendance		
NVMO congres 2017 (Egmond aan Zee)	2017	0.6
ICCA 2018 (Loughborough University)	2018	1.0
Teaching		
Differentiatie 'Onderwijs maken en geven' (HAOPL, jaar 3)	2018-2021	14.9
Course Face-to-Face Communication (CIW, UU)	2018-2019 2019-2020 2020-2021	24.4
Several courses, thesis and internship supervision (CIW, VU)	2019-2020 2020-2021	14.1
Other		
Organisation of Juniorendag	2018,2019	2.0
Organisation of ECCA 2020 (online)	2020	1.0
Organisation of AWIA 2020 (online)	2020	1.0
Total		**85.2**

LIST OF PUBLICATIONS

This thesis

van Braak, M., Veen, M., Muris, J., van den Berg, P., & Giroldi, E. (2021). A professional knowledge base for collaborative reflection education: a qualitative description of teacher goals and strategies. *Perspectives on Medical Education*, 1-7. doi:10.1007/s40037-021-00677-6

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CURRICULUM VITAE

Marije van Braak (Wageningen, 1994) volgde tweetalig onderwijs en behaalde in 2012 haar gymnasiumdiploma (cum laude) aan de Jacobus Fruytierscholengemeenschap te Apeldoorn. Aansluitend op haar interesse in taal en onderwijs volgde ze vervolgens de bachelors Taalwetenschappen en Onderwijskunde aan de Universiteit Utrecht. Na het behalen van beide (Onderwijskunde cum laude), besloot ze zich te richten op talige aspecten van onderwijs in de onderzoeksmaster *Educational Sciences: Learning in Interaction*, ook aan de Universiteit Utrecht. Tijdens deze master deed ze twee onderzoeksstages: een conversatieanalytische onderzoeksstage bij Annerose Willemsen (RUG) over verteluitnodigingen in kringgesprekken tijdens geschiedenis- en aardrijkskundelessen in het basisonderwijs, en een medisch onderwijskundige stage bij prof. dr. Nynke van Dijk (Huisartsopleiding Amsterdam UMC, locatie AMC) over reflectie op praktijkvoering door praktiserende huisartsen. Met een scriptie over *behavioral engagement* van middelbare scholieren en de rol van *scaffolding* daarin rondde ze deze master in 2017 cum laude af. Aansluitend daarop begon ze in september 2017 bij de Huisartsopleiding van het Erasmus Medisch Centrum aan het promotieonderzoek dat is beschreven in dit proefschrift. Sinds 2019 is zij daarnaast vice-voorzitter van de Anéla Werkgroep Interactie Analyse.

Marije onderzoekt niet alleen onderwijs; sinds haar derde bachelorjaar geeft ze het ook. Eerst als student-assistent aan de UU: methodologisch onderwijs aan bachelor- en premasterstudenten aan de faculteit Sociale Wetenschappen. Later als promovenda: gespreksanalytisch onderwijs bij Communicatie- en Informatiewetenschappen aan de UU en de VU, en scriptie- en stagebegeleiding op bachelor- en masterniveau aan de VU, Radboud Universiteit Nijmegen, en Rijksuniversiteit Groningen. Tijdens haar promotietraject was ze ook co-docent bij de landelijke differentiatie ‘Onderwijs maken en geven’ voor derdejaars huisartsen in opleiding en gaf ze op basis van onderzoeksresultaten trainingen aan docenten op verschillende huisartsopleidingsinstituten. Sinds 1 september 2021 werkt ze als Universitair Docent bij de afdeling Taal en Communicatie aan de Universiteit Utrecht.