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ORIGINAL RESEARCH

COLLABORATIVE GOVERNANCE IN MEDICAL PROFESSION REGULATION: LESSONS LEARNT FROM INDONESIA

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ABSTRACT

Background: Medical profession regulation are carried out through certification and licensure which can be executed by the government, the organizational profession or the collaboration of both. Having a long standing credibility in professional regulation, medical professions have required every medical graduate to undergo certification and licensure process. The UK system adopts the government-led and the USA system has opted for the professional-led medical regulation. In Indonesia currently there are two laws regulating medical profession, namely Medical Practice Law No.29/2004 and Medical Education Law. No.20/2013. These two Laws have given mandates for medical profession regulation to different stakeholders, resulting in conflicting roles and functions, particularly in certification and licensure. Attempts to overcome these situations have been initiated, by inviting all stakeholders involved to discuss the solution during the period of December 2014-January 2015. This study aims at understanding the decision making process to achieve consensus using the concept of collaborative governance.
Method: Qualitative method using a case study is applied and documents analysis is used for data collection. Thematic analysis is employed for data analysis.
Results: Six themes are identified to reflect the decision making process in collaborative governance. It starts with distrust, followed by mutual understanding and willingness to listen, then common goals are agreed. Each stakeholder conducts an internal reflection and eventually accepts a consensus.
Conclusion: The concept of collaborative governance can be applied in medical profession regulation to achieve consensus in collective decision making process.

Keywords: medical profession, regulation, collaborative governance

ABSTRAK

Latar belakang: *Regulasi profesi kedokteran dilakukan melalui sertifikasi dan lisensi yang dapat dilaksanakan oleh pemerintah, organisasi profesi atau kerjasama keduanya. Profesi kedokteran telah memiliki sejarah panjang dalam menyelenggarakan regulasi profesi yang kredibel, sehingga setiap lulusan dokter harus melalui proses sertifikasi dan lisensi. Inggris mengadopsi sistem regulasi profesi yang berbasis kendali oleh pemerintah, sedangkan Amerika Serikat memilih sistem regulasi profesi yang berbasis kendali oleh organisasi profesi. Di Indonesia, saat ini ada dua undang-undang, yaitu UU No.29/2004 tentang Praktik Kedokteran dan UU No.20/2013 tentang Pendidikan Kedokteran yang memberikan mandat kepada beberapa pemangku kepentingan untuk melakukan regulasi profesi kedokteran. Kondisi ini menimbulkan konflik peran dan fungsi, terutama terkait sertifikasi dan lisensi. Upaya untuk mengatasi situasi ini telah dilakukan*

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dengan mengundang semua pemangku kepentingan yang terlibat untuk menemukan solusinya selama periode Desember 2014-Januari 2015. Penelitian ini bertujuan untuk memahami proses pengambilan keputusan untuk mencapai consensus menggunakan konsep tata kelola kolaboratif.

Metode: *Metode kualitatif dengan studi kasus digunakan dan pengumpulan data menggunakan analisis dokumen. Analisis tematik digunakan untuk analisis data.*

Hasil: *Enam tema telah diidentifikasi yang merefleksikan proses pengambilan keputusan kolektif menggunakan konsep tata kelola kolaboratif. Proses dimulai dengan rasa tidak percaya, diikuti dengan saling pengertian dan ketulusan untuk mendengarkan. Setelah ini, dicapai kesepakatan tujuan bersama. Setiap pemangku kepentingan melakukan refleksi internal yang berakhir pada diterimanya consensus.*

Kesimpulan: *Konsep tata kelola kolaboratif dapat diaplikasikan dalam regulasi profesi kedokteran untuk mencapai konsensus dalam pengambilan keputusan kolektif.*

Kata kunci: *profesi kedokteran, regulasi, tata kelola kolaboratif*

PRACTICE POINTS

- Medical Profession Regulation could involve multistakeholders from government and non-government sectors.
- Collaborative governance could be used in collective decision-making process to overcome differences among multiple stakeholders.

INTRODUCTION

Medical professions have existed since thousands of years ago. The Hippocratic oath written by an ancient Greek physician in the 5th century BC was adopted as a code of conduct by the medical profession throughout the centuries and is still used in the graduation ceremonies of many medical schools until today. Since then, medical professions have always been regulated. Throughout the history, medical professions have developed a mechanism of how to regulate their members of which the main purpose is to protect the public and to provide patient safety.

According to Freidson, Professionalism is the most effective way to organise work when the tasks to perform or problems to work on, lack uniformity and thus require 'discretionary specialisation'. When special knowledge and skills are needed, and uncertainties are so high that discretion in the use of these knowledge and skills is necessary. The discretion given to the professional is based on trust. Trust that the professional morally uses its knowledge and skills in the interest of the 'public'. Freidson further explains that "*The institutions of professionalism organise and advance disciplines by controlling training, certification, and practice on the one hand, and by supporting and organizing the creation and refinement of knowledge and skill on the other.*" [1]

Kultgen[2] describes that professions have distinctive characteristics, because of the complexity of their disciplines, the importance of their services and the interdependence of their practitioners, as well as their meeting the needs of the population. Bourgeault and Grignon[3] explain that professions can be defined as a means of controlling an occupation or domain of work. Saks as cited in Bourgeault and Grignon.[3] Explains that this control typically involves a system of self-government, restricted recruitment and legal sanctions for a professional domain.

Professions have been described as self-regulating occupations in that professional organizations have monitored education and training requirements, accredited institutional provision of training, awarded and renewed professional licenses, controlled aspects of professional practice and disciplined members. These aspects of internal or self-regulation have been eagerly guarded by professional bodies working to

prevent intervention by state governments. This form of regulation has reflected the importance of trust and confidence in relations between professionals and their clients.[4] Dingwall as cited in Evett[5] explains that it has also reflected trust between states and professions where aspects of the social control of practitioners and service work regulation could be decentralized and delegated, with confidence, to the professional institutions. In addition, these forms of self-regulation have reflected the authority and legitimacy of professions and professionals to organize and run their own affairs.

Physicians are licensed to perform certain procedures and possess the exclusive power to prescribe drugs. Such arrangements limit the opportunity of individuals to medicate themselves or obtain care from unlicensed practitioners. In the case of medicine, physicians are permitted to control entry into their ranks, gain access to the body of knowledge on which medical treatment is based, determine the education and qualifying tests by which individuals become certified to practice, enjoy the right to practice in hospitals and clinics, and impose such discipline over individual practitioners.[5]

According to Rooney and van Ostenberg[6] certification is a process by which an authorized body, either a governmental or non-governmental organization, evaluates and recognizes either an individual or an organization as meeting pre-determined requirements or criteria. When applied to individual practitioners, certification usually implies that the individual has received additional education and training, and demonstrated competence in a specialty area beyond the minimum requirements set for licensure. Parker[7] discussed the term fitness to as being physical or mental fitness and global competence, encompassing clinical competence, acceptable behavior and freedom from impairment – particularly by registration bodies.

For licensure, Rooney and van Ostenberg[6] explains that it is a process by which a governmental authority grants permission to an individual practitioner or health care organization to operate or to engage in an occupation or profession. Licensure regulations are generally established to ensure that an organization or individual meets minimum standards to protect public health and safety. Licensure to individuals is usually granted after some form of examination or proof of education and may be renewed periodically through payment of a fee and/or proof of continuing education or professional competence

In many medical specialties certification is granted by a professional specialty board or colleges to those individuals who have met rigorous requirements, including advanced training in accordance with established educational standards, and have demonstrated specialized knowledge and skill verified through comprehensive examinations.This mechanism provides a means by which to assure the public that a physician who claims to be a specialist is indeed qualified through a professionally-accepted evaluation. Typically the governing bodies of specialty boards are comprised of specialists qualified in the particular field. There is a system of self-regulation among specialists. The certification process benefits from clear standards and standardized processes. This is especially true when certification is new in a country, or when a new area of medicine or clinical practice wishes to establish a certification program.[6]

The American experience in regulating the practice of medicine is deeply rooted, dating back to the colonial era. Most early efforts relied heavily upon state and local medical societies rather than governmental authorities. These societies performed a licensing function by examining prospective candidates for membership into the society. In UK, the General Medical Council was established in 1857. The first Medical Act was issued in 1886 which gave a mandate to General Medical Council to inspect qualifying examination.[8]

In Indonesia, the Law No.29/2004 on Medical Practice Law[9] has mandated the Indonesian Medical Council to regulate the medical profession through their authority of issuing a registration certificate for every medical graduate as one requirement to obtain a licensure from the District Health Office where the medical doctors will be practicing medicine. This Law also mandated the Indonesian Colleagues to issue certificates of competences after medical graduates successfully perform competence-based examination. The newer Law No.20/2013[10] has mandated the Ministry of Education and Culture to

be in charge for the certification examinations and the Indonesian Association of Medical Schools is authorized to carry out these exams.

There are four types of medical regulation as explained by Salter as cited in Chhaparwal,[11] namely self-regulation, physician-led regulation, professional-public partnership, and completely external regulation. From the first to the last, it is a continuum from professional self-regulation to government regulatory framework. Indonesia has opted for the 'professional-public partnership', where there is a balanced involvement of professional, public and the government. This can be discerned from the Medical Practice Law No.29/2004[9] article 14 on Memberships, where the members of Indonesian Medical Council are representatives from government, professional organization, medical schools, and public. The Medical Education Law No.20/2013[10] also reflects the involvement of non-government stakeholders in medical profession regulation.

From the public administration perspective, the professional-public partnership as explained before can be classified as 'collaborative governance'. According to Ansell and Gash[12] collaborative governance brings public and private stakeholders together in collective forums with public agencies to engage in consensus-oriented decision making. Ansell and Gash[12] further suggest the definition of collaborative governance as, *"A governing arrangement where one or more public agencies directly engage non-statestakeholders in a collective decision-making process that is formal, consensus-oriented, and deliberative and that aims to make or implement public policy or manage public programs or assets."*

This definition stresses six important criteria: (1) the forum is initiated by public agencies or institutions, (2) participants in the forum include nonstate actors, (3) participants engage directly in decision making and are not merely "consulted" by public agencies, (4) the forum is formally organized and meets collectively, (5) the forum aims to make decisions by consensus (even if consensus is not achieved in practice), and (6) the focus of collaboration is on public policy or public management.[12] Emerson[13] defines collaborative governance "*...as the processes and structures of public policy decision making and management that engage people constructively across the boundaries of public agencies, levels of government, and/or the public, private and civic spheres in order to carry out a public purpose that could not otherwise be accomplished*".

When the National Competence-based Examination was started back in 2006, the Steering and the Organizing Committee were from representatives of the Indonesian Association of Medical Schools and Indonesian College of General Practitioner. A Joint Committee comprising of these two organizations was established.

The first examination was conducted in 2007. Since then, every year the number of medical graduates who were unable to pass the exams has accumulated significantly. There is no limit to how many times a medical graduate could retake the examination. The accumulative number of medical graduates who did not pass the national competence-based examination already reached the number of 2,500 in 2012. This created tensions and protests from the medical graduates.

The Parliament initiated to propose a Medical Education Law which was decreed as Law No.20/2013.[10] This Law has shifted part of medical education regulations to Ministry of Education and Culture in Article 36 of this Law, final year medical students are compulsory to perform national competence-based examinations before graduation. The implication of these two laws is that there are two national competence-based examinations that must be performed by the medical students, i.e. before and after graduation from medical schools. The national competence-based examination as a requirement to graduate (an exit exam) is conducted under the leadership of Directorate General of Higher Education, Ministry of Education and Culture. The other national competence-based examination is conducted by the Indonesian College of General Practitioners.

Instead of solving problems of sheer number of retakers, the Medical Education Law No.20/2013[10] has created further problems where thousands of final year students could not get their medical degree unless they pass the national competence-based

examination, although they have completed all the requirements from their medical schools and have passed all the local examinations conducted by the medical schools. This has created a bottleneck in many medical schools.

This situation has created a public outcry. To tackle this problem, the Directorate General of Higher Education under the Ministry of Education and Culture signed a Memorandum of Understanding (MOU) with the Indonesian Medical Association in June 2014 to conduct just one national competence-based examination for two purposes, one is as a single exit requirement for graduating from medical schools and the other one as a pre requisite for obtaining a certificate of competences issued by Indonesian Colleague of General Practitioner. This certificate of competences is required for registration at the Indonesian Medical Council.

To follow up this agreement, the Directorate General of Higher Education under the Ministry of Education and Culture instigated a team with a mandate to produce revised guidelines on the national competence-based examination for two purposes. This team comprises of representatives from Indonesian Medical Association (non-government) and representative from Directorate General of Higher Education (government). The members of the team are not directly involved in the execution of the competence-based examination to maintain neutrality. The team worked from December 2014 to January 2015 under the guidance of Steering Committee whose members are from Indonesian Medical Council (government), Indonesian Medical Association (non-government) and Directorate General of Higher Education (government). This guideline was aimed to accommodate the interests of the diverse stakeholders. With this new arrangement of national competence-based examination, a new guideline was needed to clarify the roles of each stakeholder as well as to further detail the procedures.

This study aims at understanding the collective decision making process of the team and the steering committee during the working of revising the guidelines. The author uses the concept of collaborative governance as explained above, taking into account the composition of stakeholders involved in the team and steering committee which are from the government and non-government representatives.

The projected academic benefit of this study is to contribute to the understanding of collective decision making process in collaborative governance. As explained by Ansell and Gash[12] and Emerson et al[13] that collaborative governance is an emerging concept, by understanding the collective decision making process, this study may enrich the concept of collaborative governance, especially the stages to achieve consensus. For the practical benefit, understanding the decision making process in collaborative governance may motivate the collaboration of government and non-government sector which is in line with the decentralization policy in Indonesia.

METHODS

The qualitative methodology is used in this study, particularly naturalistic inquiry approach using a single case study. In qualitative research, researchers are concerned primarily with process, meaning and understanding, and the researcher is the primary instrument for data collection and analysis.[14] Naturalistic inquiry is an approach to understanding the social world in which the researcher observes, describes and interprets the experiences and actions of specific people and groups in societal and cultural context.[15,16] The phenomenon being studied as a single case is the collective decision making process of the team and the steering committee. The data collections were done during three meetings of the team and the steering committees which were conducted from December 2014 to January 2015. The data collected are secondary documents, in the form of minutes of meetings, official documents and meetings notes. Bowen[17] explains that document analysis is a social research method and is an important qualitative research tool in its own right.

For data analysis, thematic analysis is applied which is a form of pattern recognition within the data, with emerging themes becoming the categories for analysis.[18] The process involves a careful, more focused re-reading and review of the data. The researcher takes a closer look at the selected data and

performs coding and category construction, based on the data's characteristics, to uncover themes pertinent to a phenomenon.[17]

RESULTS AND DISCUSSION

Data of this study are minutes of meeting and meeting notes on 19th December 2014, 29th December 2014, 15th January 2015, and revised Guidelines on Competency-Based Examination. After the data were coding and unitized, the emerging themes were categorized using thematic analysis. During the first cycle, there are 24 emerging themes. The second cycle was conducted to identify new emerging themes that underlie several themes, such as internal reflection is a new theme underlying division of roles and conceptual basis. Eventually, from the second cycle six themes were identified. Table 1 shows the emerging themes identified in two cycles subsequently.

Table 1. Emerging themes in the 1st and 2nd Cycle

1st Cycle	2nd Cycle
Preconceptions	Distrust
Prejudice	
Awareness of friction	
Undermine	
Internal friction	
Vacillation of role	
Resignation	
Triggered action	Willingness to listen
Awareness of differentiation	
Agreed matters	
Entailment	
Windup brainstorming	
Awareness of conflict	
Consideration of implication	
Positive thinking	
Aspiration for the good cause	Mutual understanding
Acknowledging differences	
Prejudice elimination	
Awareness of expertise	
Representativeness	
Melting pot	
Willingness to acknowledge	Common goals
Division of roles	Internal reflection
Conceptual Basis	
Reaching agreement	Consensus

The following is description of each theme.

Distrust

When a team was established comprising of diverse stakeholders from government and non-government component, worsened by previous unsatisfactory experiences, a prejudice would naturally come up like in the following excerpt:

> *"...private medical schools deliberately attempted to ease the graduating criteria despite the poor education process. They are riding on the professional organization to achieve this purpose."* (MN lines 7-10)

Willingness to listen

After experiencing distrust for some time, the team would realize that they had differences therefore they needed to listen to each other, as exemplified in the following excerpt:

> *".....there are obstacles and differences that we have to solve."* (MOM1 lines 4-6)

Mutual understanding

Once, all the stakeholders had listened to each other, they began to develop mutual understanding. This is shown in the following excerpt:

> *".....after the meeting had been going on for some time, I began to listen to the other party sincerely. I soon realized that my prejudice about professional organization was not correct. I acknowledged that some of their ideas were very good...."* (MN lines 25-31)

Internal reflection

Once, all parties have gained mutual understanding, they started to conduct internal reflection. They consciously looked at and re-examine their actions, feelings, previous experiences, belief to lead to new perspective, new understanding, like in the following excerpt:

> *".....professional organization should be concerned with medical practice, while medical education should be under the jurisdiction of Government (Directorate General of Higher Education"* (MOM1 lines, 39-40)
>
> *".....each stakeholder has their own roles"* (MOM1 lines 103-108)

Common goals

After the stakeholders have gained new insights of the importance of collaboration, they could agree on the common goals as depicted in the following excerpt:

> *"I agree with the suggestions, I think they are very good and in line with the conceptual basis".* (PD lines 25-31)

Consensus

After the stakeholders changed their feelings, their attitude from previous experiences and had got new perspective to agree on the common goals, they were ready to achieve consensus, as depicted in the following excerpt:

> *"Roles, functions and authorities of each stakeholder in relation to national competence-based examination and certification of competences have been well understood and accepted"* (MOM 2 lines 4-6)

The six themes can be organized into a conceptual framework as depicted in Figure 1. A ladder is used to illustrate how the six themes reveal phases of collaborative governance. The six themes could be used to explain the phases of collaborative governance as follows. It starts with **distrust**, followed by **willingness to listen**, then **mutual understanding** are achieved. Once, there is a mutual understanding, each party is willing to conduct **an internal reflection** on what positive and negative attitudes they should and have adopted. After internal reflection, **the common goals** are discovered. **Consensus** are achieved after each party agreed on the common goals. These six phases could be illustrated as follows:

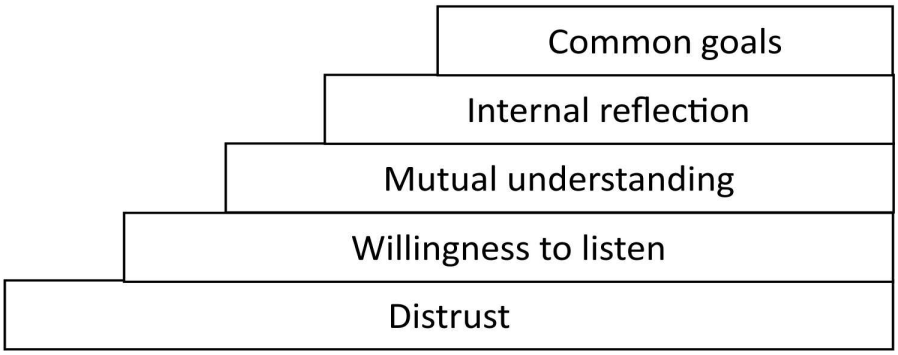

Figure 1. Six Phases of Collaborative Governance

The initiative taken by the Indonesian Medical Council to establish a team representing various stakeholders in the National Competence-based Examination reflects 'a collaborative governance' as explained by Ansel and Gash[12] as well as by Emerson.[13]

The establishment of a new team representing various stakeholders matches the above mentioned criteria of collaborative governance[12] as follows: the forum was initiated by a public agency, in this case the Indonesian Medical Council who is a public agency accountable directly to the President. The participants in the forum include non-state actors, namely Indonesian Medical Association. The members of the team were a combination of government, professional organizations, and educational institutions. The third criteria also matches the definition since during the serial meetings, the representatives from the Indonesian Medical Association and the Indonesian Association of Medical Schools had the same opportunities to contribute in the decision-making process; they were not only just consulted by the Indonesian Medical Council. The forum was funded by the Ministry of Research, Technology and Higher Education and all members were formally invited during the serial meetings. Lastly, this collaborative team was established in order to develop policies and procedures for National Competence-based Examination as mandated by the Medical Practice Law No. 29/2004[9] and the Medical Education Law No. 20/2013[10]. This process is in line with the criteria of collaborative governance that the aim is to make and implement public policy. This is summarized in the following Table 2.

Table 2. Comparisons between the Criteria of Collaborative Governance and Team's Feature

Criteria of Collaborative Governance	Team's Feature
The forum is initiated by the public agency	The forum is initiated by the Indonesian Medical Council (a public agency)
Participants in the forum include non-state actors	The participants are from government (Directorate General of Higher Education) and non-government (Indonesian Medical Association)
Participants engage directly in decision making process	All participants contribute equally during the decision making process
The forum is formally organized	The forum is formal as the participants have a letter of appointment
The forum is aimed at reaching consensus	The purpose of the team is to reach consensus
The focus of the forum is public governance	The forum discusses the public governance of national competence-based examination

Osborne[18] argued the importance of collaborative forms of governance interaction is growing. Benefits of partnership and interagency cooperation are flexible and responsive policy solutions, facilitating innovation and evaluation, sharing knowledge, expertise and resources, pooling of resources, synergy, developing a coherent service, improving efficiency and accountability, capacity building and gaining legitimization.

Potential problems and limitations in partnership and interagency cooperation have been identified by McQuaid as cited in Osborne[19] as follows: conflict over goals and objectives, resources costs, accountability, impacts upon other services, organizational difficulties, capacity building and gaps, differences in philosophy among partners, power relations and community participation.

Some key factors in partnership working which are identified by McQuaid as cited in Osborne[19] are a clear strategic focus, strategic leadership and support, the importance of trust, organizations and people in partnerships, capacity for cooperation and mutualism, organizational complementarity, co-location and coterminosity, incentives for partners and symbiotic interdependency, the value of action and outcome-oriented procedures.

Vangen and Huxham as cited in Osborne[19] mentioned that the theory of collaborative governance has two organizing principles. First, it is structured around a tension between collaborative advantage – the synergy that can be created through joint working and secondly collaborative inertia which is the tendency for collaborative activities to be frustratingly slow to produce output or uncomfortably conflict-ridden. It is also structured around issues that tend to energize those who manage collaborations – their anxieties and rewards. They further explained that there are four conceptualizations and frameworks relating to agreement on aims, trust-building, cultural diversity and attitudes. Emerson[13] suggests that when applying collaborative governance to cross-sector public health approaches in Low and Middle Income Countries, one takes a system approach that acknowledges a complex and dynamic context, uses a design approach informed by a comprehensive institutional and sociopolitical assessment, focuses on the multiple leadership demands of cross-sector collaborative governance.

On the other hand, Ratner[20] proposes three phases in collaborative governance, namely (1) phase 1 is identifying obstacles and opportunities where all stakeholders involve try to come up with common obstacles and opportunities to work on, (2) phase 2 is debating strategies for influence where all parties concern propose which most effective strategies to influence based on phase 1, (3) the last phase is planning collaborative action after phase 1 and 2 have been achieved. The six phases identified in this study enrich the three phases proposed by Ratner. The six phases are developed grounded on the situation where there are conflicting issues and interests among stakeholders and where previous discussions did not give conclusive results. Table 3 summarize how the findings in this study enrich the Ratner's three phases.

Table 3 Comparison between Ratner's three phases[20] and Six phases identified in this study

Ratner's three phases	Six phases identified in this study
Phase 1 is identifying obstacles and opportunities	Phase 1 Distrust Phase 2 Willingness to listen
Phase 2 is debating strategies for influence where all parties concern propose which most effective strategies	Phase 3 Mutual understanding Phase 4 Internal reflection
Phase 3 the last phase is planning collaborative action	Phase 5 Common goals Phase 6 Consensus

The first phase of Ratner is elaborated in this study into two phases. During the distrust phase, not only obstacles are identified but also differences are acknowledged that lead to willingness to listen to each other. The second phase of Ratner is detailed into mutual understanding and internal reflection where all parties re-examine their attitudes and gain new perspective. Phase three of Ratner is planning collaborative action where in this study it is agreement of common goals and achieving consensus for future action.[19]

CONCLUSION

The six phases identified in this research are in line with the concepts of collaborative governance[12] and contribute in expanding the three phases of collaborative governance.[20] This research shows that the steps are not separate entities but reflect phases of how the collaborative partnership has been achieved.

RECOMMENDATION

The six phases in achieving collaborative governance identified in this research might be of use and bring benefits to promote multiagency, multisectoral collaboration and multi professional practice that are recently being endorsed, involving Governments, Indonesian Medical Council, organizational professions, association of educational institutions, and association of teaching hospitals. By referring to the six phases, stakeholders involved in the collaboration might have more confidence to go through the decision making process.

COMPETING INTERESTS

The author declares that there are no competing interests related to this study.

AUTHORS' CONTRIBUTION

Titi Savitri Prihatiningsih collected the data, analyzing the data, writing and revising the publication manuscript

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