Freire, Dialogic Feedback, and Power Issues: An Autoethnography

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The centrality of feedback is undeniable in education. However, not all feedback effectively encourages learning or improves performance due to predicaments in feedback delivery and receptivity. Several studies suggest other ways where feedback is offered in a dialogic fashion instead of a monologic one. Nevertheless, few papers do so in the context of medical education, especially when the learning processes involve marginalized people such as disaster-affected patients. This paper draws on autoethnographic experiences of providing dialogic feedback for medical students using Paulo Freire's dialogue concepts. This feedback was given during reflective sessions in community-based medical education at post-disaster areas in Aceh, Indonesia. The findings show that Freire's dialogue concepts help assess dialogic feedback quality and offer insights into power relations between teachers and students. To achieve the aim of providing dialogic feedback, to obtain new understandings, educators need to establish a more equal position in student-teacher relationships. In sum, the findings highlight the applicability of Freire's concept of dialogue in offering feedback for students especially when the training takes place in a context of disaster-affected people.

Keywords: Autoethnography; dialogue; disaster; feedback; medical education.

Introduction

Providing feedback is a practice that has been described as not only central in learning, but also as complicated, multi-layered, and disputable (Boud & Molloy, 2013; Steen-Utheim & Wittek, 2017; Winstone & Carless, 2019). Feedback may produce many positive effects, such as improving student performance and enhancing learning by offering students information on their tasks, processing the tasks, self-regulation, and progress as a person to advance their performances (Hattie & Timperley, 2007). Other than cognitive or informational inputs, feedback may also offer motivational inputs (Brookhart, 2017). However, not all feedback could effectively encourage learning or improve performance. Some studies reported challenges in giving feedback including contextual constraints (Henderson et al., 2019), individual capacity in feedback provision and receptivity (Adcroft, 2011; Elnicki & Zalenski, 2013; Forsythe & Johnson, 2017), and ways of offering feedback (Kost & Chen, 2015).

In order to stimulate learning, scholars suggest various models to offer feedback. In undergraduate medical education, educators have been using models such as Pendleton rules (Chowdhury & Kalu, 2004; Pendleton, 1984), sandwich (Von Bergen et al., 2014), agenda-led outcome-based analysis (ALOBA) (Silverman, 1996), partnership-empathy-apology- respect-legitimation- supports (PEARLS) (Milan et al., 2006), and stop-keep-start

(SKS) models (DeLong & DeLong, 2011). In medical specialty education, models include continue-alter-stop-try (CAST) (Sefcik & Petsche, 2015) and one-minute preceptor (OMP) (Sabesan & Whaley, 2018). In general, these models highlight the importance of teachers' empathy when offering feedback. If carefully delivered, feedback may clarify tasks given to students or suggest how to do them more effectively (Hattie & Timperley, 2007), facilitate self-regulation and reflection (Nicol & Macfarlane-Dick, 2006; Telio et al., 2015), encourage positive motivation (Brookhart, 2017), and offer opportunities for negotiation and dialogue (Nicol & Macfarlane-Dick, 2006; Telio et al., 2015). The final aspect, dialogue, is the focus of this paper.

Dialogic feedback
Several studies suggest that providing dialogic feedback for students produces better learning than monologic feedback (Ajjawi & Boud, 2017; Merry et al., 2013; Telio et al., 2015). Dialogic feedback helps some students manage their emotional responses when receiving corrective information from their teachers (Merry et al., 2013). Compared to unidirectional feedback, dialogic feedback is more effective in encouraging students to utilize it in subsequent learning processes (Ajjawi & Boud, 2017; Merry et al., 2013). One possible explanation for this utilization is that dialogue and negotiation may construct an educational alliance between students and teachers (Telio et al., 2015).

Dialogic feedback, however, cannot always happen. Scholars have identified contexts that inhibit dialogic feedback from occurring, such as unsupportive institutional cultures (Ramani et al., 2017), discussing traumatic memories during dialogues, and silencing students through unintentional domination of teacher's ideology (Marjanovic-Shane et al., 2019). In the medical education world, especially in clinical teachings, dialogues during ward rounds and bedside teachings were inhibited by 'pimping'.

Medical educators and students are familiar with question-answer activities called 'pimping' (Chen & Priest, 2019). Historically, the word 'pimping' came from the German word 'pümpfrage', which means 'pump question' often used by medical educators to 'teach' their students (Brancati, 1989). In reality, pimping is a form of oppressive questioning of students, which usually begins with a medical teacher ignorantly posing a series of question to a group of students, inviting argumentations to produce a fuller understanding of the subjects being questioned (Kost & Chen, 2015). This so-called platonic dialogue may evoke negative emotions in medical students. They may feel ashamed and embarrassed due to their inability to provide 'smart' answers (van Schaik, 2014). This problem in stimulating learning in medical education calls for a new way of establishing dialogues with students, which may help them achieve the primary aim of dialogue: producing new understandings and shared meanings that may facilitate learning.

Dialogue
The word 'dialogue' originated from the Greek language: 'Logos' means 'meanings of words' and 'dia' means 'through' and in combination dialogue literally means a flow of meanings through the exchange of words between speakers (Bohm, 2013, p. 6). As individuals perceive meanings differently, their exchanges of meanings through dialogue may create a shared-meaning and produce new understandings (Eadie, 2009). The exchange of meanings is usually carried out through questions, and the question-answer dialogue may reflect role relationships among the speakers, for example, authority and

power (Mishler, 2005). Therefore, power relations in dialogues may influence the production of new understandings.

Extensive research has theorized and explored power relations between doctors and patients by closely examining meanings exchanged between them (Ainsworth-Vaughn, 1998; Filc, 2006; Foucault, 1990). However, a dearth of research has explored balanced power relations concepts in dialogues between medical educators and their students when educators provide feedback (Angoff et al., 2016; Lapum et al., 2012; Ranz & Korin Langer, 2018). To further explore how dialogue can facilitate feedback, I next turn to Freire's dialogue concept in learning.

Freire's concept on dialogue
Paulo Freire, a Brazilian educationalist, argued that education's ultimate purpose is to encourage people to think critically about their ways of living and try to change for the better (Freire, 1970). Freire argued that thinking, as a part of learning processes, occurs when both students and teachers communicate dialogically. These dialogues help students reflect upon the context, stimulate awareness, encourage acts to change the situations, and then reflect upon these actions (Freire, 1970). Dialogue may facilitate collective liberation of minds, especially when the learners are part of an oppressed society (Freire, 2018). Freire argued that a liberating dialogue should meet five conditions: 1) equality, 2) humility, 3) intense faith in oneself, 4) hope, and 5) critical thinking (Freire, 2018), as shown in table 1 along with their definitions in teaching and learning practices.

Table 1

Five prerequisite conditions for the establishment of dialogues in teaching and learning practices (Freire, 1975)

	Prerequisite conditions for dialogue	Teaching and learning practices
1	Equality	Avoid domination and express profound love
2	Humility	Respect students' role and previous knowledge, care for their dignity, friendship strategy
3	Faith	Recognize and have intense faith in one's ability
4	Critical thinking	Avoid normalizing situations, sensitive to epistemic inadequacy
5	Hope	Maintain an optimistic mindset, expect something from the dialogue

The first condition to establish a good dialogue is equality. Freire defined equality not as an exactly equal position between teacher and student, but as a situation where teachers express their profound love to students by ensuring students exercise their right to speak (Freire, 2018). Freire contended that colonialism destructs equality as well as any other conditions where one subjugates others because subjugation denies other's right to speak (Freire, 2018). There is no dialogue without equality, and without dialogue there is no communication, therefore, there is no learning. A better teacher should 'demystify' their

expertise to avoid subjugation over their students (Labaree, 2000) without losing the ability to direct the learning process (Bartlett, 2005). However, there is a lingering question: is it possible for student and teacher to be exactly equal in their relationship?

Studies exploring student-teacher relationship (STR) discuss power and equality issues. It is evident that teachers always have a bigger power in STR due to three factors: teachers have more knowledge and expertise, they have higher social and professional status, and students' marks are in teachers' hands as part of teachers' obligation to assess their students (Aruta et al., 2019). However, students are not powerless. They can also claim power in the STR by resisting, dissenting teacher's instructions, and misbehaving (Taylor, 2019). Therefore, there are power claiming processes in STR, which make the relationship dynamic, communicable, and hopefully, closer to equality. A study described ideal power dynamics in medical student-teacher relationships where teachers locate themselves in a 'friendly but not friends' zone' in 'superior versus friend' continuum of power claim (Blakey & Chambers, 2020). The relationships within that zone may enable students to convey their opinions about sensitive issues in health (such as alcohol use and death) and teachers to administer appropriate discipline to respect others' viewpoints (Blakey & Chambers, 2020). From medical students' perspectives, teachers and students should be able to see that 'power need not always be equally divided' and the dynamics in power claiming may serve as means to improve partnership instead of roadblocks to establish equality in STR (Kapadia, 2020).

After equality, the second condition for dialogue is humility. Humility is a frame of mind that enables a person to respect others (Freire, 2018), far from arrogance and ignorance (Heidemann & Almeida, 2011). Freire posed a question: "if I am tormented and weakened by the possibility of being displaced, how can there be a dialogue?" (Freire, 2018). He also argues that practicing dominance inhibits dialogue and humility encourages it.

Having great faith in their power to transform the condition is the next prerequisite condition to create dialogue. Both teachers and students need to believe that the power to transform a condition is more likely to exist in the struggle for liberation (Freire, 2018). Freire also suggested teachers to invest in promoting critical thinking in learning processes, which is the opposite of naïve thinking that makes one see only 'normal' occurrence in daily life (Freire, 2018). Critical thinkers can locate swift generalization, a false argument, and epistemic inadequacy in vague concepts or illegitimate truth-claiming, that may be questioned in a dialogue within liberating educational environments with their teachers (Burbules & Berk, 1999).

The fourth prerequisite condition is hope. An optimistic attitude in students is a result of teachers' efforts of instilling expectations of positive outcomes in their lives. Although hope can't stand alone in achieving the outcomes, without hope the efforts are weak (Freire, 2021). The existence of hope encourages the act toward change instead of merely waiting. Hopelessness is the opposite of hope and consists of a denial of the world and an active escape from it.

In conclusion, dialogic pedagogy needs alterations of teaching methods as well as understood power relationships between students and teachers (Aronowitz, 2015). This alteration of power relationship may positively influence medical students' relationships with patients. Reports and studies have been calling for a change in hierarchical and asymmetrical power relationship toward a more balance one, like in the case of Indonesia (Claramita et al., 2013; Indah, 2021; Ministry of Health Republic of Indonesia, 2011). This paper seeks to obtain insights on dialogic feedback provided for medical students after

their interactions with marginalized and disaster-affected communities, who have lost family members, properties, and livelihood. The next subsection presents this study's method and how Freire's dialogic feedback was employed in medical education in a post-disaster area.

Methods

This study is a part of a larger ethnographic study exploring doctor-student-patient interactions in post-disaster areas in Indonesia (Indah, 2019). It draws on participant observations, interviews, and focus-group discussions involving medical students of the Faculty of Medicine X University (FoMX). The students were assigned to learn at several health centers in areas that were devastated by a giant tsunami in 2004. The tsunami killed 126,741 people in this area and 93,285 were declared missing (Arie et al., 2009). Ethics approval was obtained from FoMX Human Ethics Committee (number 01/KE/FK/2017). The observed participants were two groups of five medical students, ages 22 to 25, most of them are female (70%), representing the gender structure in their school. The participants had completed an undergraduate program in medicine from FoMX using a reformed curriculum prioritizing competence in disaster management (Indah, 2010). When the study was conducted, they pursued their clerkship in Family Medicine Clinical Stage in tsunami-affected areas in Banda Aceh, Aceh, Indonesia.

Auto-ethnographic techniques were employed to obtain insights into my subjective experiences as a researcher (Siddique, 2011) as I explored students' perspectives in their natural settings. Despite the fact that autoethnography is an uncommon methodology in the field of medical education, it provides powerful tools to obtain "more reflective, more meaningful, and more just" education practices (Adams et al., 2017, p. 1). In this study, I refused to simply document medical student-patient interactions in situ. Instead, I tried to involve the students in reflective practices encouraged in medical education (Aronson, 2011; Branch Jr & Paranjape, 2002; Ryan, 2010).

Autoethnography also offers opportunities to employ a strong local knowledge as an insider and exercise a commitment to give back to my homeland after gaining a privileged position in advanced education (Yakushko et al., 2011). The autoethnographic writing allows researchers to write in a highly personalized style (Wall, 2006) as I exercised my reflectivity and use my positionality (Plowman, 1995) in analyzing data from my interactions with students. This methodology has been utilized by health science (Ettorre, 2010; Foster, 2014; Siddique, 2011) as well as health professional education researchers (Acosta et al., 2015; Gallé & Lingard, 2010; Grant, 2019; Indah, 2018). In the application of auto-ethnographic techniques, however, researchers should be cautious of their potential downsides, which are neglect of research ethics, too much reliance on memory, and trapped in self-indulgence (Chang, 2016; O'Reilly, 2009). Therefore, I had been continuously being cautious of the influence of my positionality in this research. I reflected on the application of the dialogic feedback diligently to accurately interpret my encounters with medical students.

In addition to reflectivity, participant observation (Hammersley & Atkinson, 2007; O'Reilly, 2009) was another method utilized in this study to produce a more complete illustration of students' experiences during their learning processes. When I was conducting the observation, I could not avoid playing double roles: a medical teacher and a researcher, which was quite challenging sometimes. I asked for the students' oral and written consent before recording almost every interaction observed.

The data were documented in many ways: logbooks, audiotaped records, and field notes. The data analysis started concurrently with data collection (Patton, 1990; Richardson & St Pierre, 2008) and included an iterative process (De Laine, 1997). I also wrote analytical and methodological memos as I reread the data (Emerson et al., 2011).

I utilized NVIVO10 qualitative software from Windows to conduct coding and interpreting the data. I created a coding scheme based on two sources. First, some of the codes were predetermined from theories I utilized and second, they came out from topics emerged from reading the data. Therefore, I drew the codes deductively (from theory-observation-confirmation) as well as inductively (from observation-pattern-conclusion). I then categorized the codes into several categories and subcategories (Saldaña, 2021). During the process, I wrote memos to connect codes and record emerging ideas and themes.

I interpreted data by developing theoretical, methodological, and emotional notes (Gobo, 2008), which were very helpful in creating a starting point to describe some concepts (Peshkin, 2000). Reflexive descriptions complemented the interpretation to maintain subjectivity and accountability (Hammersley & Atkinson, 2007; Richardson & St Pierre, 2008). To do so, I incorporated 'critical' analysis when writing the findings. I tried to resist domestication (Thomas, 1993) to describe how my position as a medical teacher established elements of Freire's dialogic concept (Freire, 2018) and maintained criticism toward the interactions between the students, patients, and myself.

Findings

This section presents some of the cases where I, as a medical educator and researcher, provided feedback in the form of dialogues to the medical student participants. They were engaged in various medical encounters in health centers at some post-disaster areas in Banda Aceh.

Harun and biopsychosocial perspective

The following dialogue was a reflection session after a home visit to understand chronic disease management. We went to visit Maryam, a 68-year-old woman, which was in a disaster-affected area. She lived with her son and his family in a house that was heavily destroyed by the tsunami. Maryam survived a stroke a year ago and had uncontrolled high blood pressure and type-2 diabetes. She had not been able to visit health centers by herself due to her poor sight. I followed Harun, a medical student who was assigned to the home visit. After the activity was completed, we had a reflection session during lunch together, and I offered him a dialogue to provide short feedback.

> Rosa: How do you think the home visit went?
>
> Harun: I think it went well. But I feel sorry for that woman. Her house was still severely damaged by the tsunami, and it has not been renovated even after 12 years. She is diabetic and has severe hypertension. It seemed that her son and daughter-in-law were not very supportive as they sat with us only briefly and left us there.
>
> Rosa: Yes, I agree. I felt sorry for her too. I appreciate your attention on the psychosocial aspect of the disease. In your opinion, what do you think healthcare providers should do to overcome the challenge?

Harun: I prescribed some anti-hypertensive drugs and oral anti-diabetic drugs as pharmacological therapy. However, I should have paid attention to the non-pharmacological approach, as well. I think I should have talked to her son and daughter-in-law. She needs family support on diet and stress management to control her blood pressure and sugar level. Yeah, I regret that I did not say anything when the son was with us briefly. I know I sometimes think that patients would not understand what I said, preferred to skip the explanation after examining them, and did not include their family members.

Rosa: Yes, you are right. But don't worry. We can discuss your ideas with the chronic disease and geriatric management team.

In the above dialogue, I applied the five elements in Freire's dialogue. The first element, equality, was established well. Both Harun and I had equal understandings on the learning objective, and we take equal turns in the dialogue to avoid domination. The second element of dialogue, humility, was employed by respecting students' evaluation of the management of the patient. I then asked about the role of healthcare providers because I believe the student, based on his concerns on lack of time spent with family members of the patient, had acquired understanding beyond the individual aspect of biomedical paradigm. He embraced family aspects of health and the biopsychosocial perspective of it. Critical thinking was employed when we discussed problematic aspects of the patient's situation and what is not proper in his approach. To affirm the student's critical reflection on his previous action, I confirmed his evaluation. To cultivate hope, I expressed my expectation for Harun to actuate his idea through the work of chronic disease and geriatric management team. This expectation was an affirmation that his progress on creating new understandings is a great achievement and would be a foundation for a more comprehensive treatment.

The dialogue with Harun was an example of many other dialogues with medical students that successfully provide opportunities to give feedback in interactive ways and achieved learning objectives of those educational activities. However, some of the dialogic feedback encountered challenges due to various reasons. The subsequent dialogue provides an example of those challenging times of offering dialogic feedback.

'I have no idea how to improve'
The second case involves Iman, a 25-year-old male medical student participant. He and I participated in a junior school-based medical check-up. The school was in a tsunami-affected district and mostly attended by students from lower socio-economic backgrounds. Some of the school's students lost their guardians in the disaster and therefore were forced to live in a nearby orphanage. Some of them appeared shy or a bit hesitant to be examined and afraid of getting some vaccination shots. Then one of the medical check-up team members clarified that there was no injection involved and the team would only perform physical examination and consultation.

The medical check-up team members performed physical examinations in several stations, including an anthropometry (height and weight), visual acuity measurement using Snellen chart, Ishihara color-blind test, dental check, chest examination, and a health promotion station where the high school students were asked to watch a documentary on the effects of smoking, followed by a Q&A session.

I could see the anxious as well as curious expression on the high school students' faces as they took turns to be examined. Iman was assigned at the chest examination post with a stethoscope in his hands. To be able to observe, I sat beside him. We both agreed that this particular session was aimed to apply excellent communication with patients.

Iman started the chest examination without greeting the students or asking for their consent. He ended the examination without offering any medical advice or suggestions. He only started with saying 'excuse me' to a student and then put the diaphragm of the stethoscope on the student's chest and ended by a short 'thanks'. Consequently, unenthusiastic students left Iman's station and moved to the next one. Their reaction stimulated me to pose some questions to Iman.

> Rosa: Iman, what do you think about the school students' responses toward your examinations?

> Iman: I think they are doing fine, Doc.

> Rosa: Do you think you can improve your interpersonal communications with them?

> Iman: Ah [thinking pause] I don't have any idea what to improve, Doc.

I encountered a challenge to stimulate Iman to think about encouraging ways to do the chest examination. I posed some other questions, but he appeared to have no idea which part of the examination that he may improve. Then I decided to provide feedback through the coaching method (Sabesan & Whaley, 2018). I did not want him to feel under pressure.

I decided to offer an example. Iman lent me his stethoscope and I started a chest examination by smiling at a male high school student in front of us who looked a bit terrified. After greeting him and introducing myself, I saw that he became more relaxed and interested. He told me his first name and some other personal information that I requested. I listened to his answers attentively and then asked for his consent before putting the stethoscope diaphragm on his bare chest.

After the examination had been completed, I reported my findings to the high school student and asked if he had any questions for me. With a curious expression he asked a question about ways to grow taller more quickly, which I answered accordingly. He seemed satisfied with my answer and then I ended the interaction with a smile and expressed his gratitude. The student left the station, and I gave the stethoscope back to Iman.

After observing my interaction with the student, Iman changed his ways of interacting with the students. He paid more attention to students' responses and modified his approach accordingly. He performed the examination in better ways than before, asked more questions to the students and was asked to answer many of the high school students' questions. As a result of his transformed ways of doing chest examination, Iman's station became the favorite station with a big crowd of students around where he sat. I observed as Iman listened to their questions and answered accordingly: on his personal experiences of smoking cigarettes and cannabis and their effects on health, how it feels to be a medical student, his favorite sports and so on. I enjoyed looking at the fascinated high school students and Iman. During a lunch break afterward, I asked Iman to reflect on the check-up session.

Rosa: What do you think about the medical check-up?

Iman: It was fun. I learned how to articulate the prevention of problems such as respiratory problems due to smoking and how smoking cessation works. I did not do this kind of patient education much when I was in hospital rotation. Most of the time, I just followed the residents, and they were the ones who did it.

Rosa: I saw that the ways you communicate with the high school students have improved. Do you think you have changed some approaches?

Iman: Yes. Definitely. I think I have changed the way I communicate. In the beginning, I did it without proper eye contact, did not greet them or introduce myself. But then I learned that I have to be less interrogative, I started to call them 'bro,' asked for their names. I introduced my name to decrease the gap. I also learned how to ask for their consent for the chest examination. The benefit came instantly: they were less hesitant, and we got along much more relaxed. Then I used my experience of smoking to understand why they smoked. Thank you for reminding me how to be empathic. I modified my words with the use of fewer medical jargon. I'm glad that I was able to recognize their reactions when I used the medical terms; they were quieter, less talkative, maybe because they did not understand what I said before. I regret what I did at the teaching hospital. I remember my patients' expression when I explained that we need to 'taper-down the metil-prednisolone use.' I think I made them confused. How silly I was.

Iman's case highlights several aspects of Freire's dialogic feedback in the context of social interactions between medical students and educators. First, it seems that an exact equal position is very difficult to obtain in a student-teacher relationship, especially when the level of understanding of the task and its goal was incongruence. In this case, to achieve an equal understanding, I provided feedback by coaching (Launer, 2014). After Iman understood the goal of the task, he had better self-regulation in improving his performance.

Second, humility can be employed when the teacher respects the student's understanding, lack of understanding or misunderstanding as ways of learning. When I, as a teacher, reflect on the interaction, I know that I wanted Iman to progress and respected his reaction and learning process through making mistakes, fixing, and improving his communication skills by further practice.

Third, I let him practice first, then provide feedback, and then let him use the feedback to practice again with a new approach, because I had faith in Iman's power to change how he interacts with his patients. I did not criticize his modification, because I know every student has his/her own way to doing things better than their teachers.

Fourth, the dialogue offered a perspective in assessing and valuing critical thinking. Initially, it was hard to stimulate a critical stance of the situation. However, through a reflective conversation during the activity, Iman could compare the patients' reactions with his previous experiences communicating with patients using many medical jargons. Iman began to criticize his past practices and was able to identify challenges in them and express his intention to change his approach in communicating with patients

Fifth, hope. I believe that Iman was able to transform his understanding to better practice, beyond imitating my approach because he provided evidence that he could do so. The dialogic feedback amplified my expectation that Iman could self-regulate his progress by observing the effects of his new approaches when establishing the dialogues with high school students.

In sum, this case highlights that Freire's approach is useful to analyze how dialogic pedagogy in giving feedback may stimulate reflective learning in classrooms and beyond (Aronowitz, 2015). The challenge of establishing a more equal understanding of the goal of learning described in this case offers an insight that to establish a dialogue in providing feedback, both medical teacher and student need to probe whether they had congruence in understanding the goal of the learning session.

'I just need to change my habit'

The two previous cases represent many other cases where dialogic feedback was established relatively well and promoted changes in attitude. However, not all dialogic feedback turned out well. Several of them failed to help my medical students achieve their learning objectives. The following dialogue took place after a ward round and pimping questions led by a senior attending doctor. The round aimed to exercise communication skills in health institution settings. An incident happened when Sakdia, a female medical student, forgot to introduce herself to a female patient, and the patient refused to be examined by Sakdia. The patient said: "I do not want to be examined by this rude nurse." After the ward round was over, I had a reflection session with Sakdia.

> Rosa: What do you think about our problem in establishing communication with the female patient this morning?
>
> Sakdia: I forgot to introduce myself, but I did not realize it was a problem until the woman refused to be examined and addressed me as 'nurse'. But the nurses, nutritionist, nursing aid in this health center wear a different color uniform. Can't the patients distinguish me as a junior doctor, Doc?
>
> Rosa: Well, this morning's round answers that question. It seemed that patients couldn't differentiate 'who is what' if we do not introduce ourselves and roles. In your opinion, what does lack of self-introduction entail?
>
> Sakdia: I have no idea. But I think if I can develop a habit of self-introduction, they will know my position and behave accordingly. I will improve my approach to patients, Doc.

The dialogic feedback with Sakdia offered an example when most of the elements of dialogue were established, but it failed to produce a new understanding. I tried to approach her by showing humility, my faith in her power while stimulating critical thinking and hope. However, the first element of Freire's dialogue, which is equality, was difficult to obtain as the dialogic feedback took place after the pimping questioning led by my fellow medical educator. It seemed that what happened during the pimping session left many medical students in an uncomfortable mood, including Sakdia. It was hard for her to locate herself on a more equal level with me and feel free to speak up. As a result, instead of critically evaluating the problems in her interaction with patients, she was defensive to maintain her power in front of me, one of her teachers. Consequently, the

problem of asymmetrical power relation, with lack of self-introduction as evidence, was abandoned. The inequality in student-teacher relationship led to less-productive dialogue and ineffective feedback. As a result, my particular dialogue with Sakdia failed to produce new understandings (Eadie, 2009).

Discussion
This study explores my experiences as a medical educator in providing dialogic feedback for medical students using Paulo Freire's dialogue concepts. The study's findings offer examples of how dialogic feedback may promote better learning through producing new understandings for both students and educators. In many attempts, including my dialogues with Harun and Iman, it seems that dialogic feedback may facilitate self-regulation and reflection (Nicol & Macfarlane-Dick, 2006), encourage positive motivation (Brookhart, 2017), and offer opportunities for negotiation and dialogue in feedback conversation (Nicol & Macfarlane-Dick, 2006; Telio et al., 2015). The dialogic feedback established in the findings may promote better learning (Ajjawi & Boud, 2017; Merry et al., 2013; Telio et al., 2015). The humble and respective approach in the dialogic feedback appears to help some students to manage their emotional responses (Merry et al., 2013). It seems that collegiality and educational alliance (Merry et al., 2013) between students and teachers allowed most of the students to express their emotions more comfortably. In Iman's case, the dialogic feedback encouraged him to utilize feedback given in his subsequent learning processes (Ajjawi & Boud, 2017; Merry et al., 2013).

Nevertheless, educators should be mindful that student might not 'get it' in the first dialogue. Dialogue with Iman presents an example where dialogic feedback should comprise iterative activities that continuously promote the exchange of ideas, produce new understandings, and enhance learning. Therefore, the educators should still respect students' achievements, being humble and faithful toward any expressions of ideas hoping that students' abilities will improve over time (Merry et al., 2013), despite the reality that the students have not immediately arrived at the level of ability that the educators expected. Dialogue with Iman also suggests that educators may also direct the student by employing another way of providing feedback, such as role-modeling, to offer insights on how a task may be executed. According to Freire, being 'equal' with students does not deny teacher's responsibility to be directive (Bartlett, 2005).

The findings also show that asymmetrical power relations between educator and student may hinder the dialogic feedback to achieve new understandings. As shown in my dialogue with Sakdia after a 'pimping' session, the big gap in power relations created by the previous teacher hindered a more equal position between Sakdia and myself. During the pimping session, Sakdia was under pressure to produce a 'smart' answer instead of being authentic about what she understood. Consequently, the situation negatively affected the dialogic feedback that came afterward, damaged the student-teacher rapport, and impeded learning (Freire, 2018). It seems that this situation related to a highly hierarchical relationship between students and teachers, which is one of the characteristics of medical education culture (Angoff et al., 2016; Donetto, 2012).

It seems there is a discrepancy between medical education culture and the culture of patients, which are two out of three different cultures around medical education practices (the other one is health facility cultures). When analyzing the dialogical feedback practices, I considered approaches at micro and macro levels (Gabler, 2021). The micro-level approach considers a smaller circle of interaction, such as dynamics in student-teacher relationships. It looks at each student specific way of learning and interpreting

their teacher's responses within a cultural context in medical education. The macro-level approach scrutinizes medical doctor/student-patient interactions. In this study, I have used both approaches.

When the culture that regulate doctor-patient interactions is gradually transformed from highly hierarchical in the past toward a more equal relationship, it seems that cultures around student-teacher interaction are transforming in a relatively slower pace. Medical doctors are expected to treat patients as their equals when in medical education there is a rather big power distance between senior and junior medical doctors and between medical teachers and their students.

This situation creates a gap in the relationships between patients and medical students. The students are used to tension between them and their teachers and struggleto apply a more equal approach with their patients. For example, I have never seen a medical teacher introduced herself to her students although they have never met before. Medical teachers I observed also rarely share their power of knowledge by suggesting reference to read or theoretical framework to understand. What mostly shared were medical opinions. The asymmetrical power relationship due to medical education cultures were obvious and worsening with regular pimping sessions and one-way feedback provisions. In sum, it appears that there were strong influences of culture on the way student participants responded to dialogical feedback that I wanted to establish with them.

The dialogues in findings, however, provide evidence that medical students benefited from a more balanced power relation between teacher and students offered by dialogical feedback provision. Harun, Iman, and other students in this study have increased their ability to reflect on their actions, which potentially benefit their future patients, especially those who had been experiencing political, financial, and social oppressions. In addition, they were not the only beneficiaries of the new understandings. I, as a medical teacher, also obtained new insights from the established dialogues. As I employed critical thinking during dialogue with Harun, I obtained insights that medical education should pay more attention to change the biomedical paradigm into biopsychosocial one. From a pedagogical point of view, those dialogues taught me the teacher's responsibility to offer direction in learning, be aware of students' long journey of learning, and always be respectful along the way. From employing autoethnography as a methodology and reflectivity and participant observation as methods, I learned that providing dialogic feedback is a skill as well as an art that needs to be practiced with humility and perseverance.

As with most studies, the design of the current study is subject to limitations. First, this study involved only a few groups of medical students at only one medical school. The unique cultures of the medical school, educators, and patients involved affect how they interacted. Consequently, analysis of the findings considered elements of cultures where the interactions occurred. Second, autoethnographic methodology employed in this study relied on my personal assumption about the world, which includes my interpretation of the ways people speak, value, and believe. What I find interesting may be different compared to what other people do. Therefore, the findings of this autoethnographic study should be understood in light of my positionality and personal view as a tsunami survivor, medical doctor, and teacher working with marginalized patients at the disaster-affected area, which made writing this article both reflective and uncomfortably challenging (Farrell, 2017). Despite these limitations, the application of the autoethnographic methodology in this study contributes methodologically to production of meanings and emotional dynamics in the student-teacher interactions (Ellis et al., 2011).

Given the limited scale, scope, and the specific methodology of this study, further explorations are recommended to study the utilization of Freire's dialogic concepts in dialogic feedback in broader and different settings and use different approaches such as phenomenology, critical discourse, or conversation analysis.

Conclusion

The employment of Freire's ideas in this research indicates the usefulness of these ideas in providing feedback for medical students. Freire's five elements of dialogue provide directions for medical educators in offering dialogic feedback. The findings of this study also call for medical educators to be cautious of the challenges of providing dialogic feedback, such as asymmetrical power relations between teachers and students. Other instructional methods employed (e.g., pimping) may also affect the power relations between teachers and students and negatively impede dialogic feedback effectiveness, especially in a context where medical education is in a context where hierarchical relationship is a norm of student-teacher relationships. Without careful attention to power relations, it is challenging to stimulate students' reflexivity toward self-actions. Therefore, this paper calls for an implementation of educational transformation that creates a more balanced power relation between teacher and students. This may enable dialogic feedback to take place, which may benefit medical students, teachers, and their future patients, especially those who have experienced marginalization.

Disclosure Statement

The author reported no potential conflict of interest and confirmed that she contributed to research proposal writing, data collection and analysis, and the publication of this article. All personal identifiers have been removed or disguised so the persons described cannot be identified through the details of the story.

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